Troubled Inside:
Responding to the Mental Health Needs of Men in Prison

Dora Rickford and Kimmett Edgar
# Table of Contents

Preface iv  
Foreword: Erwin James v  

**EXECUTIVE SUMMARY** VI  
**INTRODUCTION** VIII  

**PART ONE: KEEPING MENTALLY ILL OFFENDERS OUT OF PRISON**  

1. **DIVERSION OF MENTALLY ILL OFFENDERS TO TREATMENT** 1  
   1.1 Background to diversion and liaison schemes 1  
   1.2 Measuring the effectiveness of the diversion system 2  
   1.3 Transfers from prison 4  
   1.4 Outcomes of psychiatric admission through the courts 4  
   1.5 The current state of court diversion and liaison schemes 5  

2. **THE CONTEXT OF DIVERSION AND LIAISON SCHEMES** 7  
   2.1 The legal context 7  
   2.2 The absence of a national framework 9  
   2.3 The new partnerships and agencies 9  
   2.4 The lack of adequate funding 10  
   2.5 System wide failures 11  
   2.6 Tension between the health route and the criminal justice route 13  

3. **BARRIERS TO DIVERSION** 15  
   3.1 Failures to identify vulnerability at first contact with the criminal justice system 15  
   3.2 Coverage and quality of court diversion and liaison schemes 16  
   3.3 Criteria for inclusion in diversion schemes 16  
   3.4 Criteria for acceptance by local services 17  
   3.5 Barriers to the use of community placements and NHS facilities by the courts for mentally ill offenders 18  
   3.6 Availability of alternatives to prison 21  
   3.7 Transport to hospital 22  
   3.8 Conclusions 22  

**PART TWO: DELIVERY OF CARE**  

4. **THE PROVISION OF MENTAL HEALTHCARE IN PRISON** 25  
   4.1 The Healthy Prison: a contradiction in terms? 25  
   4.2 The framework for delivery 29  
   4.3 Challenges to the new developments 30  

5. **RECURRING THEMES FOR ACUTELY MENTALLY ILL PRISONERS** 35  
   5.1 The use of seclusion in healthcare centres and segregation for mentally ill prisoners 35  
   5.2 Training and the delivery of care by prison staff 38  
   5.3 Consent and coercion 41  
   5.4 Delays in transferring prisoners into hospital care 43  
   5.5 The Care Plan Approach 44
6. RECURRING THEMES FOR THE MAJORITY OF PRISONERS 47
   6.1 Prisoner escort services 47
   6.2 Reception screening 48
   6.3 Induction and first night arrangements 49
   6.4 Access to mental health services 49
   6.5 Family ties 50
   6.6 Relationships with staff 50

7. PRISONER-PATIENT INVOLVEMENT 53
   7.1 Background 53
   7.2 The importance of involving prisoner-patients 53
   7.3 Defining prisoner-patient involvement 55
   7.4 The nature of involvement 55
   7.5 Methods of consulting service users 57
   7.6 How much involvement is required? 58
   7.7 Barriers preventing prisoner-patient engagement 59

PART THREE: AREAS FOR KEY PRISON SERVICE POLICIES IN RESPONDING TO PARTICULAR MENTAL HEALTH NEEDS

8. SELF HARM IN CUSTODY 63
   8.1 Questions of definition 63
   8.2 Repetitive self harm 64
   8.3 Previous prison policy 64
   8.4 A therapeutic response in the NHS 65
   8.5 The guidelines promoted by the National Institute for Clinical Excellence 68
   8.6 ACCT in the Prison Service 69

9. SELF INFlicted DEATHS: SUICIDE PREVENTION 73
   9.1 Extent of the problem 74
   9.2 Risk factors - personal characteristics 75
   9.3 Risk factors: the social climate of prisons 75
   9.4 The damaging effects of imprisonment 76
   9.5 Population pressures 77
   9.6 Strategies for prevention 78
   9.7 Investigating deaths in custody 81

10. THE DANGEROUS AND SEVERE PERSONALITY DISORDER PROGRAMME 85
    10.1 Background 85
    10.2 Prevalence of personality disorders and mental health problems in the prison population 86
    10.3 Prison mental health services 86
    10.4 The programme for dangerous and severe personality disorder 88
    10.5 Concerns about the DSPD programme 89
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>DUAL DIAGNOSIS</td>
<td>93</td>
</tr>
<tr>
<td>11.1</td>
<td>The extent of dual diagnosis</td>
<td>93</td>
</tr>
<tr>
<td>11.2</td>
<td>The varied nature of dual diagnosis</td>
<td>93</td>
</tr>
<tr>
<td>11.3</td>
<td>Appropriate treatment</td>
<td>94</td>
</tr>
<tr>
<td><strong>PART FOUR: GROUPS WITH PARTICULAR NEEDS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>LEARNING DISABLED PRISONERS</td>
<td>99</td>
</tr>
<tr>
<td>12.1</td>
<td>Background</td>
<td>99</td>
</tr>
<tr>
<td>12.2</td>
<td>Numbers of people with learning disabilities in prison</td>
<td>100</td>
</tr>
<tr>
<td>12.3</td>
<td>Prevalence of mental illness among people with learning disabilities</td>
<td>101</td>
</tr>
<tr>
<td>12.4</td>
<td>The DoH and mental health services in prison</td>
<td>101</td>
</tr>
<tr>
<td>12.5</td>
<td>The prison environment</td>
<td>102</td>
</tr>
<tr>
<td>12.6</td>
<td>Lack of access to treatment programmes, the Human Rights Act and the Disability Discrimination Act</td>
<td>103</td>
</tr>
<tr>
<td>12.7</td>
<td>Conclusion</td>
<td>104</td>
</tr>
<tr>
<td>13</td>
<td>DEAF PRISONERS</td>
<td>105</td>
</tr>
<tr>
<td>13.1</td>
<td>Background</td>
<td>105</td>
</tr>
<tr>
<td>13.2</td>
<td>Numbers of Deaf people in the prison population</td>
<td>106</td>
</tr>
<tr>
<td>13.3</td>
<td>Prevalence of mental illness in Deaf people</td>
<td>106</td>
</tr>
<tr>
<td>13.4</td>
<td>The DoH position and mental health services in prison</td>
<td>107</td>
</tr>
<tr>
<td>13.5</td>
<td>The prison environment</td>
<td>108</td>
</tr>
<tr>
<td>13.6</td>
<td>Lack of access to treatment programmes, the Human Rights Act and the Disability Discrimination Act</td>
<td>110</td>
</tr>
<tr>
<td>14</td>
<td>OLDER PRISONERS</td>
<td>113</td>
</tr>
<tr>
<td>14.1</td>
<td>Background and prevalence of older men in prison</td>
<td>113</td>
</tr>
<tr>
<td>14.2</td>
<td>Prevalence of mental health problems in older prisoners</td>
<td>113</td>
</tr>
<tr>
<td>14.3</td>
<td>The position of the DoH and prison mental health services</td>
<td>113</td>
</tr>
<tr>
<td>14.4</td>
<td>The prison environment</td>
<td>114</td>
</tr>
<tr>
<td>15</td>
<td>PRISONERS HOLDING FOREIGN NATIONALITIES</td>
<td>115</td>
</tr>
<tr>
<td>15.1</td>
<td>Background</td>
<td>115</td>
</tr>
<tr>
<td>15.2</td>
<td>Numbers of foreign national prisoners</td>
<td>115</td>
</tr>
<tr>
<td>15.3</td>
<td>The prevalence of mental health problems in prisoners holding foreign nationalities</td>
<td>115</td>
</tr>
<tr>
<td>15.4</td>
<td>The prison environment</td>
<td>116</td>
</tr>
<tr>
<td>15.5</td>
<td>The DoH and mental health services in prison</td>
<td>117</td>
</tr>
<tr>
<td>16</td>
<td>BLACK AND MINORITY ETHNIC PRISONERS</td>
<td>119</td>
</tr>
<tr>
<td>16.1</td>
<td>BME representation in the prison population</td>
<td>119</td>
</tr>
<tr>
<td>16.2</td>
<td>Scale of mental health problems among BME prisoners</td>
<td>119</td>
</tr>
<tr>
<td>16.3</td>
<td>Particular issues for BME prisoners</td>
<td>120</td>
</tr>
<tr>
<td>16.4</td>
<td>Coercive controls</td>
<td>122</td>
</tr>
<tr>
<td>16.5</td>
<td>Conclusions</td>
<td>123</td>
</tr>
<tr>
<td><strong>PART FIVE: CONCLUSIONS AND RECOMMENDATIONS</strong></td>
<td></td>
<td>125</td>
</tr>
<tr>
<td>References</td>
<td></td>
<td>141</td>
</tr>
<tr>
<td>Appendix</td>
<td></td>
<td>151</td>
</tr>
</tbody>
</table>
Troubled Inside: Responding to the Mental Health Needs of Men in Prison

Preface

This report, the final one in the ‘Troubled Inside’ series, examines the mental health needs of men in prison. Prison Reform Trust (PRT) seeks to improve and accelerate the response from the authorities to offenders with mental health needs. We believe that by receiving timely and appropriate treatment, fewer will be imprisoned unnecessarily.

As part of the Troubled Inside programme, PRT, together with MIND, convened a conference in 2003. In addition, PRT has held three Nuffield seminars, on diversion, the user’s voice, and equivalence in care. Contributions to these events have informed this report.

Prison Reform Trust wishes to thank the Nuffield Foundation for supporting the research and publication of this Report. We are indebted to the following: Dr David James, Dr Adrian Grounds, Dr Monteiro of Alpha Hospitals, Dr Lorna Duggan of St Andrews Hospital, The Sign Charity, Nuala Mole and Clair Murray from the AIRE Centre (Advice on Individual Rights in Europe), Tish Laing-Morton (Prisons Inspectorate), Kathy Biggar (Safer Custody Group), and Dr Janet Parrott from the Bracton Centre who have given invaluable support and guidance in its preparation.

At PRT, we thank: Juliet Lyon for supervising the project through to completion; Diana Ruthven for managing the printing; and Mairi-Clare Rodgers for help in preparing the manuscript for publication.
Foreword

Erwin James

Every person in prison is vulnerable, but the most vulnerable are those with poor mental health. Though prison can seem like a refuge for many such people, providing as it possibly does some relief from difficult lives outside, the demands it places on them soon overwhelm any merit it might have appeared to offer as a sanctuary. While it may be true that it is frequently the most vulnerable who present the biggest danger in society, there must be a more well thought out response than to subject them to the robust and unforgiving routine of regular prison life for any length of time. For prison life is not conducive to feelings of well-being. Neither does it encourage consideration for others.

Even for those who are relatively well the mental pressure that prison life creates among prisoners is intense. Yet fellow prisoners and unscrupulous members of staff often treat those who exhibit signs of mental distress with disdain. I once tried to explain to a wing probation officer that the life we led on the landings was badly affecting the mental health of many of us. He said to me, “Are you saying you are mentally ill?” The last thing I wanted on my record was anything that might complicate my “progress” so I quickly backtracked and said that this was just my observation. I kept to myself the fact that I hadn’t had a full night’s sleep for months, that I felt constantly anxious, that I was having to drag myself out of bed in the mornings and that the times when I felt that I could not face another day of life on the wing were becoming more frequent. “All I’m saying,” I said, “is that it isn’t doing any of us much good.”

On the wing there was plenty of evidence of behaviour brought on by mental distress, from those who neglected their personal hygiene, to people who would “smash up” (wreck their cell furniture and fittings) during bang-up. Some stood out more than others. One young man only ever wore the same pair of jeans and a green nylon cagoule. He never wore shoes or socks, never went out on exercise, hardly spoke to anyone and was understood to have been taken advantage of sexually by predatory prisoners. He was in his early 20s with many years in prison still ahead of him. Another had a habit of inserting objects into his body: a pencil in an arm, matchsticks in his ankles. He was marked down as “manipulative” by prison officers, and called a “Fraggle” by fellow prisoners.

It came as no surprise to me therefore when I read in this report that 72 per cent of sentenced male prisoners suffer from two or more mental disorders. Nor was I surprised when I read of the case of a prisoner who had been awarded 7 days cellular confinement for damaging prison property, even though the property had been damaged while the man had been attempting suicide. Such instances of insensitivity were not uncommon in my experience.

The plight of the mentally ill in prison has been neglected from the prisons debate for too long. This report brings the issue to the forefront of that debate with rigorous and forceful detail.
Executive Summary

This report, the third in PRT’s Troubled Inside series, aims to prompt a long overdue coherent response to the mental health needs of men in prison.

The lack of an integrated, national system of court diversion and liaison schemes means that many people who have serious mental health problems are not being identified at an early stage in the criminal justice process. The under-investment in comprehensive community mental health services combines with the failures of diversion, resulting in prisons being used to warehouse, in unacceptable conditions, people who have significant mental health problems. The rates of mental illness among prisoners demonstrate that the Prison Service has become a back-up social and mental health service, as well as a breeding ground for despair and poor mental health.

Part one of this report explores why men who have mental health problems end up in prison. The court diversion and liaison schemes, covering police stations, the courts and prisons, are intended to identify mental health problems early, ensure that people charged with, or convicted of, offences get appropriate help and treatment, and are kept out of the prison system. Custody is an ill-suited environment for managing mental health and prisons and prison staff have profound difficulties coping with the complex needs of mentally ill offenders. Home Office research is cited, which finds that re-offending rates of offenders using court diversion schemes are improved, with better treatment outcomes. The report examines why these encouraging results have not been more actively developed and promoted by the government.

There have been some positive developments. Mental health in-reach workers have been established in over 100 prisons. The Department of Health has undertaken responsibility for commissioning prison healthcare. The report discusses the newly expanded role of Primary Care Trusts (PCTs) and health care commissioners in providing mental health care in prisons. When these developments are assessed against the principle of equivalence - that people in prison should have access to an equal standard of healthcare as in the community - the conclusion is that the gap between prison and community health service is, if anything, widening. Equivalence in mental healthcare, while laudable and supported by heroic efforts by healthcare staff, is unattainable in present conditions, because of the high mental health morbidity of prisoners, the low level of existing services in prison, the pressure of overcrowding and the ‘churn’ factor, which can result in prisoners being moved around the country with little notice, away from families, and losing any continuity of care.

Part two of this report describes how prisons are coping with mentally ill prisoners. The mental health of prisoners needs to be considered in the context of the ‘healthy prison’. The failure to make prisons healthy environments affects the mental health of all prisoners. The mental health of many deteriorates as a result of the stressful conditions within the prison environment and culture.

Section 5 focuses on the group of about 5000 prisoners who have a severe and enduring illness. The report discusses the use of seclusion and segregation as a control mechanism or to house people during long delays until they can be transferred to psychiatric services. When segregation is used in NHS hospitals, it is governed by a code of practice under the Mental Health Act 1983, and routinely monitored and inspected. Also discussed are questions about prisons managing people with mental illness in relation to consent and coercion, lack of aftercare, and training of prison staff. Section 6 discusses treatment for the vast majority of prisoners, many of whom suffer from anxiety, depression, and other mental health problems. The need to engage users of services, now widely recognised in NHS services in the community, is just as relevant in the prison environment. But service user involvement presents unique challenges in custody.

Self-inflicted deaths and self-harm are discussed in Sections 8 and 9. These acts reflect the levels of distress among prisoners and witness to the dysfunctional impact of the prison environment. The
focus in this report is on a new prison procedure (Assessment, Care in Custody and Teamwork). A comparison with guidelines from the National Institute of Clinical Excellence (NICE) shows room for improving the prison's responses to self harm and the risk of suicide. The role of the Prisons and Probation Ombudsman in investigating self-inflicted deaths is also explored. New developments in the response to people with dangerous and severe personality disorder are examined in Section 10. Also discussed is how many men in prison have a dual diagnosis of mental health and substance misuse.

The misuse of prison as a disposal for mentally ill offenders seriously affects the ability of the Prison Service to meet its core objectives. Training prisons, for example, are now being required to cope with offenders who are not suited to the regime. Managing disruptive and ill prisoners takes prison staff away from their core duties and, because training of staff is often inadequate, officers are poorly equipped to respond to needs of men who are mentally ill.

Part four looks at groups with particular needs. There is a marked failure to address the needs of mentally ill offenders, who also have learning disabilities, or rely on sign language or are hard of hearing, are elderly, or hold a foreign nationality. These offenders may have particular mental health problems and face exclusion, discrimination, misdiagnosis and neglect in prison. Black and Minority Ethnic people who have mental health problems also face difficulties in a prison system which is not geared to respond to their needs.

The annex to the report, prepared by the centre for Advice on Individual Rights in Europe (AIRE) provides an analysis of human rights legislation and recent case law as they affect the delivery of mental health care in prison.

The report outlines a framework for the future developments that are essential to redress the failures of mental health care for offenders. It is crucial that offenders are recognised as part of the community and that it is in everyone's interest to ensure that they get necessary treatment and support.

- Prison should be restricted to those offenders who represent a real danger to the community. Other offenders should be convicted in the courts if appropriate, and alternative criminal justice outcomes sought with necessary mental health and social provision for those offenders who have fallen through the net.
- Policies such as the national service framework for mental health need to suggest a particular model of service for diversion and liaison services and include it in performance assessments and monitoring. Practice should reflect this with more inclusive front line services.
- Government, as part of its agenda for reducing re-offending and promoting public safety, need to require health and social care commissioners to include offenders in their plans and to provide the funding for their needs to be met.
- The failure of services for offenders who have learning disabilities or are Deaf needs urgently to be addressed.
- Research is needed into how the mental health problems (and their manifestation) of Black and Minority Ethnic offenders is interpreted by the prison service. There needs to be improved training in cultural awareness for all service providers.
- The objective of equivalence of services within prison must be supported by more than rhetoric. The level of funding must be matched to the level of need, with clear lines of accountability and responsibility and the same inspection and monitoring regimes as exist in the community.
Introduction

As prisons continue to be overcrowded, prison healthcare becomes ever more vital. Responsibility for providing the full healthcare needs of prisoners is being transferred to the NHS and Primary Care Trusts (PCTs). In that context, this report addresses the following key issues:

- Why are court diversion and liaison services failing to keep mentally ill offenders out of the prison system?
- What effect does this failure have on the ability of prisons to meet their primary objectives?
- Which groups in prison are particularly at risk?
- How is mental health care delivered in prisons?
- What challenges does this service face?
- How is the voice of the mentally ill prisoner heard and responded to?
- How are family and community links, essential to rehabilitation and recovery, sustained?
- What constitutes a 'healthy prison' and how do levels of distress in a prison affect levels of suicide and self harm?
- What will be the effect of the new mental health bill and recent European Court of Human Rights decisions?

The backdrop to this report is the increasing numbers of offenders in prison. The population on 7 October 2005 stood at 77,373. The number of prisoners in England and Wales has increased by more than 25,000 in the last ten years. Over the last year prison overcrowding has been at its highest recorded level. At the end of July 2005, 74 of the 139 prisons in England and Wales were overcrowded. In December 2004, a retired professor of forensic psychiatry wrote to the Guardian:

‘Already we top the European league table for the numbers per capita of population of young and adult offenders detained in prisons. The USA has a per capita prison population some five times larger than ours, held in conditions of frequent terrifying harshness, with self harm and suicide rates to match. It seems that this is the system which our policy makers are determined to emulate, as they compete in the law and order Olympics.’

(Cordess, 2004)

Since he wrote, the prison population of England and Wales has risen less swiftly than another Western European state, so it is no longer the top of the table. But it is revealing that a forensic psychiatrist should find reason to compare the situation here with the United States.

Social deprivation marks the backgrounds of many offenders. The Social Exclusion Unit (SEU, 2002) found that, compared with the general population, prisoners are thirteen times as likely to have been in care as a child, thirteen times as likely to have been unemployed and ten times as likely to have been a regular school truant.

A survey by the Office for National Statistics (Singleton, et al., 1998) found that the majority of prisoners suffer from a mental disorder. The extraordinarily high levels of mental illness in the prison population contrast starkly with the rates in the UK general population. The ONS used similar diagnostic and assessment methods for the population as a whole in 2000. The comparisons demonstrate the extent of the problem.
Table One
Mental Health of Prisoners
Compared with the General Population

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<thead>
<tr>
<th>Characteristic</th>
<th>General Population</th>
<th>Prisoners</th>
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<tr>
<td>Suffer from two or more mental disorders</td>
<td>5% men 2% women</td>
<td>72% male sentenced 70% female sentenced</td>
</tr>
<tr>
<td>Suffer from three or more mental disorders</td>
<td>1% men 0% women</td>
<td>44% male sentenced 62% female sentenced</td>
</tr>
<tr>
<td>Neurotic disorder, i.e. sleep, worry, anxiety and depression</td>
<td>12% men 18% women</td>
<td>40% male sentenced 63% female sentenced</td>
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<tr>
<td>Psychotic disorders, i.e. schizophrenia and manic depression</td>
<td>0.5% men 0.6% women</td>
<td>7% male sentenced 14% female sentenced</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>5.4% men 3.4% women</td>
<td>64% male sentenced 50% female sentenced</td>
</tr>
</tbody>
</table>

(SEU, 2002)
1. Diversion of Mentally Ill Offenders to Treatment

This first section of the report describes the background to diversion and liaison services from the early 1990s. It examines the current uses of sections of the 1983 Mental Health Act to keep mentally ill offenders out of prison. It highlights research which points to the effectiveness of court diversion in reducing re-offending and treating mental illness. The report draws on the broader context to suggest why so many mentally ill offenders go to prison, before turning to some of the barriers which offenders with mental health problems will face as they progress along the criminal justice route.

1.1 Background to diversion and liaison schemes

There is a long history of concern about the numbers of mentally ill offenders held in prison. The problem remains endemic and has yet to be adequately addressed.

In 1992, Dr John Reed referred to Thomas Holmes’ description of courts from 1900:

… “the ever increasing army of the demented” coming before magistrates courts, the remanding of defendants for medical reports and the training needs of prison doctors.

(Reed, 1992; from Holmes, 1900)

The Reed report (1992), based on his review of services for mentally disordered offenders, contained 278 recommendations, of which 18 were specifically about diversion, discontinuance and transfers out of prison. Many of these recommendations are as relevant now as in 1992, or for that matter, 1900.

Diversion refers to processes that identify seriously mentally ill defendants in courts and police stations, and divert them to NHS treatment, and away from prison. Once in prison, the process for removing mentally ill prisoners into NHS care involves transfers, and is covered later in this report.

In the 1990s, the surge of interest in diversion was precipitated by the extent of mental illness in the prison population, and in particular, in the remand population (Maden et al., 1996). Diversion could achieve two objectives; increasing the identification of mental illness and making a transfer to hospital quicker.

The Home Office and Department of Health issued a joint circular, Home Office circular 66/90, on the arrangements for mentally disordered offenders. The responsibility for providing treatment for offenders with mental health problems was now to belong to both health and social services. The Department of Health encouraged joint working between these two agencies so that they used powers they had.

Diversion and liaison schemes needed to cover the full range of defendants, from people whose mental state did not justify hospital admission but who needed to be linked into community agencies and services (through court liaison) to those who needed to be diverted to hospital either voluntarily or under the Mental Health Act 1983. In order to be fully effective, these schemes needed to cover key stages in the offenders’ criminal justice route, starting at the point of arrest (usually the police station) continuing onto the court and following on to the prison.

Court assessment schemes were set up at a number of sites so that psychiatrists could divert mentally disordered defendants from custody. Home Office circular 66/90, referred to above, commended one such operation in Peterborough. A study by Dr David James of the service at Clerkenwell magistrates courts (James, 1991) showed the benefits of the scheme. The mean time from arrest to hospital admission was reduced from 50.8 days to 8.7 days. Clear evidence of the benefits to mentally ill people of such schemes has thus been available for over ten years.
those assessed, but not sent to hospital, the mean time from arrest to appearance in court with a report was 5.4 days, compared with 33.7 days for those assessed in prison (James, 1991). Again, there was clear evidence of the benefits.

The Reed report recommended the development of services and facilities and proposed changes to the law. The most significant legislative proposal was intended to remove or restrict the courts’ powers to remand to prison for the primary purpose of medical assessment (Reed Committee Report, 1992). The reasoning behind this was explained by the Committee’s Prison Advisory Group:

> ‘In principle it is wrong that courts should be able to remand to prison for the primary purpose of medical assessment. It is also an unjustifiable use of the prison system. … Achieving a policy aim of diverting the mentally disordered from prison requires not only alternative provision but also a restriction in the powers and incentives which encourage existing bad practice to continue. Most of the mentally disordered entering the remand prison population have been remanded by magistrates courts for medical reports.’

(Reed Committee Report, 1992)

1.2 Measuring the effectiveness of the diversion system

A range of evidence is needed to establish how well the diversion system is working. One source compares data on formal admissions under the MHA 1983 directly to NHS and independent hospitals with those via the courts and prison. Further evidence compares diversions from courts with transfers from prisons. There is also evidence from monitoring visits by the Chief Inspector of Prisons (HMCIP) and from Dr John Reed.

Looking first at evidence from within prisons about the numbers of acutely mentally ill offenders, Dr Reed estimated in 2003 that prison health care centres were holding up to 500 prisoners who were sufficiently mentally ill to require immediate NHS admission (Reed, 2003). On the basis of visits to local prisons, the Chief Inspector of Prisons estimated that 41 per cent of prisoners being held in health care centres should have been in secure NHS accommodation (HMCIP 2002a).

John Reed’s estimate refers only to prisoners being held in prison healthcare centres. If we add the number on normal location, in segregation units, and in vulnerable prisoner units, the number who should be in NHS accommodation would be much higher. Dr Adrian Grounds recently stated in an article by Nick Davies:

> ‘The scale of the problem is huge. Based on the best research we’ve got it may be that about four per cent of prison population need to be in hospital beds and in current terms that means something in the order of 3000 prisoners, possibly up to 3700, need to be in a psychiatric hospital.’

(Davies, 2004)

Evidence also demonstrates that the problem is getting worse. People who have severe mental health problems and who come into contact with the criminal justice system (CJS) are more likely now than in 1992 to receive a punitive response rather than a therapeutic one.

Department of Health statistics show that in the past decade, while the total number of people admitted to NHS and independent hospitals under the Mental Health Act 1983 has increased steadily, the number of court and prison MHA disposals to these facilities has fallen.
Table Two
Total formal admissions to all hospitals under the Mental Health Act compared to those Mental Health Act admissions via Court and Prison 1993-2004

<table>
<thead>
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<th></th>
<th>1993-4</th>
<th>2003-4</th>
<th>Percentage difference</th>
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<tr>
<td>Total formal MHA admissions</td>
<td>23,766</td>
<td>26,235</td>
<td>+10%</td>
</tr>
<tr>
<td>Court and prison MHA disposals</td>
<td>2253</td>
<td>1601</td>
<td>-29%</td>
</tr>
<tr>
<td>Court and prison disposals as a proportion of total MHA admissions</td>
<td>9.5%</td>
<td>6.1%</td>
<td>-36%</td>
</tr>
</tbody>
</table>

(DoH, 2004)

This chart shows that the total number of people formally admitted to hospital under the Mental Health Act in England rose by 10 per cent between 1993/4 and 2003/4. In the same period, the number of court and prison disposals fell by 29 per cent.

It appears that the share of secure mental health places devoted to offenders has decreased in the years from 1993/4 to 2003/4 by over a third. This decrease has coincided with an increase of over 25,000 to the prison population. The increase in the prison population and their higher prevalence of mental health problems would lead to the expectation that the use of MHA disposals from the court and prison would have increased rather than the reverse.

The declining use of MHA sections which would enable an offender to be transferred to hospital at an early stage of the criminal justice process illustrates how court diversion has failed to make a real impact. If these schemes were well established, one would expect to see a rise in the use of these sections of the MHA.

Table Three
Declining use of MHA sections to admit accused and offenders to hospital from court 1992 - 2003

<table>
<thead>
<tr>
<th></th>
<th>1993-4</th>
<th>2003-4</th>
<th>Percentage difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 35 Accused remanded to hospital for report</td>
<td>320</td>
<td>141</td>
<td>56%</td>
</tr>
<tr>
<td>Section 36 Accused remanded to hospital for treatment</td>
<td>65</td>
<td>14</td>
<td>78%</td>
</tr>
<tr>
<td>Section 37 with S41 restriction Convicted person sent to hospital for treatment with restriction</td>
<td>400</td>
<td>235</td>
<td>41%</td>
</tr>
<tr>
<td>Section 37 without restriction</td>
<td>578</td>
<td>319</td>
<td>44%</td>
</tr>
<tr>
<td>Combined section 37 &amp; 37/41 all Hospital orders</td>
<td>1027</td>
<td>554</td>
<td>46%</td>
</tr>
</tbody>
</table>

(DoH, 2004, Table 1, Page 15)

These figures, which cover a ten year period, point to a 46 per cent decline in the use of this key section of the MHA which would enable an early transfer of offenders to hospital.

Further data are available from Home Office statistics. Although these figures are not comparable to DoH statistics, they provide another indication of the position in the last ten years.
Table Four
Convicted offenders diverted to hospital by the courts Under MHA Section 37

<table>
<thead>
<tr>
<th>MHA Section</th>
<th>1993</th>
<th>2003</th>
<th>Percentage reduction in ten years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 37 with restriction</td>
<td>218</td>
<td>196</td>
<td>10.1 %</td>
</tr>
<tr>
<td>Section 37 without restriction (1) &amp; (3)</td>
<td>670</td>
<td>559 (provisional)</td>
<td>16.6 %</td>
</tr>
</tbody>
</table>

(ONS, 20040)

These figures confirm the trend noted above. In the ten year period from 1993, there has been a 10 per cent reduction in offenders diverted from prison and admitted to hospital under a section 37/41 from 218 in 1993 to 196 in 2003. The figures for those admitted to hospital under an unrestricted hospital order fell by 16 per cent from 670 in 1993 to 559 in 2003. The significance of the increasing use of restriction orders will be raised later in this section.

1.3 Transfers from prison

The situation faced by offenders who have been sent to prison, either on remand or sentenced, and need to be transferred to hospital is, in many ways, worse than in court.

Home Office statistics show that in the period 1993 to 1999, the numbers of prisoners transferred from prison to hospital under a section 47 or 48 fluctuated between 723 and 785 per year. Since then, the number fell to 662 (2000) and to 635 (2001) before rising to 644 in 2002 and 721 in 2003. The 2003 figure represents a 12 per cent increase over the 2002 figure and is welcomed.

However it needs to be highlighted that of these 721 transfers to hospital from prison:

- 425 (59 per cent) were untried or unsentenced (and so, under the MHA 1983 were in ‘urgent need of treatment’)
- 296 were transferred after sentence;
- 96 returned to prison from hospital after treatment to resume their sentence.

(Home Office, 2004a)

In summary, the data clearly illustrate the failure to provide mentally ill offenders access to appropriate mental health services. Given the apparent impetus to develop court diversion and liaison services discussed earlier, the declining use of the Mental Health Act 1983 to divert offenders from custody in court requires some explanation. Could it be because diversion is not an effective use of scarce resources?

1.4 Outcomes of psychiatric admission through the courts

A study on the outcomes of psychiatric admissions through the courts demonstrated that in two very important aspects - improving mental health and reducing re-offending - diversion is significantly more effective than prison custody (James et al., 2002). These findings should be informing government strategy.

The research showed that people admitted from court were no less likely than community admissions to benefit from mental health treatment. In addition there was no significant difference in rates of re-admission between court and community cases and the majority were not re-admitted within two years. Nor did the court admissions need to spend longer in hospital. Dr James concluded that admissions to hospital were not inappropriate nor were persons with personality disorders being misdiagnosed at court as mentally ill.

Treating mentally ill people works in reducing re-offending. The two year reconviction rate of court admissions to hospital of 28 per cent is half that of standard rates for people given non-medical disposals at court. For those with a similar age and offence profile given a custodial sentence these are 56 per cent and for community penalties, 58 per cent.
‘This is a similar figure to that in discharges from maximum and medium secure facilities. From these results, there is no justification for the view that diversion to hospital is a ‘soft option’ or that it fails to offer public protection. On the contrary, these results indicate that it may constitute an effective means of crime reduction in those suffering from mental illness.’

(James et al., 2002)

1.5 The current state of court diversion and liaison schemes

Writing about court diversion schemes almost 15 years ago, Dr James sounded a caution about their future:

‘Unless some degree of central pressure is applied, it is unlikely that any but the most integrated services will remain in another 10 years time.’

(James and Hamilton, 1991)

This worrying conclusion was amply borne out by Nacro’s 2004 survey of court diversion/criminal justice mental health liaison schemes for mentally disordered offenders in England and Wales.

Nacro showed that some areas of the country are without any coverage. A pilot scheme had been discontinued in Avon and Wiltshire and to Nacro’s knowledge there were no schemes covering North Wales. Areas that are covered have schemes that are increasingly at risk. Nacro’s 2004 survey shows that 25 per cent of schemes had seen a decrease in staffing levels in the last year; and 30 per cent cited staffing issues as a barrier to the schemes operating. Nine percent of schemes had seen a reduction of their funding. A third were operating with only one member of staff. Half had no sessional input from either a psychiatrist or a psychologist.

The lack of a clear pathway of care through the criminal justice system for mentally ill offenders means that there is likely to be significant waste of professional resources and poor outcomes for mentally ill offenders caught up in the interface between prison and hospital.

What are the barriers to court diversion and what are the levers for change? Unless change is made, mentally ill offenders will continue to enter the prison system with the result that prisons will still be required to house some of the most vulnerable members of society. A deputy governor recently described his prison as ‘a mental asylum in all but name’ (in conversation with PRT).

We can understand better how the current situation has developed by looking first at the context in which the diversion process operates; and second, at the various barriers faced by an offender as he progresses through the criminal justice system (CJS). Consideration can then be given to how this situation can be reversed.
2. The Context of Diversion and Liaison Schemes

Section two looks at how diversion schemes fit into the larger picture. Six factors bear analysis, starting with the legal framework which defines what rights offenders have to treatment. The absence of a national framework and political will has had a major impact on the failure of court diversion and liaison services to become established as a service with minimum standards and quality control. The new partnerships and agencies in an integrated social and health care model have potential to be a lever for change but the lack of committed and adequate funding has had a fundamental impact on the ability of services to get off the ground. System wide failures have resulted in bottlenecks at key stages of care such as medium and low secure facilities. There is a tension between the health route and the criminal justice route. Consequently, the danger is that it might be considered more acceptable to provide mental health care in prisons rather than in the community for offenders.

2.1 The legal context

It often surprises professionals and practitioners in the field, who retain a sense of moral outrage about how mentally ill offenders fare in the CJS, how rare it is for prisoners who have mental health problems to complain about the level of service they receive. It is also quite unusual for any legal action to be brought by these men or their families to redress failures in the system. It is also quite rare for responsibility or blame to be apportioned following tragedies that occur within the system. There seems to be lack of accountability and transparency about who is responsible when things go badly wrong.

Certain rights are enshrined within the Human Rights Act (HRA) such as:

- (Article 2) the right to life
- (Article 3) the right not to be subject to torture or cruel and inhuman treatment or punishment
- (Article 5) the right to liberty and security of person, which includes the lack of arbitrary detention.

In law, negative rights are stronger than positive rights. It is harder to argue that the state must do certain things than that there are things it cannot do. Nonetheless, positive rights can help determine how a mental health service is provided. There is no overall right to treatment, and offenders with mental health problems have no right to treatment rather than punishment. It could be argued, as it has been in certain European cases, that it is contrary to Article 5 to imprison a mentally disordered offender.

The effect of human rights legislation on the delivery of mental health care in prison is analysed in an annex to this report prepared by the AIRE Centre (Advice on Individual Rights in Europe).

Under the current MHA 1983, the courts do not have the power to order a defendant or an offender with mental health problems into hospital treatment, even with a clinical assessment that they need treatment. A hospital must agree to take him or her. In order to use a section 37, a bed needs to be available within 28 days. If this cannot be found, apart from constantly returning the offender to court for sentencing (as happened in R v Galifetti, 2002), the courts’ only recourse is to send the person to prison unsentenced for clinical reports.

Until an offender is transferred out of prison under a section 47 or 48 - and delays can last several weeks - compulsory treatment cannot be given for mental illness under the MHA because he is not in a hospital. The patient’s mental health is very likely to deteriorate during those weeks in
custody, compounded by the uncertainty of remand status; and during this time, the Prison Service must struggle to meet his needs until the transfer can be arranged. This report will show that the way in which these patients are managed is damaging for the patient and limits the ability of the Prison Service to carry out its core tasks.

The Draft Mental Health Bill

The draft mental health bill will provide a new power to remand on bail for a mental health report (Clause 86). There is also provision to remand to hospital for medical reports (Clause 88); and to remand to hospital for medical treatment (Clause 93). The last two powers exist already under the existing MHA Act (section 35 and 36), but these powers are underused. Magistrates have no means of securing compliance with them. For these new sections to be effective these factors need to be addressed. The bill would introduce this power for a wider group of offenders, who come within the new broader definition of mental disorder in the draft bill. But the new bill fails to address some key issues.

The most crucial of these is the failure of the bill to provide new but necessary powers for the court to enforce such orders. Nor does it follow the recommendation of the Reed Committee Prison Advisory Group that government should remove or restrict the courts’ powers to remand to prison for the primary purpose of medical assessment. These problems will remain unless there are additional resources for mental health, including essential facilities such as extra local psychiatric beds.

The bill provides for possible assessment in the community for offenders. But a risk-averse culture and shortage of suitable bail provision is likely to have an adverse affect on decisions about community assessments for offenders. Clause 86 provides for ‘remand on bail for mental health report’. Subsection (4) provides that courts ‘may require’ a mental health report. The magistrates court has a discretion to require a report and whether they use it will depend on the defence solicitor making the point or the clerk to the court advising the court or magistrates themselves being aware of this provision.

Clause 88 of the draft mental health bill would give the courts power to remand to hospital for mental health report provided two conditions are met. The first is that the person must be suffering from a mental disorder on the evidence of a registered medical practitioner and the second is that the court must believe that it would be ‘impracticable’ for the report to be made if the person were remanded in custody. It is not clear exactly what this means or how it will be interpreted by the courts but it seems to imply that it would be preferable if a report could be done in prison. This would continue the present unsatisfactory situation in which people are sent to prison to facilitate the preparation of a mental health report.

Clause 116 (5) (a) of the draft mental health bill specifies that the admission to hospital must be within 28 days beginning with the date of the order; and clause 120 (4) states that:

“If because of an emergency or any other special circumstances, the patient cannot be admitted within the period under subsection (b) i.e., 28 days, the court may discharge the mental health order and deal with him in any way in which it could have done if that order had not been made.”

These clauses also repeat the current unsatisfactory situation.

Subsection (2) of Clause 120 retains the power to convey to and detain to ‘a place of safety’ for those patients pending an admission to hospital. However, levels of victimisation, self harm and suicide demonstrate that prison is far from a place of safety for a mentally ill offender.

Without more resources and much clearer power to the court, the present situation is unlikely to change significantly for mentally ill offenders who come before the courts. Indeed as indicated above, the bill may possibly make the situation worse. There is a strong argument for an amendment to the draft bill making it unlawful to send someone to prison when the court is satisfied on medical evidence that they should be in hospital.
2.2 The absence of a national framework

At the time of the Reed report, in 1992, the aim, to which the government was committed, was to ensure that:

… ‘wherever possible, mentally disordered offenders should receive care and treatment from health and social services rather than the criminal justice system.’

(Tim Yeo, Sec of State for Health 1992, in his introduction to the Reed Report)

At present, the role of central government with regard to court diversion and liaison services is ambiguous. The Care Service Improvement Partnership, which will be discussed in the next section, works to a national programme which recognises many of the key issues. The present policy of allowing latitude for local areas to find the best solutions for achieving standards is unlikely to produce the necessary outcomes for court diversion without a much stronger steer from the government and political will to make the required changes.

Government policy rightly highlights the importance of preventing re-offending yet its recent document ‘Reducing Re-offending: National Action Plan’ Home Office, (2004b) fails to grasp the research evidence discussed in the earlier section which shows the importance of much earlier mental health intervention and treatment. Hence, the National Action Plan has minimal reference to court based mental health diversion/liaison schemes.

What is urgently needed is a service-wide strategy to reduce offending through a national network of diversion and liaison schemes. This needs clear direction from government, to Primary Care Trusts (PCTs) and providers/commissioners of services, to provide court diversion services.

The government has so far failed to provide any of the tools and guidance required to make a comprehensive diversion system work. There are no blueprints for a national service with minimum requirements, no audit and no quality controls. Other mental health initiatives, such as assertive outreach teams and early intervention, have been informed and encouraged by, for example, the mental health policy implementation guide (DoH, 2001a). The plethora of guidance documents and targets by central government which encompass other areas of mental health are significantly absent in the critical field of diversion. It is a non-governmental agency, Nacro, which has taken the welcome initiative to publish a series of standards starting with initial contact with the police, which proceed through to the court, the prison and the community (Nacro, 2005).

Diversion schemes require accessible hospital places for seriously mentally ill defendants and offenders, in order to get them the treatment they need. Unless diversion services are an integral part of core local psychiatric provision with access to beds (James et al., 2002) these services will fade away.

Opportunities were missed in the National Service Framework (NSF) to dictate or even suggest a particular service model. Standards four and five of the NSF task local health and social care communities to focus on “implementing arrangements and, where appropriate, care of people who are detained by the police, brought before a court or are in prison” (DoH, 1999).

But the NSF does not clarify that such arrangements need to be integrated into local mental health services. Nor does it include them in the list for performance assessment or monitoring through local milestones.

2.3 The new partnerships and agencies

The lack of national strategy and political will to support court diversion and liaison services needs to be seen against an institutional landscape which has seen some seismic changes. The key players in the evolving new agencies and partnerships face considerable challenges. There are fresh opportunities for new joint working and better oversight of the continuum of care needed by mentally ill offenders. But there are dangers that the policy-makers and practitioners will be
overwhelmed by the change agenda required by government and diversion and liaison services will fail again to become a priority.

Some of the players at the national level include the new Health Partnership Directorates, Care Services Improvement Partnerships (www.csip.co.uk) and National Offender Management Service (NOMS). Identifying the problems they face is not the difficult part. For example, through its Health in Criminal Justice programme, the South East Development Centre is seeking to develop integrated working between the criminal justice and health systems. This centre has specifically cited court diversion and liaison schemes in its draft strategic plan for 2005-2007. The real challenge is to unpick the entrenched problems that are so evident.

At a regional and local level Primary Care Trusts (PCTs), the hubs of the National Institute of Mental Health in England (NIMHE), Regional Offender Managers (ROMS) and Strategic Health Authorities (SHAs) amongst others need to have a central role in court liaison and diversion.

‘Multi-agency working’ has undoubtedly produced valuable links between local agencies, but frequently no single agency is required or mandated to take the lead with overall responsibility and control of the process. As a result, local health providers and purchasers have been able to avoid the responsibility of playing that critical central role.

Without a clear impetus from government this is unlikely to happen. PCTs, SHAs and NIMHE need to be encouraged to integrate court diversion and liaison into their already overstretched local services. How could this be achieved?

One possibility is to make effective use of the existing ‘audit culture’. Central government could be encouraged to widen targets for Health and Social Care Trusts to include the performance of court diversion schemes. In a similar vein, chief executives of regional agencies with responsibility for delivering health and social care could have diversion and liaison schemes as part of their agreed overall objectives against which their individual performance is reviewed. Another route would make mental health court diversion and liaison schemes mandatory for PCTs within their local delivery plans.

Whether the situation will improve under the new National Health in Criminal Justice Board remains to be seen. What is clear is that, without much-improved co-ordination and a clear sense of what is needed, offenders who have mental illness and need treatment from mental health services, linked up with other services, will continue to fall between different agencies, such as health, social services, and housing. Many of them, unnecessarily, will end up in prison.

Organisations such as the Revolving Doors Agency report regularly about the energy and time needed by their link workers to find basic contact details, liaise, advocate, prompt and intervene with the statutory agencies whose primary purpose is to assist needy clients, just in order to get basic survival services for offenders with mental health problems.

An overarching authority is needed at a regional level, with a cross-agency mandate, to ensure a consistent and integrated response to mentally ill offenders. Standards and procedures at critical stages in the care pathway need to be agreed, under principles such as the desirability of a single point of referral and a response commensurate with clinical need. Further, such a body could be empowered to negotiate between different agencies. Such an agency is envisaged in the work of the London Mentally Disordered Offenders Care Pathway Project which is developing a ‘Prison Interface Care Pathway’ which is almost ready to be piloted in some South East London boroughs (Guite, 2004). This type of initiative needs to be promoted and supported by the commissioners in the new partnerships and institutions.

2.4 The lack of adequate funding

For diversion schemes to be effective, there needs to be adequate and committed funding, based on a comprehensive local needs assessment. In the 1990s, pump priming monies to develop the early schemes were allocated by central Government. These monies are, in the main, no longer
available. Trusts and local authorities, facing constant financial pressures, are less likely to fund services such as diversion and liaison if they are not defined by central government as a high priority. As noted earlier, the Nacro 2004 survey result shows that 25 per cent of schemes had seen a decrease in staffing levels. Nine per cent had seen a decrease in their funding levels from the previous year.

Primary Care Trusts with a prison(s) in their area are in the process of taking over the commissioning and providing of health care in prisons. These PCTs are struggling with this new area of responsibility. There are no obvious financial incentives for them to commission mental health services to provide diversion and liaison schemes, because the bulk of the cost of imprisonment is born centrally. For PCTs without a prison in their area, the needs of offenders with mental health problems entering the criminal justice system are likely to be very low on their agenda and any incentive to provide diversion services for this group will be largely absent.

Finn and colleagues conducted an analysis of the costs of failing to provide early liaison services (Revolving Doors Agency, 2000). This study looked at people who have mental health and multiple needs but who do not need a Mental Health Act assessment. The group comprised those who were identified by the Link Worker Scheme in three police stations, clients who had been arrested and were not receiving support in the community. The approach was based on very broad referral criteria of mental health and multiple needs. The study costed the services used.

The study found that police have more contact with this group than social services, and that more money is spent on making the arrest than is invested in supporting them. Accommodation costs represent 70 per cent of the total costs for the study group. The results of the study showed:

‘In the longer term the reduced costs to crisis services and of temporary housing offset the increase in costs in providing appropriate services to health, social services and local authority housing. This suggests that greater cost effectiveness for both client and the community services concerned can be achieved.’

(Revolving Doors Agency, 2000)

Health and Social Services, re-organised into a single directorate, and local authorities, are increasingly delivering combined health and social services and need to review the costs and benefits of providing early intervention. Combined budgets are more likely to facilitate the joint working and funding to provide the range of parallel support services such as housing which keep mentally ill offenders out of prison.

The costs of failing to provide diversion and liaison need to be recognised and borne by the agencies whose failure to provide early intervention result in increased costs elsewhere, not least by offenders. A report published by Turning Point estimated that gaps in the present system cost £7 billion a year. Lord Victor Adebowale compared this to, ‘placing an ambulance at the bottom of a cliff, rather than trying to stop people falling off in the first place’ (Guardian, 4 October, 2004).

Would a detailed cost effectiveness analysis of providing prompt Mental Health Act assessments and diversion from prison - lead to a similar conclusion? There are a range of obvious costs of failure to do so which need to be considered, e.g. court time, emergency services, escort services, and prison services. Less obvious costs could include more expensive secure psychiatric beds, longer periods in hospital, delays in diagnosis and treatment, disruption of the prison system’s capacity to deliver its primary purpose, reduced opportunities to stabilise the mental health conditions of offenders so that their treatment is less costly, an increased risk of re-offending, and of course, wasted lives.

2.5 System wide failures

There was common agreement among the commentators reviewed by NIMHE in their report on Forensic Mental Health Services that the issues at stake are so fundamental that only a whole system approach can suffice. A complete spectrum of services is required with sufficient capacity
at all levels, from supported accommodation in the community through to beds in medium and high secure settings, to provide the right sort of support at the right time. In the absence of a sufficiently comprehensive and integrated service, efforts to resolve problems at any single stage (e.g., transferring mentally ill prisoners into NHS care) are likely to have limited success.

There is an acknowledged failure to provide adequate supported community provision and low secure provision for vulnerable groups, including people who have learning disabilities, the Deaf1, and those with mental health problems. Insufficient specialist community support may result in individuals being kept in secure facilities, sometimes a long way from their homes, which can be inappropriately and unnecessarily restrictive. Likewise people may be kept in higher levels of security than necessary because of insufficient provision of local services:

‘Surveys have suggested that between 37 per cent and 67 percent of patients do not need maximum-security provision … and that delays largely come about because of inadequate provision of catchment area resources and a reluctance or delay on the part of the Home Office in agreeing to transfer.’

(Coid and Kahtan, 2000)

The accelerated early transfer programme has moved 400 people out of high secure hospitals and there are plans to reduce substantially the capacity of high secure hospitals over the next few years. While the transfer of patients who no longer need high security is welcome, the closure of high secure hospital places is of concern, because they are needed by prisons, medium secure units and the courts to enable prompt transfer of people who pose the highest risk because of mental disorder.

A seminar held by the forensic faculty of the Royal College of Psychiatrists in October 2003 analysed factors which could have an effect on the utilisation of high secure beds. Some of these were the longer stay of patients in medium secure units as the patient mix changes, the level of unmet need in the prison system, the impact of better case identification as mental health care is being provided in the prisons by the NHS, the new mental health bill and changes in the criminal justice system, such as lengthening sentences and more use of indeterminate sentences. These factors are likely to provide pressure throughout the secure hospital system.

There has to be enough hospital capacity at all levels, and despite a significant current increase in medium secure beds, sufficient capacity across the `whole spectrum is unlikely.

The failure to provide the right level of care at an early stage may have implications for how that offender is regarded by the system. In South East London, the current care pathway for mentally disordered offenders was mapped in a pilot project. One of the high level issues that emerged from this process was that people were perceived as more dangerous the further they were along the care pathway, leading to higher levels of security than would have been needed if they had been transferred earlier (Guite, 2004).

Restriction orders can be imposed when crown courts make a hospital order and consider there should be particularly stringent controls over discharge from hospital in order to protect the public from serious harm. With the closure of long stay institutions and emphasis on community placements, there clearly is a need to keep control of patients who warrant concern, and increased treatment and rehabilitative periods may act to minimise risk. Few would question the need for public safety to be prioritised. Restriction orders enable the home secretary to retain control of the movements and location of offenders with mental health problems.

However, it seems likely that there has been an increasing use of restriction orders, perhaps reflecting sentencers’ concern to maintain public confidence at a time when media coverage fosters an exaggerated perception that mentally ill offenders are likely to commit appalling offences should they escape from NHS facilities or be released into the community. Many mentally disordered offenders on less serious charges can be safely treated using a hospital order (section

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1 The report uses a capital D to refer to people whose first language is sign language and who may not be able to communicate in or understand the spoken word, members of the Deaf community (see Section 12 below).
37) without a restriction order, and the unnecessary use of restriction orders has substantial impact on the offender’s liberty and the use of hospital resources.

Table five (below) shows that since 1993-1994, the combined proportion of those sections of the Mental Health Act which enable hospital admission from the courts and prisons under restriction orders or directions (ss. 37, 47, 48) has increased from 44 per cent to 52 per cent. The biggest rise has been in relation to hospital orders made by the courts (s.37), where the proportion of restriction orders has risen by over a half from 39 per cent in 93/94 to 62 per cent in 03/04.

Table Five
Restrictions under Sections of the MHA 1983 (percentages)

<table>
<thead>
<tr>
<th>Section</th>
<th>1993-4</th>
<th>2002-3</th>
<th>2003-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Court and Prison Transfers Under Restrictions</td>
<td>44%</td>
<td>50%</td>
<td>52%</td>
</tr>
<tr>
<td>s.37</td>
<td>39%</td>
<td>41%</td>
<td>62%</td>
</tr>
<tr>
<td>s.47</td>
<td>88%</td>
<td>85%</td>
<td>79%</td>
</tr>
<tr>
<td>s.48</td>
<td>78%</td>
<td>96%</td>
<td>92%</td>
</tr>
</tbody>
</table>

(DoH, 2004)

What has been the effect of the rise of the use in restriction orders in the last ten years? It may have reduced access to low secure beds for offenders at the beginning of the criminal justice route, namely the diversion process. Local Psychiatric Intensive Care Units (PICU), which focus on providing short-term care, sometimes for only a few weeks, may be less willing to accept these offenders because discharge or transfer requires Home Office consent, and therefore restriction orders can lead to extended lengths of stay. Hence PICUs are likely to favour community admissions over admissions of restricted cases from the courts and prisons. Over-use of restriction orders will also extend lengths of hospital stay in medium secure facilities. In addition, delays in the convening of MHA tribunals for restricted patients can also add to delays in discharge and increase the costs borne by commissioners of mental health services.

2.6 Tension between the health route and the criminal justice route

Both health and criminal justice agencies clearly have a role in working with offenders who have a mental health problem. But are this group primarily patients or prisoners? Do they become prisoners because they have failed to be treated as patients and entitled to a range of services in the community? The people in the James (2002) study were, in most cases, not criminals who became ill but rather mentally ill people who had offended. After admission to treatment, acquisitive offending decreased significantly, indicating that diversion has clear social benefits. This study found that a quarter of those admitted were sleeping on the streets and one fifth were in temporary accommodation. This is a group with basic survival needs which should be being met by social housing and health care services.

A focus on the criminal justice system can result in money being channelled and led by the CJS. Improving treatment in prisons, while welcome, can mean that developing more appropriate and earlier provision in the community for those at risk of offending is not given priority. The Nacro survey (2005) reported that the Doncaster Mental Health and Criminal Justice Liaison Service had had their funding decreased because money had been diverted to prison in-reach services through the secondment of a CPN until January 2005. Drug treatment is another example of health services being more readily available in prison than in the community.

Having described the context within which many mentally ill offenders are brought into the CJS, the report next identifies how these factors create barriers for offenders with mental health problems.
Troubled Inside: The mental health needs of men in prison
Section three traces the route mentally ill offenders might take if they were to be diverted from custody. It starts with the police station and looks at some of the barriers within current mental health provision, at the court stage and finally in reaching hospital.

3.1 Failures to identify vulnerability at first contact with the CJS

The first contact vulnerable offenders make with the criminal justice system (CJS) is normally the police. Although failure to recognise vulnerability is evident throughout the CJS, the police station is usually the first opportunity to recognise vulnerability and respond appropriately.

Gudjonsson’s (2002) study of the response to vulnerable people by police found that the major problem was that of identification. The present study found that less than two per cent of adult custody records recorded the attendance of an appropriate adult (AA). This figure of less than two per cent identification is at variance with the 4.3 per cent judged to be at risk by the researchers and substantially less than the numbers reported to the Royal Commission on Criminal Justice by Gudjonsson et al. (1993) whereby a brief clinical interview estimated the demand for AA’s for vulnerable adults to be approximately one in five.

(Gudjonsson, 2000)

His research showed that of the 23,321 adults whose custody records were examined, 4.3 per cent were vulnerable in some way. Of this group:

- 60 per cent appeared to be in an abnormal mental state
- 13 per cent had reading and writing difficulties
- 12 per cent had had a recent psychiatric history and
- three per cent had learning disabilities (mental disability).

Only 19 per cent of the diversion schemes surveyed by Nacro operated in all the venues offenders passed through, i.e. police stations, magistrates courts, crown courts and prison. Coverage at the police station improves identification and early care of vulnerable offenders.

Vaughan (2002) found that where there was a diversion scheme, seven per cent of detained individuals with a mental disorder went undetected by the police; but where there was no diversion scheme that rate doubled to 14 per cent.

Diversion schemes need to be adequately staffed and resourced. Vaughan (2001) highlights the professional isolation experienced by single postholders in these settings, particularly when they must work in non-mental health environments like a police station. Vaughan found it was also unrealistic for one individual to service more than one centre, especially when they were geographically distant from each other.

It is only at the discretion of the police that an offender becomes entitled to protection afforded by the codes of practice relating to vulnerable offenders in the Police and Criminal Evidence Act 1984 (PACE). Police are not routinely trained to recognise vulnerability. This entitlement in law for vulnerable adults is, according to Professor Gudjonsson, often not implemented. Many police doctors are general practitioners and have limited, if any, psychiatric training, and are often the final arbiter in the decision to call an AA. Gudjonsson found that even when vulnerability was acknowledged by the police, it was not always acted upon. This is in breach of the PACE codes which state that an AA should be called when there is a suspicion of vulnerability.

AA Schemes have the potential to link into liaison and diversion schemes if there is one locally. The Portsmouth appropriate adult scheme undertakes an advocacy role making immediate links with the local diversion and liaison scheme at the police station. Most other AA schemes do not have similar arrangements, so the chance to alert health professionals at this critical early stage is often missed.

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2 Appropriate Adult (AA) schemes were introduced to comply with the codes of practice which accompanied the Police and Criminal Evidence Act 1984 (PACE). Their role is to ensure that the detained person’s rights and interests are upheld and to facilitate understanding between the detained person and officers in the police interview.
The lack of co-ordination and linkage between agencies working in this area manifests itself in the way the police can often be left to manage mentally ill offenders in custody cells. Over a third (40 per cent) of the diversion and liaison schemes Nacro (2004) surveyed had no jointly agreed policy on section 136 of the Mental Health Act (which refers to transfer to a place of safety for a mentally ill offender found in a public place). One third (34 per cent) were using the police station solely as their ‘place of safety’ for persons detained under section 136 of the MHA 1983.

The Mental Health Act 1983 code of practice states that a hospital is to be preferred to a police station as a place of safety. The Joint Committee on Human Rights reported, in its review of deaths in custody, that just over half of the 153 deaths that had occurred in police cells (1998-2003) were people who had identified mental health needs (JCHR, 2004). The draft mental health bill dropped a suggestion, originally in the White Paper, to the effect that when a police station is used as a place of safety, there would be a duty on the local PCT to conduct a preliminary examination within six hours or to transfer the person to hospital for examination.

How is the possibility of vulnerability handled beyond the police station, once the person appears in court? Most court diversion and liaison services rely on non-medical staff to raise such issues. While they might be able to identify people in an abnormal mental state who are behaving in a florid and eccentric way, recognising learning disabilities or less obvious forms of mental illness by observation alone is very difficult when there may be no obvious signs. Screening procedures such as use of questionnaires can improve the rates of detection of those with mental health problems (Shaw et al., 1999). But special expertise is required to identify accurately offenders with learning disabilities and Autistic Spectrum Disorders (ASD). Identification also requires people to be aware that a person’s offending history, current behaviour and responses may stem from their learning disabilities or ASD.

A ‘process map’ of the current care pathway carried out by the South East London Mentally Disordered Offenders Care Pathway Project revealed four opportunities to identify people with severe mental health problems along the pathway, of which the police station is one, and most of these use staff with minimal or no training in recognition of severe mental illness.

Assuming that an offender’s mental illness has been recognised, the next stage is the availability of a court diversion and liaison scheme.

### 3.2 Coverage and quality of court diversion and liaison schemes

Nacro found that diversion schemes were patchy, with inconsistent and inadequate hours of operation, and threats to funding and staffing levels (Nacro, 2005).

If an offender is sufficiently ill to justify detention under the Mental Health Act, then contact with a psychiatrist is essential for providing statutory assessment or to secure a move to a hospital bed. Just under half (42 per cent) of schemes had a policy on conveying to hospital. The MHA 1983 stated that authorities should agree joint policies and procedures on this issue. Well over half of the schemes (69 per cent surveyed by Nacro) operated on a reactive basis, i.e. they only screened people who were referred to them. Clearly, even if there were a court diversion scheme in place, it would be far too easy for a vulnerable offender to fail to be picked up.

### 3.3 Criteria for inclusion in diversion schemes

Having had the good fortune to be in an area where there is an adequately functioning service, can the criteria for determining eligibility for diversion create a barrier for the mentally ill person who commits an offence? Diversion services often restrict diversion to offenders when the circumstances indicate that their mental health problems were the main causes of the offence. Those with obvious drug and alcohol problems, combined with a less obvious mental health problem are likely to be excluded.

Consider the following example: a man with a known psychiatric history appeared before a South London magistrates court in 2001, charged with committing an affray. He had had too much to
drink, having been refused admission to his day centre. He was considered unsuitable for diversion because the trigger for the offence was alcohol. In this case, the defence interposed and pointed out that the defendant had had three hospital admissions in the previous ten years. A
adjournment was granted to allow time for a report to be prepared. Yet for both sections 35 and 36 of the Mental Health Act, ‘it is not a necessary to establish a link between the person's mental disorder and the alleged offence’ (Mental Health Act 1983 guidelines (Maudsley 1997) pp. 38 and 40.) It would seem right that this approach should guide work with all offenders in need of community liaison as well as Mental Health Act diversion.

Research is needed to establish what proportion of referrals for diversion are refused by court diversion services, either because an offender was under the influence of alcohol or drugs or, despite having a mental illness, because the professionals take the view that the defendant's illness is not related to, or not the main contributor to, the offence. In the absence of mental health treatment, some numbers of offenders self medicate with drugs and alcohol. A system which fails to provide accessible intervention and treatment for mental illness and then imposes a punitive sanction upon someone who has used drugs or alcohol to self medicate, is truly perverse.

3.4 Criteria for acceptance by local services

Having been accepted as suitable for diversion, will the mentally ill offender be accepted by local services? In order to be diverted from prison, mentally ill offenders must meet the local criteria for service provision. Questions of risk assessment and security necessarily arise. Psychiatric Intensive Care Units (PICU) see their role as part of the care continuum; not part of the security spectrum. The referral needs to meet clinical criteria for admission, and these can often exclude people with substance misuse problems and personality disorders, even when combined with a mental illness.

Attitudes amongst general psychiatrists towards offenders can be mixed. Consultants can be reluctant to accept them arguing that they need forensic specialist services. Offenders can be seen as disruptive, long term and less deserving of treatment than their community counterparts. Research by James et al. (2002) challenges this. They found:

- There was no difference in length of stay in hospital between community admissions and court admissions.
- Court admissions were less violent and disruptive in hospital than the community admissions. The court admissions were responsible for significantly fewer physical assaults whilst in hospital, the community admissions being responsible for more assaults by a factor of six.
- Court admissions demand for intensive resources in hospital was significantly less than community admissions.
- Court admissions were less likely to use alcohol or illicit drugs in hospital than community admissions.
- Court admissions were offered less follow up than community admissions but there was no difference in attendance patterns of those referred to outpatients.

(James, et al. 2002)

However, the majority of offenders with mental health problems do not require hospital admission and should be able to access services in the community but the barriers they encounter there can pave the way to prison.

Many offenders who have mental health problems have multiple needs, present challenging behaviour and may be difficult to engage with. A study by the Revolving Doors Agency (2000) found that a greater multiplicity of need actually made it harder for people to gain access to health and social care. Those with a dual diagnosis are most in need of comprehensive services but paradoxically are most likely to be excluded. When resources are limited, there is a strong tendency to gate-keep access to services, and users need someone to advocate on their behalf with service providers.
A report by John Hedge on diversion in the Thames Valley concluded that many agencies, both statutory and non-statutory, continue to provide services that either exclude or work unsuccessfully with many clients (Hedge, 2000).

Ten years later, Vaughan et al. (2000) conducted a survey in Wessex which complimented Hedge’s report and found that people’s tendency to shun services was related to a structure of community services which failed to make contact feasible. Strict boundaries for each team and the compartmentalised nature of services meant that the offender was unlikely to get the comprehensive range of interventions they needed. Failing to provide accessible services increases the likelihood of progression along the CJS route towards prison custody.

The fact that 36 per cent of the Nacro court diversion and liaison schemes surveyed had no policy on information sharing and just over a third had no operating policy in place appears to reflect a general failure in the community to provide for people with mental health problems, multiple needs, and a consequent high risk of offending. Revealingly, Nacro’s survey (2005) quoted one scheme as follows about barriers to working:

‘…limited commitment from participating agencies supposedly involved in the steering group…’

(Nacro, 2005)

For people who have learning disabilities, the barriers to accessing services are even more problematic. Many community mental health teams (CMHT) exclude people who have learning disabilities; and forensic services may also exclude them. This report will show, in a later section, how these barriers to service can put people with learning difficulties at risk of prison or out of area medium secure hospital provision. The development of a comprehensive forensic service for people with learning disabilities in North Derbyshire shows how risk can be managed so that clients can receive the appropriate level of services and support locally. The reduced levels of reconviction rates shown by this service are impressive (Hutchinson, 2002).

Other examples of good practice, detailed in the NIMHE report on forensic mental health services, show that services can meet the needs of people with challenging mental health problems when there is leadership and commitment. The right level of support provided in the community to potential or actual offenders with mental health problems means that they will be less likely to offend, to experience deterioration in their mental health, or to appear repeatedly before the courts.

### 3.5 Barriers to the use of community placements and NHS facilities by the courts for mentally ill offenders

After the police, the next step in the CJS journey, for many offenders with mental health problems is an appearance in the magistrates court. Courts have at their discretion a variety of orders for mentally ill offenders. To enable magistrates to use disposals other than prison, magistrates must be familiar with the alternatives, have confidence in them, and space needs to be available in the relevant facilities. Information to the court about the offender and their suitability for these alternatives is equally important and needs to be timely and of good quality.

**Knowledge and confidence**

Magistrates receive some training and there are justifiable concerns not to overload those undertaking a part time public office. The possibilities of diversion under the MHA is not part of current training and the ‘Bench Book’ issued by the Magistrates Association and regularly updated does not detail all the options for mentally ill offenders who come before the courts. The clerk to the court can advise magistrates and they can draw upon an effective court diversion and liaison scheme (where one exists). Provided the court diversion and liaison scheme can devise a deliverable plan for the offender, then the system has the potential to work well. But this does not routinely happen. How defendants are treated by the court will depend on the courts’ perceptions of the options available to them.
Sentencers need to have confidence in alternatives to prison. If offenders do not comply with orders, they may be sent to prison, and magistrates’ confidence in the alternatives is bound to diminish. But the inability of offenders to comply is often a reflection on the failure of services in the community to engage with them. (Shaw et al., 2001) found that less than a third of patients referred from the courts to psychiatric community teams or outpatient clinics attended their first appointment. Of these, almost a third had become disengaged from services before the follow up 12 months later. They concluded:

*There is a need to develop more effective outreach services to assist patients with serious mental illness to engage with services immediately following court appearance.*

(Shaw et al., 2001)

The services offenders need are quite basic: housing, drug treatment, mental health care. Failure to provide these are significant factors in the reconviction of people receiving community orders (Home Office, 1999a). Without these services, many offenders receiving community orders have been set up to fail.

What options do sentencers have regarding offenders with mental health problems?

People who face prosecution and do not argue that they are unfit to plead can be remanded on bail (possibly with conditions) by the magistrates. A mentally ill offender may go to hospital from the magistrates court as a condition of residency. Alternatively S35 of the Mental Health Act 1983 can be used which provides for assessment. The crown court has the option of using section 36 which provides for treatment. These sections are used minimally. Those offenders who are remanded to custody and are subsequently assessed as being mentally disordered may be transferred to hospital for urgent treatment under section 48 of the MHA.

Post conviction and prior to sentencing, the court may remand on bail, again possibly with conditions and a S35 or S36 order as above. Alternatively, they can remand the person in custody. During the remand period, information will be collected to assist sentencers. These pre-sentence reports (PSRs) are produced by the Probation Service. Due to the difficulties courts face in obtaining full and accurate information pre-trial, custodial remand is used far too often, in order to facilitate a psychiatric assessment.

At the time of sentencing, courts have a full range of available options, including a community disposal with psychiatric conditions. A disposal under Part 111 of the Mental Health Act can be made. For magistrates, this would be a S37, with or without restrictions. An interim hospital order, under S38 order can be used to evaluate the offender’s response to hospital treatment without any irrevocable commitment on either side to this method of dealing with the offender if it should prove unsuitable (Mental Health Act 1983 guidelines, Maudsley, 1997). This option does not appear in the MHA statistics and seems never to be used. Crown courts can also impose hybrid orders, so that an offender is first admitted to hospital but after treatment will be transferred to prison.

The report has noted earlier (Table 3) that the use of these sections has declined very markedly in the last ten years.

The Criminal Justice Act 2003 has increased the sentencing options available to magistrate and offenders can be ordered to do one or more of a range of requirements as part of a community order. Those listed and relevant to this discussion, include mental health treatment (with the consent of the offender) and a residence requirement. These provisions became operational from April 2005. They do not appear to differ substantially from the orders contained in section 3 of the Powers of Criminal Court Act 1973 which was minimally used. Whether sentencers use these orders now will depend on the provision and accessibility of local mental health services and how confident magistrates are about using these. The new anti-social behaviour orders (ASBOs) have the potential to encompass those with mental health problems. If breached (which is likely, without help and support) these orders will result in a prison sentence.
Information sentencers need about the offender

Pre sentence reports (PSRs) provide sentencers with information they need to make decisions about the most appropriate way of dealing with someone convicted of an offence. Performance levels on PSRs are part of the key performance indicators (KPI) and national targets for the probation services. Following steady improvement until 2001-2, national performance on the 15 day national standard for PSR timeliness has fallen in the last two years (Probation Circular Ref 53/2004). Currently, it can take between three and six weeks for a magistrate to obtain a non specific sentence report which they are required to obtain for certain categories of offences.

One of the ways of tackling the problem of timeliness was by introducing the offender assessment system (OASYS). Probation Circular 53/2004 covers court report formats and OASYS and seeks to ensure consistency of coverage in same day reports by the probation service to the court without compromising effective assessment. The purpose is to ensure the engagement with sentencers on the issue of report provision in all areas (National Probation Directorate, September 2004).

PSRs and the new offender assessment system (OASYS) include questions about mental health. But in the context of a highly pressured system, unless the offender is floridly ill, and without timely access to specialist assessment, the information provided to the court may not be accurate or complete with regard to mental illness or other vulnerabilities.

Medical reports

Courts face a legal obligation to consider detailed investigation and reports if they believe the person to have a psychiatric problem and custodial sentence is under consideration. Medical reports are a vital part of the information needed by the court. The need for these can be highlighted in the PSR discussed above and causes further delay. These reports are also costly, with fees that range from £43 for a written report by a registered medical practitioner to £248.55 for two hours work by a consultant. Payment for this service comes from magistrates’ funds if they request an assessment. As the payment comes from court central funds, there may be a disincentive against requesting such assessments.

Fortunately, ways of providing necessary reports in a prompt and cost effective way have been developed by several agencies. The Wessex Consortium’s Criminal Justice Liaison Group under the chairmanship of Dr John O’Grady has recognised the frustration magistrates may feel when they cannot obtain timely psychiatric reports, and when as a result, many mentally disordered offenders face inappropriate incarceration. Within Hampshire and the Isle of Wight about 250 requests are made each year for a psychiatric opinion on mentally disordered defendants. Of these, only a handful proves necessary for action by the courts. It is likely that the Hampshire and Isle of Wight figures are roughly representative of a national pattern.

The Wessex Consortium’s Report states:

> ‘Most requirements can be fulfilled by personnel from court diversion schemes and prison mental health teams or care co-ordinators within community mental health teams.’

(Wessex Consortium, 2003)

Hampshire and the Isle of Wight have developed an invaluable tool to help magistrates access psychiatric input in a timely manner. Their protocol is available via their website on www.hants.gov.uk/wessexconsortium

The use of this protocol means that not only do magistrates have the information to make a correct disposal for the majority of less severely mentally ill offenders, possibly avoiding the misuse of prison for psychiatric assessments. It also enables courts to target their limited resources on those defendants who require specialist psychiatric assessment. And because these consultants are not overburdened by unnecessary referrals these can be done much more quickly.
Another model provided by the Mental After Care Association (MACA) provides a forensic mental health practitioner (FMHP) team in four London borough magistrates courts. The practitioners attend magistrates courts for the morning sessions and provide mental health screening for individuals who have been flagged up as potentially in need of assessment. Costs are reduced because the FMHPs service provides almost instant assessments to the court and bureaucratic overheads are minimal (Dorrel-Dahl et al., 2003).

A last example of how the problem of reports can be alleviated is that suggested by Tom Hore of the Bristol Mind Advocacy in Action project. Advocates can work with the mentally ill offender to help them provide a written account of their dealing with mental health services. This can then be shared with the court. In the absence of any official reports, this scheme both alerts magistrates to the mental health needs of the offender and gives that person an authoritative voice.

### 3.6 Availability of alternatives to prison

#### Approved hostels

Magistrates can consider a residential requirement such as a probation hostel (approved premises). Elliott House in the West Midlands is described in an article by Geelan et al. (2000) as ‘one of very few specialised approved bail and probation hostels for mentally disordered men in the UK’. They concluded that the hostel demonstrated that a close partnership between separately managed agencies can successfully care for a previously deprived group. Only four per cent reoffended while resident at the hostel. But places are very limited because of the specialist care required by mentally ill offenders. For those with learning disabilities or who are Deaf, this type of specialist provision is even more limited. The issue of diverse needs will be discussed in more detail in a later section of this report.

#### Drug rehabilitation and alcohol treatment

Drug Treatment and Testing Orders (DTTOs) became effective from 1 October, 2000. They do offer a potential mechanism for individuals with a dual diagnosis to enter mental health and/or substance misuse services. Some UK drug service experts (e.g., Mind, 2002) have estimated that as many as a third of people who come into contact with drug or alcohol services may also have some kind of mental health problem.

A report by Rethinking Crime and Punishment (2004) estimated that there are 1,700 residential rehab beds available. The report’s author, Joe Levenson, argued that this number is clearly insufficient to meet the needs of the half million problem drug users in England and Wales. Some of these drug misusers account for the rise of 14,000 in the prison population since 1997. This reflects a finding from Independent Monitoring Board (IMB) annual report from HMP Lewes highlighting the fact that a prison can have more places to help people with drug problems than is available in the general community. Lewes IMB despaired that the provision of drug treatment in prison:

> ... ‘will encourage the courts to send people to prison inappropriately to obtain drug rehabilitation. We strongly recommend that more facilities are made available in the community.’

(IMB HMP Lewes, 2004)

Under the Criminal Justice Act 2003, drug rehabilitation and alcohol treatment can be made as part of a community order, but provision must be available locally for the courts to be able to use this option.

#### Psychiatric beds for mentally ill offenders who need to be in hospital

The report has noted that offenders need to meet the criteria for local services, but an additional problem is a lack of capacity. If sentencers are to divert an offender away from custody the alternative to prison needs to be available in a timely way.

The case of R v Galfetti (2002) highlights how mentally ill offenders may be particularly disadvantaged by delays in finding a hospital bed. In this patient’s case, no bed could be found
within the 28 days required by Section 37 (4) of the 1983 MHA and the court was compelled repeatedly to adjourn sentencing until a bed was available: nine months after conviction. At this point the order was finally made. The court concluded that:

"Whenever a hospital bed is not available within a reasonable time ... the court is disabled from affording justice in the way in which Parliament has provided."


Shortage of local psychiatric intensive care beds is clearly a barrier to diversion for offenders with serious mental health problems, even without any of the additional problems that result in offenders being placed low on the priority list. They can, of course, be sent to prison on remand and, increasingly, this is what happens to them. Inappropriate use of custody is undoubtedly to the detriment of their health because the Prison Service lacks resource to cope with their complex needs. It also prevents the Prison Service from working towards its main objectives.

3.7 Transport to hospital

The final barrier the offender may encounter is getting to hospital after a Mental Health Act order has been made by the court. Responsibility for providing transport and necessary escorts in these cases lies with the court. When court escort services were privatised, no provision was made in the contract for taking mentally ill offenders to hospital. There is anecdotal evidence that this gap raises logistical problems and may act as a deterrent to the making of such orders. In any event, this last obstacle, at the end of a difficult road causes additional problems and frustrations for the hard pressed professionals and agencies involved in the welfare of the offender. Escort services are geared to taking the vast majority of offenders straight to prison rather than the acutely mentally ill to hospital.

3.8 Conclusions

Research shows that there is considerable overlap between admissions made in the community and those from court in terms of psychiatric history, socio-demographic variable and previous criminal record. The majority of cases admitted from the courts were those already known to psychiatric services and who were in receipt of ‘community care’. Some will be those ‘whose symptoms failed to elicit medical intervention until they crossed the threshold of arrest’ (James et al., 2002).

Those in the research group were to some extent lucky, because the courts in the study had a well resourced diversion service and they received care in hospital rather than being sent to prison. This report has shown how most offenders with mental health problems, by default, end up in the prison system. There are clear and convincing reasons in concluding that this situation is both unacceptable and unnecessary.

Government policy highlights the importance of preventing re-offending, yet in their recent document ‘Reducing Re-offending: National Action Plan’ (Home Office, 2004) minimal reference is made to court based mental health diversion/liaison schemes which research tells us has good indicators for reducing re-offending. The plan holds no promise of a nation wide strategy to remedy the current unsatisfactory position. The position regarding diversion and liaison services is likely to continue to deteriorate if PCTs and new commissioning bodies do not prioritise court diversion and liaison services and ensure they are fully integrated with accessible local services.

High quality, accessible services are costly, but the costs of allowing the present situation to continue are greater. Exclusion and dispossession are standard responses to mentally ill people who get caught up in the criminal justice net. The pattern of neglect and stigmatisation identified in this report will, in the end, be more costly for us all.

Detailed recommendations follow in part five of the report.
4. The Provision of Mental Healthcare in Prison

There has been a plethora of glossy documents, conferences, reorganisations and structural changes on the day-to-day delivery of mental health care to prisoners. But how far have the ambitions of the Modernising Strategy (1999 and 2001) been achieved?

Section Four explores how mental health care is delivered in prisons. Key themes will be discussed:

The concept of a healthy prison
The framework for delivery
The challenges of numbers of mentally ill people in prison and the aspirations to equivalence with the NHS
The recurring themes arising from the delivery of care in prison to men who have severe and enduring mental illness or are vulnerable to poor mental health.

4.1 The Healthy Prison: a contradiction in terms?

In his 1999 thematic report, Suicide is Everyone's Concern, the then Chief Inspector of Prisons, David Ramsbotham, outlined four tests of a healthy prison. These were:

- The weakest prisoners feel safe
- All prisoners are treated with respect as individuals
- All prisoners are busily occupied, are expected to improve themselves and given the opportunity to do so
- All prisoners can strengthen links with their families and prepare for release

(HMCIP, 1999)

This list can be summed up as safety; respect; constructive use of time; and family ties and resettlement.

In 1999 Martin Narey, the then director general of HM Prison Service, outlined seven principles of decency:

- Prisoners are not punished outside of prison rules
- Promised standards within the prison are delivered
- Clean, properly equipped facilities
- Prompt attention to proper concerns
- Prisoners should be protected from harm
- Actively filled time
- Fair and consistent treatment by staff.

These two tests of prisons are a useful guide to thinking about the impact of time in prison on a person's mental health.

Both include a concern for personal safety. The concept of safety is broader than the danger of physical injury, encompassing a sense of trust in one's environment, emotional safety (from threats and bullying), and security from theft and fraud. Full inspection reports now include a prisoner survey that measures both the proportion of prisoners who feel safe in the prison and the rates of assault, theft and other types of victimisation. There is strong evidence that many prisons - though not all - are high-risk settings (Edgar et al, 2003).

When prisons cannot reduce the risks of assault, threats of violence or theft, emotional stability is compromised.
Suicide is Everyone’s Concern linked respect to the conditions in which prisoners are kept, the manner in which staff relate to them, and care for their physical and mental health. Similarly, the decency agenda calls for clean facilities and the delivery of promised standards. The Chief Inspector explicitly tied respect to treating the person as an individual, and this is a particularly difficult challenge for prisons to fulfil, especially in large local jails where there is a high turnover, and relations tend to be very impersonal. He stated that prisons practise respect when, “prisoners are spoken to be staff with courtesy and treated with fairness and openness” (HMCIP, 1999: 62).

It is hard for prisoners to maintain their mental health and dignity when they are forced to defecate in front of strangers and eat their meals in a lavatory. It is hard for prisoners - particularly for those who have experienced abuse as a child - not to be distressed by regular physical searches, or the less frequent but more intrusive strip searches which are part of maintaining security. As well as the training and procedures the physical environment is important. The Prisons Inspectorate commented on HMP Liverpool:

‘It was unacceptable that prisoners on their first night were held in dirty, poorly maintained and unhygienic conditions.’

(HMCIP Annual Report 2003)

A lack of privacy is an intrinsic feature of prison life but sometimes the lack of respect for privacy seems punitive, rather than a requirement of security.

‘The location of the changing rooms remained as it had been at our last inspection... on some of the landings on both the old and new wings, prisoners in showers were in full view of anyone who walked past.’


Respect for one’s individuality goes further, requiring prisons to provide opportunities to exercise choice and to take responsibility. Although it is likely that attitudes are shifting since the Inspectorate’s 1999 report, the punitive values in prisons can contribute to an atmosphere in which prisoners are subjected to disrespect. As a governor stated in evidence to the Chief Inspector:

‘Our systems and relationships with them [prisoners] usually stress their inferiority and exclusion.’

(HMCIP, 1999)

To maintain good mental health, purposive activity is essential. Spending hours in a cell with little or no occupation is likely to increase vulnerability to poor mental health. The decency agenda referred to actively filled time. The Chief Inspector drew a strong link between engaging prisoners in meaningful activities and maintaining their mental health:

‘There is nothing worse for the mental well-being of those who find it difficult to cope with life in prison than being idle.’

(HMCIP, 1999)

The Chief Inspector’s report also directly linked constructive activity to support for the person’s self-esteem.

The Prison Service had a target of providing 24 hours a week purposeful activity per prisoner. In 2002-2 prisoners had, on average, 22.6 hours per week: that is just over three hours per day. The purposeful activity time varies widely, depending on the type of prison. Some training prisons routinely have a high level of activity, while prisoners in overcrowded local prisons can spend 23 hours per day in their cells.

The Prison Service re-defined its key performance indicator for purposeful activity in 2005, after nine years of failing to meet its targets (PRT, 2005a). The new definition was intended to be tighter,
and to focus on involvement in offending behaviour courses and education. It is helpful to have a clearly defined target that minimises the chances to massage figures. However, this means that informal activities which may have provided some benefit to a person’s mental health are even less likely than before to be made available, as they will no longer contribute to meeting targets.

The target had been 24 hours of purposeful activity per week. There was widespread evidence that some establishments over-stated the number of hours of meaningful activity (PRT, 2004a). Even so, fewer than half of all prisons met the 24 hour target, and no male local prison did so (PRT, 2004a).

The ONS survey showed that prisoners whose psychiatric tests indicated a high degree of neurotic symptoms were twice as likely as prisoners with few neurotic symptoms to spend 19 or more hours per day in a cell. There was also an association, though less strong than for neurotic symptoms, between evidence of psychotic disorder and time spent in cell.

In the Ormsby study prisoners and staff emphasised the negative effects on prisoners’ mental health of being locked up for as long as 23 hours a day. Remand prisoners do not normally work or have access to education, and sentenced prisoners have limited access to both. This inevitably leads to extreme stress, anger and frustration:

…”not letting me get to education, not giving me a change to work, not giving me a chance to do anything. You build up anger, you know what I mean. It’s going to release one day. It’s just building up inside you and got to hold it down, hold it down, hold it down.”

(Nurse and Ormsby, 2003, citing a prisoner)

Among the Chief Inspector’s recommendations for resettlement and family ties are that all prisoners are prepared for release, through involvement in resettlement programmes; and that prisons make it a priority to develop links with family and friends.

Family ties are, oddly, omitted from the list of measures in the decency agenda. The Prison Service has a mixed record of encouraging family ties.

Family contact can reduce the feelings of isolation and stress that hit the prisoner in the early days of imprisonment. Telephone calls constitute a vital link. Where prisons have modern new reception areas such as HMP Birmingham, the ability to phone home is not a problem. However, in most prisons, it can be much harder on the wings, with telephone time limited to association periods which can be cancelled due to staff shortages.

The Prisons Inspectorate’s expectations include the following:

‘Prisoners and their immediate family or partners, with appropriate instructions or permission, are sensitively informed of significant news about each other within 24 hours.’

(HMCIP, 2004)

Prisons are mandated to contact the next of kin whenever a prisoner’s health conditions change, for example, when hospitalisation is required. But PRT’s advice and information work suggests that this is rare.

A recent PRT report by Nancy Loucks advocated the expansion of family contact development officers in all prisons, but the majority of establishments in England and Wales have yet to appoint anyone in this role (PRT, 2005b).

So, does the available evidence support the proposition that the impact of prison can be to improve mental health? In their discussions about the background causes of deaths in custody, the Joint Committee on Human Rights (JCHR) explicitly examined the question of the impact of prison on mental health.
The Royal College of Psychiatrists stated bluntly, “A healthy prison is almost a contradiction in terms.” (JCHR, Ev 186) They presented a detailed picture of negative practical consequences of imprisonment, any one of which could have serious implications for a person’s levels of emotional distress.

‘Separation from family and friends, entry into an alien environment, sudden withdrawal from drugs and alcohol, an uncertain future, loss of job and income, the rupture of many social relationships and supports, all induce mental distress and disorder.’

(JCHR, Ev 186)

The practical hardships they cite closely match the circumstances faced, in particular, by prisoners on remand and help to explain why that group might be at a greater risk of suicide.

In her evidence to the JCHR, the policy director of MIND, Sophie Cortlett, stated:

‘From the evidence it appears that [people with serious mental health problems] become more ill and it would appear that people who have less severe mental health problems in prison develop more severe mental health problems. Prison appears to be a good greenhouse for developing mental health problems.’

(JCHR, 2004)

The JCHR concluded:

‘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.’

(JCHR, 2004)

Similar conclusions were reached in a seminar convened by the European Health in Prisons Project:

‘It was agreed that, although the effects on mental health of imprisonment were not universally damaging, for example in the case of some homeless, mentally disturbed or drug misusing prisoners, nevertheless imprisonment adversely affected the mental health of a significant number of prisoners in all countries.’

(HIPP)

The same seminar produced a detailed list of the practical consequences of imprisonment, each of which can be harmful to mental and emotional health:

- Isolation from families and social networks
- Austere surroundings, loss of privacy and poor physical and hygienic conditions
- Aggression (including sexual), bullying, fear, suspicion and the attitudes of unsympathetic and uninformed staff
- Lack of purposeful activity, of personal control, of power to act and loss of identity
- Pressure to escape or to take drugs
- Shame and stigmatisation
- Uncertainty, particularly among remand prisoners, and concern about re-integration into the outside world.

(HIPP)
Reviewing the above evidence, the same themes emerge persistently: prisons cause social isolation, subjecting people to danger and idleness, failing to respect their human dignity, and maintaining them, too often, in inhumane conditions. The impact on someone in good mental health would be negative: for people who arrive in a vulnerable state of mind, the damage can be irreparable.

4.2 The framework for delivery

The framework for delivery is a development of the DoH strategy for improving and modernising mental health services, ‘Changing the Outlook’ (DoH, 2001). It built on the National Health Service Plan (2000) and promised ‘key deliverables’, including the following:

- By the end of March 2004, there would be 300 additional staff providing mental health care to prisoners
- 5,000 prisoners at any one time with severe and enduring mental illness would be receiving more comprehensive treatment
- No prisoner with a serious mental illness would leave prison without a care plan and a designated care co-ordinator.

An early development was the creation of mental health In-reach teams. These teams were provided by local NHS services with new DoH money, ring fenced until 2006. By the end of 2004, In-reach teams were working in 88 prisons. There are now teams in over 100 establishments.

Prison healthcare remained the responsibility of HM Prison Service until early 2004. Since then, responsibility for commissioning and funding of prison healthcare has been transferred to the Department of Health. Dr Stephen Ladyman, Minister for Health at the DoH, commented:

‘This transfer will enable PCTs to use their considerable knowledge and experience to tackle some of the wider health and social exclusion problems such as mental health, substance misuse…. and will bring about real health improvements.’

(Ladyman, 2004)

Local PCTs now hold responsibility for commissioning healthcare services at all but three publicly run prisons in England (Rosie Winterton MP, House of Commons, 18 July, 2005). The commissioning of health services in contracted out prisons differ, as each provider is responsible for making its own healthcare arrangements, either with a PCT or an independent source in order to meet the requirements detailed in their contracts.

The model of integrating prison health into the NHS and mainstreaming Prison Health delivery plans has resulted in a new range of agencies working together. In 2002, prison mental health collaboratives were formed under the umbrella of the regional branches of National Institute for Mental Health (NIMHE). They have been working to seven nationally agreed priority areas as a basis for local programmes of improvement. These are the care plan approach (CPA), therapeutic input, transfer of prisoners to NHS facilities, mental health screening, mental health promotion, PCT contracts and staff training. The modernising agenda was overseen by the Prison Mental Health Expert Group, chaired by Professor Louis Appleby.

The plan is that through such joint working, each prison, local mental health community and PCT should have a clear model of working to provide in-reach mental health services to local prison populations. As part of this process, benchmarking exercises are being held in all regions which will provide information of how far the process still has to go in bringing mental health services for prison to NHS standards. PRT recommends that the outcomes of these exercises be public documents.

A key tool in the model is the Offender Mental Health Care Pathways document produced by DoH and NIMHE in January 2005. This presents an ideal scenario for the offender beginning the criminal justice pathway. It is perhaps intended to be used as an implementation tool for all
agencies working with prison mental health, such as commissioners and providers of mental health services (e.g., PCTs and Mental Health Trusts). The Care Pathways document should act as a checklist of delivery for those charged with oversight of the process, such as Strategic Health Authorities (SHAs) and, to be agreed, the Healthcare Commission. However, it is a matter of concern that Offender Mental Health Care Pathway includes a range of agencies and professionals which are often not encountered by the offender as they pass through the police station, courts and finally prison.

The local and regional stakeholders in prison mental health, such as PCTs and SHAs, are to be brought together with prison governors and representatives of Prison Health in the DoH to new regional forums under NIMHE. The remit of this potentially powerful group is to unblock the obstacles to delivery and make the necessary changes happen. Given some of the enduring problems identified in this report, much will hinge on the effectiveness of this group. If they fail to surmount the ensuring obstacles that hinder the delivery of good quality mental health care in prisons, then it is difficult to see how any other agency could effect change systematically.

Clearly a huge amount of new work is being developed with the potential to make great improvements for prisoners with mental health problems but it is fair to say that considerable challenges remain. In many prisons, there has been little change in the day-to-day life of prisoners suffering from mental illness.

**4.3 Challenges to the new developments**

New developments are bound to experience problems. In prison mental health care, these stem from three sources. The first relates to the organisations themselves and the new service agenda. The second concerns the greater mental health needs of the prison population (its 'psychiatric morbidity') and the ambitious agenda for change in the wider NHS to which this service seeks equivalence. The third source of problems is the continually rising prison population.

**The organisations involved and the new service agenda**

In 1996, the Chief Inspector of Prisons published a discussion paper entitled, Patient or Prisoner? (HMCIP, 1996). The paper highlighted the principle that prisoners are entitled to the same quality of healthcare as in the wider community and called for prison healthcare to be taken over by the NHS. It also argued that people in prison who have health problems should be seen as patients foremost, to distinguish medical needs from the demands of security and discipline.

The prisoner/patient dichotomy gives an indication of the different approaches to offenders in the Prison Service and local NHS services. The NHS have been in a constant period of change for the last 20 years with increasing focus on accountability, transparency, users and choice. Prison Health, while lodged within the Prison Service silo, was lacking in accountability, with little transparency, largely invisible to outsiders, and a backwater of outdated professional practice. Within prisons themselves, the unequal relationships, differing priorities and lines of accountability are likely to cause tension between operational and NHS staff.

New decision making processes and priorities have to be established. Ambiguity about the sources of power, responsibilities, accountability, and financial risk can add to the challenge of establishing new relationships. A performance and audit driven culture can encourage risk-averse thinking by senior managers in the institutions under scrutiny. Differing targets (key performance targets - KPTs - and star ratings), complex funding arrangements, staffing issues, and possibly many others, add to the factors that impede the change process.

The new model of service delivery places great demands and responsibilities on PCTs and the SHAs above them. There are considerable concerns that PCTs do not have the necessary expertise and experience to commission and provide prison mental health services. Performance management by the SHAs is the tool for ensuring the process is working; but how well equipped are they to undertake this role and what effective steps can they take if performance is not satisfactory?
After the initial start up funding by the DoH, prison health costs are no longer effectively ring-fenced. This means that budgets for prison mental health will have to take their place amongst all the other demands on PCTs. The allocation for prison health care is based on what has been given in previous years, that is, resource led, rather than needs led. In policy terms it makes sense to hand health care to PCTs, but without adequate funding, based on properly carried out needs assessments, the scope of change required to make significant improvements to prison health care following from commissioning decisions by PCTs, is not realistically achievable.

An advocate is required to raise the priority of providing quality services to prisoners. But who will be the voice for a group of people who are unlikely to attract public support? The development of practice based commissioning for GPs may, if realised, further affect the ability to commission the specialist services many prisoners with mental health needs require.

**Mental health needs of prisoners, delivery of care and NHS equivalence**

The benefits of closer links to the NHS are obvious in some prisons. The 2003 Chief Inspector of Prisons’ annual report states:

> ‘They can bring in effective and professional management, improve the clinical supervision of staff and review the skills mix of health care staff in order to support prisoners’ needs… the arrival of mental health in-reach teams in many prisons has been of benefit to prisoners and staff, enabling those with chronic mental disorder to be better managed on the wings.’

(HMCIP, annual report 2003)

But these welcome improvements face a challenge when set against the high levels of serious mental disorder found in the prison population as compared to the general population (see Introduction, above).

Dr Adrian Grounds has noted that the ONS studies indicate that the rates of psychotic illness are in the order of 20 times higher among remand prisoners than in the general public. Therefore, a typical large local prison, with 1000 places and a turnover of 5000 receptions per year, will have about the same caseload of serious mental illness as a town of 20,000 people into which 100,000 newly arrive and leave each year. According to DoH implementation guidance for community mental health teams, (2002) a typical team, with a caseload of 350 service users (only half of whom present complex problems) would consist of three to four CPNs; two to three social workers; a minimum of one full time clinical psychologist; support worker and administrator; and two full time psychiatrists: in total between 12 and 14 professionals. A large local prison is likely to have at least the caseload that would be served in the community by a full CMHT, and in the prison there will be additional demands of providing assessments for courts, arranging aftercare for those leaving custody, and trying to look after seriously ill prisoners who should be in hospital though places are unavailable. However, a prison mental health in-reach team is very unlikely to have the personnel resources that would be found in community mental health services (Grounds, 2005).

Prisons Inspectorate reports on individual establishments suggest that in-reach teams are often under heavy pressures, handling huge workloads and urgent cases. Anne Owers stated:

> ‘These teams are still fire-fighting: in most cases they can only deal with those whose mental health problems are both severe and enduring, rather than chronic and sporadic.’

(Owers, 2004)

Since April 2004, the in-reach team in HMP Belmarsh had received nearly 1,200 referrals, half of whom had been admitted to the in-patient unit (HMCIP, Belmarsh, 2004). The core team at Brixton looked after a total of up to 40 patients at any one time and faced an average of 20 new referrals each week (HMCIP, Brixton 2004). The in-reach team at HMP Wandsworth, lacking a full...
complement of CPNs and with poor performance by the prison’s own health care team, carried a
caseload of 1,000 in the last year (IMB report).

In a previous report (Rickford, 2003), PRT has drawn on Dr Adrian Grounds’ work to explore in
some detail the rhetoric of equivalence as against the reality of prison health care. In essence,
equivalence means that the prison population should be treated as a subset of the general
population. The health targets, priorities and policies that the government sets for the general
population must apply to the prison population. There should also be equivalence of standards and
services. When the National Service Framework was reviewed by Professor Louis Appleby in
December 2004, mental health services for prisoners, who have higher psychiatric morbidity,
should have been included in that analysis. Such an exercise would surely have confirmed the
increasing gap between the improving services enjoyed by the general population and those found
in prisons. To achieve equivalence, an objective of the DoH requires much more political focus
than the ‘direction of travel’ envisaged in the DoH strategy document, ‘Changing the Outlook’
(2002).

Two of the building blocks on which the new services will be commissioned and provided are
prison health delivery plans (PHDP) and health needs assessments (HNA). But there are
problems with both of these. According to the toolkit developed by the University of Birmingham,
the aim of HNAs is to ensure:

‘That the services provided correspond to patients’ needs and that patients’
demand these needed services.’

(Marshall et al., 2000)

HNAs have been carried out in all prisons, as part of the transfer of responsibilities to the PCTs.
Unpublished research (Quinn 2005) which examined several HNAs and PHDPs from one of the
English regions questions the extent to which the toolkit was used in preparing the health needs
assessment. HNAs regularly state that their data are collected from incomplete sources. On one
occasion ‘anecdotal’ evidence was used, others took evidence from prescription records and
poorly kept paper records. Prison Health development plans appear to be aspirational, so do not
provide a mechanism for addressing outcomes. It is therefore difficult to know if planned projects
have been taken forward. The result is that barriers and problems are often identified without the
subsequent development of a plan to address the problem.

It can be argued - on economic, public health, prison management, and justice grounds - that
equivalent healthcare is not sufficient: standards in prison need to be higher than in the community.
A recent study by Harty and others at the Institute of Psychiatry has shown that the mentally ill in
prison have not only greater need but less of it is met than people with same illnesses in the
community (Harty et al., 2003).

But it is also important to guard against the potential danger that improvements in prison mental
health services could lead sentencers to see prison as an attractive option for offenders who have
been failed by services in the community. This would be a greater injustice than the present
unacceptable situation, and safeguards are needed to prevent it.

Key to the DoH aspiration to equivalence for prison health care is the essential requirement that
inspection and monitoring requirements for prison mental health care should be as good as those
in the community. The Healthcare Commission should be able to visit prisons unannounced and
regularly access the views of prisoners about their care. In addition, advocacy and support
services, now seen as necessary in the wider community are vitally needed in the prison
environment.

Prison numbers and overcrowding

The backdrop to the healthcare reforms in prisons is a combination of an increasing prison
population, overcrowding of the prison estate, and much movement of prisoners between
establishments to meet the needs of the service (the churn factor). To provide a healthy prison where prisoners feel safe, are treated with respect, and their individual needs understood is very much harder in this context.

Several Independent Monitoring Boards (IMBs) have recently chosen to highlight the increasing numbers of mentally ill prisoners as an area of concern. These include the 2003/4 annual reports from the following prisons: Bedford, Lewes, Littlehey, Norwich, Stocken, Swaleside, the Mount, Wandsworth, and Whitemoor.

'The board is still very concerned with the number of prisoners suffering from mental illness who are being kept inappropriately at HMP Lewes, where they are unable to be treated under the Mental Health Act.'

(IMB Lewes, 2003/4)

The prison system has coped with increasing numbers by juggling prisoners throughout the system to find spaces for them. The result has been that new prisoners, who used to remain at their local prisons until having completed induction and assessment, are moved on much earlier to wherever there is space for them. So, prisons which used to have a more settled and stable population are forced to cope with volatile and unknown prisoners.

The system of health care, Type 1, 2, and 3, is based on the historical needs of the prison. So, local prisons such as Wandsworth and Norwich, which expect admissions straight from court, typically have a type 3 health care system with 24 hour health cover. Training and open prisons would have type 2 (health care services provided for an extended period 0800 - 2100) or Type 1 with health cover during normal hours (0800 - 1700). In these prisons, health cover at weekends and out of hours must be provided by the emergency GP and hospital services. These prisons can hold mentally ill men who, in the community, might be considered ill enough to be admitted to hospital.

The Chief Inspector’s annual report, 2003, reflects on the effects of the increasing population and overcrowding on training prisons. These establishments are now receiving recently sentenced prisoners. As a result, prisoners sent to them can be unsuitable for the regime and facilities. Quite apart from compromising the purpose of training prisons, there are concerns voiced by the IMB about the availability of adequate health care at these prisons.

'There is continued overcrowding, increasing numbers of prisoners who are volatile, require large amounts of staff time or are mentally ill, being allocated to the prison…these prisoners are unsuitable for the regime at the Mount, its staff profile or level of medical cover available.'

(IMB, HMP The Mount)

The IMB at HMYOI Onley commented on:

‘… the presence of significant numbers of trainees with significant mental health or behavioural problems.’

(IMB, HMP Onley)
5. Recurring Themes for Acutely Mentally Ill Prisoners

According to the NHS Plan (2000), around 5,000 prisoners (between five and eight per cent of the population) have severe and enduring mental illnesses. Of this group, significant numbers would be suitable for sectioning under the Mental Health Act 1983.

Dr John Reed (2003) estimated that 500 were suitable for immediate admission. In an earlier publication he recognised that the threshold for admission under the Mental Health Act in prison was higher than that in the community. This in itself is inequitable. Offenders' illnesses have to be significantly more serious than their counterparts in the community before they can be given help under the Mental Health Act.

This report has noted that diversion services have failed to prevent these very ill prisoners entering the prison system. This failure is combined with a failure to transfer ill offenders out of prison in a timely way. Conditions for these offenders are exacerbated by targets for the in-reach model to reduce prison hospital beds and reduce length of stay in prison health care beds.

Recurring and persistent themes in the mental health care delivery in prison - to which this report now turns - illustrate the stress the system is under and the harm that results to prisoners with mental health needs.

5.1 The use of seclusion in healthcare centres and segregation for mentally ill prisoners

Prisoners with acute mental health problems do not come within the MHA 1983 and it is right that this remains so under the new draft bill. They should either have been diverted before they entered prison or transferred out as quickly as possible when their treatment required it. But there is a stark contrast between the lack of safeguards in prison health care centres and segregation units, and the care provided to people in the community who have acute mental health problems requiring hospital treatment and occasional seclusion in psychiatric in-patient units.

Despite acknowledged shortfalls in the practice in some NHS hospitals and the concerns of the Mental Health Act commissioners in their Biennial reports at their findings on some areas of seclusion practice, these NHS patients do have the code of practice, following the Munjaz 2003 case to govern procedures and a system of redress. Compare this to mentally ill prisoners, who have until they have been transferred out of prison to hospital, have fallen off the edge of our health care system.

The Mental Health Act 1983 code of practice states that seclusion should be used as a last resort and for the shortest possible time. It should not be used as a punishment or threat, as part of a treatment programme, because of shortage of staff and where there is any risk of suicide or self-harm. There should be clear written guidelines on the use of seclusion, to ensure the safety and well-being of the patient, to require record-keeping, and to stipulate standards for the rooms to be used (DoH, 1999).

Mental Health Act commissioners (MHAC), on their visits to NHS hospitals, monitor services and encourage their compliance with the guidance in the code of practice. There is, at present, no such detailed and specialist oversight for prisoners with mental health problems. However, there is a new programme of joint work so that an MHAC specialist will be part of the prisons inspectorate teams in prisons with large in-patient facilities.

In 2000, Dr John Reed and Maggie Lyne looked at unpublished data from the MHAC and made comparisons with the use of seclusion in prison inpatient units (based on returns from only four inpatient units). While noting the different legislative basis for seclusion in prison health care and the NHS, they showed that in 1996-7 there were around 4,800 episodes of seclusion amongst the 24,191 patients detained under the Mental Health Act. They compared these figures to the prison health care centres where there were 5,268 episodes of seclusion for the 14,784 mental health admissions.
In the NHS nearly all seclusions were because of risks to other patients and staff. In prison nearly all seclusions were because of the risk of the patient self harming.

(Reed and Lynne, 2000)

Prison Service order 1700 (November, 2003) covers segregation, its purpose and authority. Prisoners can be placed in a ‘close supervision centre’ for reasons of good order or discipline, or for their own protection, either at their request, or at the governor’s discretion. A prisoner might have been identified by an officer as disruptive; or, the prisoner might have a particular reason to fear for his or her safety. Prison rule 53 authorises the use of separation for a prisoner awaiting adjudication and rule 55 authorises the governor to impose cellular confinement for up to 21 days or removal from the wing for up to 28 days on those found guilty of an offence against discipline (HMPS Prison Rules, 2004).

To what extent is segregation being used to manage mentally ill patients

PRT maintains a database on deaths in custody. Between January 2002 and the end of September 2005, there were 318 self-inflicted deaths in prison custody. Twelve percent of these took place in segregation units. Forty-eight of the 318 who killed themselves in this time period were adult males who were registered as at risk of suicide or self harm at the time. Seven of them (or 15 percent) were located in segregation units at the time of their death. Thus far in 2005, 13 adult male prisoners who suffered a self-inflicted death were registered as at risk at the time; four of them (almost a quarter) were located in a segregation unit. This evidence clearly demonstrates that the practice of holding men at risk of suicide in prison segregation units is continuing.

The use of segregation in prisons was reviewed in early 2002 after the European Court of Human Rights judgement that the Prison Service was in breach of the Human Rights’ Convention, concerned with the inhumane and degrading treatment over the suicide of Mark Keenan in HMP Exeter’s segregation unit in 1993 (See Appendix 1 for further reference to the Keenan case and HRA implications).

Eleven IMB 2003/4 annual reports raise the issue of the use of segregation for prisoners with mental health problems in order to manage and contain them.

‘The board is very concerned at the use of the SCCU for the long term accommodation of mentally ill prisoners because of the lack of suitable hospital places.’

(IMB Littlehey, May 2004)

These concerns are echoed in IMB annual reports from the following prisons: Lewes, Long Lartin, Norwich, Oney, Pentonville, Reading, Stocken, Swaleside, and Wandsworth.

‘The segregation unit has been used numerous times during the year as the only location within the prison for severely mentally ill prisoners.’

(HMP Lewes)

In the absence of adequate mental health care for acutely ill prisoners, there is a risk that use of segregation for their management is being sanctioned under prison rules.

Under Rule 45 (own protection) there is a duty of care imposed on the Prison Service, the governor (or director) and all staff to take ‘reasonable care in the circumstances to protect the prisoner from injury’. Rule 45 (Good Order and Discipline) has the requirement of ‘reasonable grounds for
believing that prisoner's behaviour is so disruptive or cause disruption that keeping the prisoner on location is unsafe’. These requirements can be used to contain acutely mentally ill prisoners.

Prisoners deemed to be troublesome are removed to the segregation unit with the aim of maintaining order (Rule 45). It is possible that such prisoners are displaying signs of mental illness which had not been recognised. The Scottish Executive publication ‘On the Borderline’ reports that prisoners with learning difficulties can be placed in segregation units, or locked in their own cells for long periods, for their own protection (Myers, 2004).

If a medical report subsequently finds that the prisoner is not suitable for segregation, some are sent to another prison on transfer. This merry-go-round can happen repeatedly, ruling out any chance of mental health care, as they are shipped around the country.

The following case history illustrates the impact of the new arrangements on the care of prisoners with mental health problems. It also highlights some of the challenges faced to get care and treatment for ill prisoners whose mental health related behaviour brings them within the ambit of prison discipline.

X was referred to the team in late 2003 by healthcare staff at the YOI with a history of increasingly bizarre behaviour, fluctuating mental state and escalating violence. At the time of referral he was in the CCU subject to a four-man unlock. His forensic history was mainly robbery and shoplifting; there were no convictions for violence although he had one conviction for possessing a lock knife and a caution for a similar offence. In the six months prior to assessment he accrued increasing numbers of adjudications regarding his behaviour.

He was assessed initially by a member of the in-reach team, who believing him to suffer from a psychotic illness, arranged for him to be assessed by the team’s consultant. Before this could take place he was transferred for disciplinary reasons to an adult jail in the area, fortunately one covered by the team. He was not felt to be mentally ill by the receiving prison and he was placed on ordinary location.

When seen again X was unhappy at the transfer because he had been told he was moving to a prison nearer to his home, the conditions in the jail were exacerbating his symptoms as he had little occupation or distraction as a consequence his auditory hallucinations intensified. It was however possible for the team consultant to assess X, he concluded that X was suffering from a psychotic illness most likely paranoid schizophrenia and that his behaviour recently was in all probability related to his mental state. Unfortunately before this could be investigated further he was moved again, to another adult prison even further away from his home area.

As this jail had an In-reach Team it was possible to forward the relevant information on so that he was not lost in the system. X was transferred yet again to another adult prison in his home area this time however on medical grounds to facilitate assessment by his local service. The prison moves further and further away from his home had made assessment by the appropriate service increasingly difficult.

(Mental health in-reach worker, private correspondence with PRT, January 2005)

The detailed requirements for seclusion under the Mental Health Act, described earlier, need to be compared to the care and treatment provided in the segregation unit to mentally ill prisoners kept there. Segregation units are not staffed routinely by healthcare staff. They may visit on a regular basis but the 24 hour cover is provided by prison officers, who are not trained in mental health, as was noted in the IMB annual reports of Littlehey, Reading, Stocken, and others.

‘We remain concerned that the Segregation Unit can sometimes be used as a place of containment for the most seriously disturbed prisoners, when their behaviour is too difficult for other parts of the prison to manage. This is not fair on the staff or prisoners, some of whom may be awaiting suitable placements in NHS psychiatric hospitals.’

(IMB HMP Pentonville)
Many boards acknowledged that officers were doing a very good job in extremely difficult circumstances, despite their lack of training, and highly commended their work in this area. But the point needs to be made that prison staff should not have the responsibility of looking after very ill and unstable people.

Physical conditions in the segregation unit of some of the older prisons can be very poor.

‘Substantial improvements have been made to both the unit and the regime but prisoners are still confined in subterranean conditions 24 hours a day. The board continues to be concerned at the high temperature in the cell when the heating is on.’

(IMB HMP Bedford)

‘The board has great concerns about the conditions in the segregation unit. It is subterranean, has little natural light and is very damp. Because of bad ventilation the cells are very hot in the summer and cold in winter.’

(IMB HMP Lewes)

Close Supervision Units are not designed for close observation of prisoners. This requires gated cells so that the view of the prisoner is unimpeded. Without this facility, the ability to observe is limited and the ability to prevent self harm reduced. And gated bars are not necessarily the answer, as they raise concerns about treating the prisoner with dignity.

Mentally ill prisoners have been kept in the segregation unit for a variety of reasons. There may be insufficient staff to deal with them in the healthcare centre (IMB annual report, Long Lartin). The healthcare centre may not have enough beds. Chief Inspector’s reports show that health care beds in prisons are predominantly used for mentally ill prisoners. The inspector’s report on HMP Brixton (2004), for example, shows that of the 33 in-patients at the time of the inspection, 30 were psychiatric patients.

Some prison healthcare beds are being reduced to be replaced with more day care facility in order to fit in with the new strategy of in-reach treatment and less reliance on healthcare centres. Wandsworth is mentioned in the HMCI annual report as a prison where the number of beds has been reduced to 15 to accommodate a day care centre in keeping with this new approach. We do not know how the reduction in hospital beds (seen as a refuge and respite) is affecting the management of mentally ill prisoners but it is worth noting that the Wandsworth IMB report for 2003/4 states:

‘The biggest problem here during the past year has been the huge increase in the number of mentally ill prisoners who have spent time in the CSU. They come from the wings and the hospital. Appropriate placements are very hard to find.’

(IMB Wandsworth)

Pentonville IMB flags up their concern at their proposed reduction of available beds from 38 to 30, asking how the prison will cope when transfers are so slow.

Another reason for the use of CSSU is that the observation cell in the HCC may be unsuitable with better facilities in the CSSU (IMB, Littlehey). Or, that health care provision at the prison may not extend to having 24 hour cover or in patient beds, as is the case in some of the training prisons. With the problem of having to contain a very disruptive mentally ill patient, the CSSU may be the only immediate answer to keep the prisoner and others safe. But it is a situation which is intolerable in any but the very short term, as the solution lies in developing effective schemes for timely diversion and transfers to NHS provision.

5.2 Training and the delivery of care by prison staff

An institution with responsibility for holding large numbers of acute mental health patients needs, at a minimum, adequate staffing. A recurring theme in the care of such people in prison is the
inadequate numbers of specially trained prison nursing and medical staff, their professionalism and attitude, and the awareness and basic knowledge of prison staff about mental health.

We have noted earlier the influx of NHS staff to prisons, through the in-reach teams (the target for in-reach nurses has now exceeded 300 and stands at 380) and consultant led sessions who bring their NHS professionalism and clinical leadership into the prison environment. NHS staff have had a steep learning curve to understand and comply with the constraints of the custodial environment.

Reed and Lyne (2000) revealed that in the 13 prisons inspected, no doctor providing health care of inpatients had competed specialist psychiatric training, only 24 per cent of nursing staff had mental health training and almost one third of staff were in face non-nursing trained health care officers. The situation for prison healthcare staff has no doubt improved since then. But the yardstick for judging improvement is the standard that would be found in the NHS in the community and in hospital.

The Prison Health workforce team faces the challenge of drawing the prison staff into mainstream NHS, which is modernising at a rapid pace and to devolve the majority of decisions on workforce matters to a local level.

A 2002 working group, on 'doctors working in prisons', generated 50 recommendations, all of which were accepted by the DoH, Home Office and Prison Service. All full time, part time doctors and locums are now required to be appropriately trained.

The risks of isolation are now recognised: the advice is that no doctor should work solely within the prison environment. At the time of writing this report, around 83 doctors still hold prison service contracts. About 40 of these are NHS GPs who work part time in prison under older prison service contracts. Some of the remainder have chosen to train in primary care, or are being supervised in their practice. A pilot for clinical appraisal has been carried out successfully showing that GP clinical appraisal can be used in prisons. All prison employed doctors should have a personal development plan folder (Howells, 2004). However, anecdotal evidence remains about prison doctors' lack of training in mental health work and inappropriate attitude to mentally ill prisoners.

'Nursing in Prison' (DoH, 2000) made 37 recommendations, most of which have been achieved. Areas of work since then for nursing have been clinical supervision, nurse leadership, more flexible working, new links with the Queen's Nursing Institute, skills mix activity. Development of the role of the nurse practitioner in prison and other NHS nursing developments have resulted in higher standards of care.

Funding to support external training will be devolved from Prison Health directly to each SHA in 2005-6. From April 2006, each PCT will receive their individual allocation for training from their SHA. So it will become the responsibility of the PCT to determine the funding required to support the prison health workforce. Responsibility for prison healthcare training and development was transferred to the National Health Service University (NHSU) in April 2004. Mental health awareness is currently being piloted in nine establishments, a NVQ level 3 has been established for custodial health care, along with a short induction programme specifically for healthcare staff (Mitchell, 2004).

What mental health training is required for non-medical prison officers who have 24 hour oversight of prisoners? Such training is still not mandatory for prison staff. Governors retain discretion to decide on training priorities for their staff. So, although good training packages are increasingly available through the NHSU and others, and though there is an obvious need, they are not necessarily being used.

Wing-based care is central to the prison healthcare strategy. In-reach nurses assist in maintaining quite ill but stable prisoners on normal location. They undoubtedly are able to provide support, information and even training for prison staff. But it remains essential that the prison staff...
themselves, who have 24 hour oversight of prisoners are both aware and have some mental health training. The new wing-based mental health liaison officer role is a welcome development. But it remains the case that governors hold discretion about whether such a role is needed in their establishment, as they do about the level of training their staff require.

The Chief Inspector’s report on HMP Birmingham detailed the lack of training for prison staff responsible for vulnerable prisoners (which includes those who have mental health problems). However, more recently, prison health has begun to deliver a two-day training programme for prison staff, developed by Bournemouth University, and designed to improve their awareness of mental health problems, and inform them of the treatment options available. It is likely that this training will be primarily for Senior Officers and healthcare centre staff. While the training pack is useful, the more important question is the extent to which it will reach officers on the landings.

The Joint Committee on Human Rights expressed its concern that prison staff are not mandated to receive refresher training in mental health awareness and suicide prevention.

The culture of the prison provides additional hurdles for initiatives using the new technologies. Those working in the prisons on a daily basis find it difficult to access computers and get telephone lines into prisons to facilitate the training packages developed by the National Health Service University (NHSU). So there remains a considerable gap between the availability of training and its take up by the key front line staff. Announcements made by the DoH and Prison Health on this aspect of the modernising agenda tend to gloss over the local and detailed difficulties of implementation.

The planned changes are welcomed, but the acid test is in the actual day-to-day routine care and treatment of offenders in prison, many of whom have mental health problems. The accounts below from HMP Birmingham and HMP Wandsworth illustrate how far there is still to go and how easy it is for standards to slip in a closed institution like a prison, many of which also have an embedded, negative culture towards offenders.

The inspection at HMP Birmingham found that strip clothing and blankets were still routinely being used in the in-patient facility. Staff “did not appear to know that this was no longer acceptable.” Anecdotal evidence tells of use of strip cell conditions at other establishments as a way of managing severely mentally ill patients in a crisis. The Prison Service, having banned the use of stripped cell condition, needs urgently to discuss with their DoH partners what additional resources should be made available to those at the front line, to ensure that the treatment and handling of prisoners complies with acceptable standards.

The attitude of health care staff can also give cause for concern. Despite caring and professional treatment by some nurses at Wandsworth, the Chief Inspector’s report of September 04, witnessed this example of poor care:

‘A prisoner … who had severely cut his throat with a razor was taken to the treatment room and, after initial first aid, appeared to be ignored by the nurses. He was not asked how he felt or what prompted his self harm. … having been treated at St Georges Hospital, he was returned to the prison at about 3 pm but reception staff seemed unaware of who he was… after perfunctory question he was left to wait to see the doctor… he was eventually taken to the health care centre at 5.30, put in a double cell and left bewildered. Staff seemed disgruntled that he had arrived when he did and we observed minimal interaction with him.’

(HMCIP, Wandsworth)

What is particularly worrying about this account is that this attitude and behaviour happened during the course of a full announced inspection. What sort of attitude is evident when nobody, apart from the prisoner is there?

Staff shortages in healthcare centres give cause for concern. Lincoln IMB recorded night cover and of only one agency nurse, when there was an average of nine patients in the HCC over the year.
IMB Stocken mentions long term sickness, problems of recruitment, use of locum doctors and nurses with the result that very little health screening taking place. Inadequate staffing levels, particularly at weekends and evenings were highlighted by the inquest jury following the death of Sarah Campbell at Styal prison. The problem of inadequate staffing levels is not confined to women’s prisons.

5.3 Consent and coercion

Many prisoners are prescribed medication. The prison is not a hospital for the purposes of the Mental Health Act 1983. Hence, guidance (DoH, 2002a) makes clear that prisoners who demonstrate a need for treatment and care; who exhibit severe mental distress; and who have the capacity but do not consent to take their medication will need to be moved to NHS provision to be treated under the Act.

This guidance suggests that seeking consent should usually be seen as a process, not a one-off event. Provided people still have the capacity (are ‘competent’) to do so they can give consent to a particular intervention but are then entitled to change their minds and withdraw their consent at any point. Prisoners need to be told this so they feel able to talk to staff and possibly change their minds. Crucially, prisoners should be given enough information to enable them to decide whether they want to consent to, or refuse treatment. This means they need information on the benefits and risks of the proposed treatment, what the treatment will involve, the implications of not having the treatment, and possible alternatives. People also need to know the practical effect on their lives of having, or not having, the treatment.

The information needs to be provided in a form that the prisoner can understand, in a private place, with time for the prisoner to raise issues and questions. Prison staff have a role to play in discussing options and providing reassurance; nonetheless, the prisoner must not feel forced into making a decision about their health care because of perceived or real pressure from others.

This guidance sets a high standard, particularly for the prison environment. To give informed consent, the prisoner has to understand and retain information relevant to making that decision. In particular he needs to understand the consequences of having, or not having, the intervention in question, and to use this information in the decision-making process.

Assessing someone’s capacity to do this may sometimes require specialist psychiatric and psychological expertise and detailed knowledge about the patient. In reality there may not be a doctor available in the healthcare centre and a prisoner may have arrived with no useful information about their mental health history so professionals caring for new prisoners face challenges of a different order from practice in the community.

The Mental Health Act 1983 code of practice states:

‘The assessment of a patient’s capacity to make a decision about his or her own medical treatment is a matter for clinical judgement, guided by current professional practice and subject to legal requirements. It is the personal responsibility of any doctor proposing to treat a patient to determine whether the patient has capacity to give a valid consent.’

(DoH and Welsh Office, 1999)

The professional standards to assess capacity to consent, which apply to people subject to the Mental Health Act in the community, need to be consistently applied to prisoners.

The MHAC suggested that:

‘… prisoners who are undergoing psychiatric treatment inside prison should be subject, at least, to similar visitorial safeguards as apply to psychiatric patients detained in health care establishments.’

(MHAC, 2003)
Prisoners who have been assessed, found to meet the criteria for compulsion, and are then awaiting transfer to NHS care should be treated as a specific group and have some of the rights, such as advocacy services and oversight by a healthcare inspectorate, which will be available to patients in the community under the draft mental health bill.

The MHAC has concerns about the possibility of abuse of mentally ill prisoners:

“In our view the potential for unrecognised and unchallenged coercive psychiatric treatment is extremely serious in a prison environment, where prisoners have far fewer residual freedoms than detained patients and may also feel that their compliance with psychiatric treatment may determine their assessment for release.”

(MHAC, 2003)

The use of control and restraint (C & R) requires careful training and supervision of staff, and monitoring by independent persons, so that abuses do not take place. Its use in prisons is detailed in Prison Service order (PSO) 1600 with the following Prison Service instruction (PSI) amendments on the abolition of mandatory training PSI 09/2003 and PSI 38/199 use of force.

The Chief Inspector’s report on HMP Birmingham shows that the prison had not met its own target for control and restraint refresher training (only 66 per cent as opposed to 80 per cent). The prison had not implemented the Inspectorate’s recommendation that a manager who authorises the use of force should not also act as the certifying officer.

According PSO 1600, when a prisoner is finally removed from special accommodation or a mechanical restraint is finally removed the record in an F2323 must be sent to the prison doctor, and copied to the IMB. These forms, signed by the prison doctor, must be sent to the ‘Data Collection Unit’. It is therefore theoretically possible to monitor the use of such methods. However, in practice there is no central monitoring of this difficult area.

Some IMBs record the number of incidents. For example, at HMP the Mount, C & R procedures were employed on 66 occasions during the reporting period 2003-4 as against 23 times the previous year, a threefold increase. At HMP Swaleside on two occasions C & R was used to administer drugs in 2003-4 which is described as ‘medical restraint’. In addition, mechanical restraints were used twice in 2003/4.

Mentally ill men are likely to be among those subjected to C & R. There is also evidence that prisoners with mental health problems are charged with offences and punished, often inappropriately. The prisons inspectorate detailed how one mentally ill prisoners had been awarded seven days cellular confinement for damaging prison property; he had done this in the course of an attempted suicide (HMCIP, Norwich, 2005).

Much more light and research needs to be shed on this hidden area. The Prison Service needs to ensure that:

• All staff - healthcare and discipline - follow protocols and procedures when restraint is required
• Separate rules govern the interventions typical of healthcare staff from those of discipline officers.

(HMPS 2002c)

But governors, and others who conduct adjudications, need to be aware that punishing mentally ill prisoners for behaviour which is an effect of their illness is blatantly unjust and should have been abandoned long ago.

In addition, rigorous and independent monitoring is needed for consent, capacity and compulsion in psychiatric treatment used in prisons. Discrepancies between the PSOs and Instructions and the reality of delivery in a prison with a disturbed psychotic prisoner could be dangerous for both staff and prisoners.
5.4 Delays in transferring prisoners into hospital care

Delays in transferring diagnosed mentally ill patients to NHS provision under section 47 or 48 of the MHA result in the prisons having to contain very ill prisoners for extended periods of time. As noted above, some of these people are held in segregation units, under the care of staff who are not trained or managed to care for them adequately.

At any one time there are likely to be at least 40 prisoners who have been assessed under the MHA 1983 and have waited three months or more before being transferred to hospital. But prisoners can wait considerable lengths of time before an assessment takes place. (Hansard House of Commons 17th March 2004).

The transfer process can be slow and laborious.

‘There are a range of institutional and organisational barriers which impart their own fingerprints in delaying the transfer process.’

(Henderson, speech to PRT conference May 2004)

Detailed work on the prison interface care pathway carried out by South East London public health network and South East London forensic strategy group under the chairmanship of Dr Hilary Guite which ‘process mapped’ the existing system revealed the following:

- People with severe mental health problems will often see at least 23 different people from around seven different agencies from point of arrest to return to the community
- No one manages the whole pathway.

There can be long delays in obtaining initial and then secondary psychiatric assessments in prison. At the most basic level the information exchange that needs to take place between courts and the prison health care team can be problematic because information does not necessarily pass from the courts to the prison. But it can become more difficult when establishing the address of the prisoner and his GP. This is crucial information which decides who is the ‘responsible commissioner’ who will finance the hospital care of mentally ill prisoners. If the prisoner is homeless, or without a GP then financial responsibility is borne by the area where the offence was committed. If the prisoner has been in custody for more than six months, he is classed as ‘ordinarily resident’ in the PCT where the prison is located.

Identifying the responsible commissioner, while likely to be surrounded by confusion and disagreement, should not affect the treatment of the prisoner. With the cost of maintaining a man with mental health problems in a secure NHS place in the region of £160,000 per year, discussions can be protracted. But there can also be additional problems. It is not unusual for health care staff to find ‘their’ prisoner has been moved to another prison with little or no notification. The process of getting information forwarded and organising a mental health assessment has to begin again for the receiving prison.

The prison mental health transfer project - an important acknowledgement that the DoH understands the severity of the issue - has produced draft guidelines dealing with transfer arrangements. Its authors felt the need to reiterate that disagreements about funding should not affect care; and that once a section 48 is pending, the prisoner must not be transferred to another prison unless absolutely necessary. This is welcome but how will it be assessed and monitored? It is clearly being breached at the moment.

The draft guidelines repeat the present position that if the prisoner is transferred, the assessment process must be started again. It is not clear why an assessment by an accredited professional should not be accepted by another. This resulting delay is likely to be detrimental to the care of the prisoner.

There is a perverse incentive in the system for measuring transfer delays. At the moment the three month period for arranging transfers, by which trusts are measured and monitored, starts when the NHS provider has accepted in principle the transfer request. It does not start when a
prison has made the initial request for a transfer. This means that trusts who are willing to consider requests for such patients will be penalised when they fail to finalise the transfer in the three month period, while trusts who refuse to meet requests for transfers are able to avoid this problem.

The MHAC biennial report for 2001/3 suggested that data should, in future years, be collected from the start of the assessment process, when a request for assessment is made by the prison. The following data need to be captured.

- The number of requests for assessments from prison
- The total number of assessments carried out
- The number of prisoners assessed and accepted for mental health transfer
- The number of mental health transfers
- Transfer delays of more than three months' duration.

(MHAC, 2003)

This range of data would give a much better picture of how the system was working and where the problems lay.

To encourage quicker transfers out of prison, capacity at the appropriate level of secure accommodation must be increased. Commentators have argued that the number of secure beds (high, medium, and local psychiatric intensive units) is inadequate. John Gunn, Tony Maden and colleagues at the Institute of Psychiatry surveyed large, representative samples of the remand and sentenced prison population, and estimated the implications for NHS bed numbers (Gunn et al. 1991; Maden et al. 1996). They extrapolated to estimate the number of hospital beds needed for the sentenced and remand populations. The figures (combining sentenced and remand populations) were between 1,300 and 2,300. Dr Adrian Grounds, updating these figures to include the rise in the prison population by 60 per cent (assuming the rates of mental illness among prisoners remain the same) suggested that the bed numbers now needed may be in the region of 2,100 to 3,700.

Currently there are just over 3000 medium secure places (split about half and half between the NHS and independent providers). There has recently been a substantial increase of medium secure beds, but the issues discussed in section 2.5 (above) suggest that there still will not be enough beds.

The longstanding failure to provide local specialist community provision has led to inappropriate placements in the secure units (NIHMHE 2004). But any plans to contract high security hospitals need to have appropriate alternative provision available. The blockages in the system are endemic with secure hospitals slow to move patients onto more appropriate placements because of the lack of capacity elsewhere in the system. So finding a suitable NHS secure bed for a mentally ill prisoner can become a long and entrenched waiting game.

The earlier section of this report, on diversion, noted that system wide failures and organisational barriers have resulted in mentally ill offenders being sent to prison but once there, these problems mean they spend far too long in the prison, in conditions that are dangerous and damaging both to themselves, their fellow prisoners, prison staff and the prison system as a whole.

5.5 The Care Plan Approach

The care plan approach (CPA) should link the prisoner, once discharged, to appropriate community services. Otherwise any work achieved within the prison is lost, the offender’s mental health will deteriorate and the chances of re-offending are high. The National Service Framework (NSF) states:

‘...no prisoner with serious mental illness will leave prison without a care plan and a care co-ordinator.’

(DoH, 1999)
These care plans should include secure suitable occupational activity, adequate housing and appropriate entitlement to welfare benefits. Care plans need to be attended by all the key professionals. Ideally, relatives and carers of the prisoner with severe mental health problems will be encouraged to attend. In addition, equivalence with the NHS requires that a severely ill prisoner should, as their counterpart in the community, receive a follow-up contact with a clinician within seven days. These requirements were due to be met by April 2004, but have not been achieved in many areas. For example, the health in criminal justice draft strategic plan for the South East Development Centre acknowledges that CPA is a key piece of work and if it is to be mainstreamed into South East prisons by the end of March 2006 (the suggested date when an outcome would be achieved) would require additional capacity. Scoping work is needed to establish a seriously mentally ill register (SMI).

It is perhaps not surprising that research found that 96 per cent of prisoners with mental health problems were put back into the community without supported housing, including 80 per cent of those who had committed the most serious offences: more that 75 per cent had been given no appointment with a psychiatric health professional after release. For violent or sexual offenders, 41 per cent, less than half, had been given psychiatric appointments (Melzer et al. 2002).

Attendance of key professionals at CPAs for prisoners can be patchy when they are arranged and it is most unusual for relatives and carers to be involved in a meaningful way. The current situation results in profound damage to individual prisoners, a waste of public resources, and a negative impact on rates of re-offending. Given the DoH NSF commitment, the conclusion one must draw is that there is a lack of political will by all government departments involved in this process - housing, welfare benefits, health, and employment - to resolve these issues.

We commonly see mentally ill men being released at the end of their sentences who at the very least should go out to suitable accommodation, they should be registered with a GP, and have had follow-up by their local mental health service arranged. Distressingly often, and notwithstanding efforts by their probation officers, they leave with no address: only an instruction to present themselves as homeless to the housing authority. In the absence of an address, the relevant mental health team either cannot be identified, or they will refuse to commit to seeing the patient, or both. There will be no GP registration. Housing authorities may refuse to accept a prisoner on their waiting lists before he is released because he is not potentially available to take up a tenancy should one arise.

(Grounds, 2004)
Troubled Inside: The mental health needs of men in prison
6. The Situation for Most Prisoners

Prisoners who have acute mental health illnesses are the minority. What is the position for the majority of prisoners who while not severely ill, experience significant mental health problems? Seventy-two per cent of male sentenced prisoners suffer from two or more mental health disorders. Almost half of recently sentenced male prisoners had used heroin, crack or cocaine in the 12 months prior to imprisonment (Ramsay, 2003). Clearly, one effect of this profile of social background is that people who enter the prison system are vulnerable to a deterioration of their mental health.

Given the negative influence of imprisonment on mental health; and given that many reports by the prisons inspectorate judge that individual establishments fail to meet the criteria for a healthy prison, what do the majority of prisoners need to maintain their mental health? Are there recurring themes which need to be addressed so that a prisoner’s anxiety, stress or depression does not become unmanageable and reach a crisis point?

Prisoners need to:
- Reach prison without undue delay
- Be screened adequately when they come into the system
- Experience a thorough and accessible induction procedures
- Encounter staff who are responsive to them and treat them decently and have some awareness of mental health
- Be able to access good primary care services
- Be treated by medical staff to a high professional standard
- Be able to contact medical help in an emergency
- Have adequate occupation and time out of cell
- Live in conditions which meet standards of decency
- Have good contact with their families and friends.

In addition staff need to:
- Be trained to recognise key mental health indicators
- Be prepared to engage positively with prisoners
- Have support and be well managed
- Have further advice available
- Have time to be able to put into practice the policies and procedures designed to protect and safeguard those who are vulnerable
- Be responsive to families and carers of prisoners.

There can be no doubt that considerable investment has been made in prison mental health services and there are many examples of leadership and inspired work being done. In-reach teams have been able to provide mental health services to prisoners on the wings. In addition they can offer training, support and advice to staff. But, given the scale of unmet mental health need, the ingrained culture of prisons and the low base of prison mental health services, it is not surprising that recurring problems remain.

6.1 Prisoner escort services

There is some evidence that problems with courts and prisoner escort services can result in compromised personal safety, disrespectful treatment, and increased vulnerability to poor mental health (HMCIP Annual Report, 2003).
Basic services to prisoners can often be absent. The 2004 Joint Inspection with Gloucester probation service showed that no agency had overall responsibility for at least one substantial meal a day for prisoners attending court. Some prisoners were ‘barely adequately fed’ on the days they appeared in court. Journeys over two hours without comfort stops were not uncommon. The IMB at Onley revealed a lack of equipment to monitor van temperatures (IMB Onley 2004). Following new escort service contracts in August 2004, the situation has become worse.

The most recent Joint Inspection report from the courts and prisons found:

... ‘a very mixed picture, with late arrivals at court and late returns to prison a continuing problem, affecting the safety of prisoners as well as the welfare of custody staff and court business ... The problem requires better joint working.’

(HMIC A and HMIP, 2005)

What is the impact on the well-being of prisoners? Information important for the health and safety of prisoners can be absent, such as provision of their normal medication, documentation about their mental state, and court papers. Procedures such as risk assessments of prisoners sharing vehicles can also be absent.

‘Prisoners frequently arrive at prisons late, after 7 p.m. The result is that not only do they arrive exhausted and stressed at the prison but also prison staff have inadequate time to carry out the essential healthcare screening process which identifies those particularly vulnerable.’

‘No time to settle in prisoners, deal with their concerns and to assess their vulnerability.’

(IMB Survey at HMYOI Onley)

Nottingham IMB reported that the average number arriving from court was 80 a day and as late as 7 p.m. This is made worse by the poor communication between the courts and the escort services so that the prisons often have no advance warning of the numbers arriving on their doorstep.

The lack of effective monitoring of this service means that abuse of prisoners by escort services, for example deliberately turning up the heating in vans in the summer and turning it down in winter, or worse, can take place without much risk of exposure.

‘Driving safety appalling, many accidents have occurred, staff refused to put my seatbelt on properly and I was given the choice of having it across my neck or not to wear it at all. Staff smoked in the van even after I asked them not be because of my health. I was told to show some respect for the uniform.’

(HMCIP, Belmarsh, 2003, Prisoner Survey)

6.2 Reception screening

Prisoners can arrive at prison reception late in the evening after long and difficult journeys. The numbers passing through local prisons has increased with the rise in the prison population. IMB Wandsworth reports that their optimum capacity has risen during the year by 16 per cent. HMP Wandsworth effectively empties and refills itself every month. The total annual turnover in a prison with a capacity of 1370 was 31,000 movements in and out.

The new reception screening tool developed by the University of Newcastle in 2002 is still in its early stages, and not all staff are trained in its use. The combination of staff waiting to go home at the end of the day, prisoners arriving late and exhausted is not conducive to conducting the interviews and successfully identifying those vulnerable to suicide. The lack of privacy in those prisons still awaiting refurbishment makes confidential questioning impractical; hence it is unlikely that the process will gain a full and complete response from a prisoner who is often exhausted and disorientated.
6.3 Induction and First Night arrangements

For all prisoners but especially for first time prisoners this early period of imprisonment is particularly distressing. Most suicides occur within the first weeks of imprisonment. Chief Inspector reports show improvements in many prisons with a much more 'integrated' approach. But in others:

‘...significant elements were missing: risk assessments not completed, or completed badly: no effective first night provision with new prisoners being placed anywhere there was space; staff who were redeployed or untrained; induction programmes that failed to reach all prisoner or were cancelled or truncated.’

(HMCIP Annual Report, 2003)

This is confirmed by some of the IMB reports from Norwich and Nottingham.

But staff attitude, reflected in how they treat prisoners, is as important as their training. It is a time of extreme stress for prisoners when they are stripped of their individuality. Many IMB reports speak highly of how well staff do this job under very difficult conditions and treat prisoners with humanity and respect. However, prisoner surveys can illustrate a different approach.

‘The reception is inhumane and degrading. Even if you bring personal belongings from home with your own money or from another prisoner they are confiscated. The feeling is that you have not rights and if you try to discuss this you are threatened with the block or violence.’

‘Officers at reception had an aggressive attitude and treated everybody the same way. For a first timer this was uncomfortable.’

(HMCIP, Belmarsh, 2003, Prisoner Survey)

It is not unusual for prisoners go without a drink or a meal until the reception process is completed. Given that some will have had long journeys from court, again not necessarily with a meal, their ability to cope with the process and maintain mental equilibrium is surely effected.

Efforts have been made to ameliorate the intrinsic stresses of the early days of imprisonment. The Insiders scheme, promoted by Safer Custody Group, provides support for the first 24 hours in custody. Selected prisoners are trained to provide reassurance and basic information to newly received prisoners shortly after they arrive. It is intended to complement the Listeners schemes, by reducing the stress of entry into prison - not by providing specialist peer support to people who are potentially suicidal. Insiders are currently operating in 47 prisons and the scheme is particularly needed in large, busy local prisons.

6.4 Access to mental health services

Prisoners need to have good access to primary care cover as do their counterparts in the community. Early symptoms of distress need to be identified and addressed. The division of responsibilities between prison health staff who provide primary care and the in-reach teams who provide a more specialist service is not always clear. Without protocols in place there is the potential of inappropriate referrals from prison health care staff to the new teams. This can threaten to overwhelm the in-reach teams, as can the level of demand on their services (see HMCIP, Norwich, 2005). Undoubtedly the new arrangements have the potential to make significant improvements in this area (see, for example, HMCIP's report on Blantyre House, 2005).

There is emerging evidence of problems in the delivery of care through mental health in-reach workers. For example, the inspectorate report on HMP Bristol (2005) judged that the process of handing responsibility for healthcare to the PCT had not gone well, and found that Bristol North PCT had been reluctant to take ownership.
Maintaining the mental health of prisoners will also depend on the environment in which these better services are offered. A qualitative study by Nurse and Ormsby (2003) used focus groups of prisoners and prison staff. In line with the doubts expressed in this report about the impact of prison on mental health, the Ormsby study concluded that environmental factors such as isolation and lack of mental stimulation, drug misuse, negative relationships with prison staff, bullying and lack of family contact were contributory factors to poor mental health in prisons, and pointed to the need for prison policy makers, managers and PCTs to understand the impact of prison on mental health.

6.5. Family ties

Family contact can reduce the feelings of isolation and stress that hit the prisoner in the early days of imprisonment. It is therefore vital that they are able to make telephone calls. There are many examples of good practice. Where prisons have modern new reception areas such as HMP Birmingham, the ability to telephone home is not a problem. Once beyond reception and first night procedures it can be much harder with telephone time limited to association periods which can be cancelled due to staff shortages.

Over the longer term, a closer family involvement in the prisoner’s life in prison can have very beneficial effects which are stymied when prisons fail to welcome their input. Anna Davey, whose partner was in prison, drew attention to the immeasurable impact that forced separation can have on loved ones.

We might talk about staff training or suicide watches or the effects of overcrowding, but I hardly ever hear anyone ask the question:

“what does it do to people’s mental health and well-being to be denied a basic right like privacy with your loved ones?”

(Davey, 2004)

The effect of prison is to demand toughness and love for one’s family is a dimension in which one can be most vulnerable.

‘Probably one of the greatest stressors a lot of prisoners face is seeing or hearing their loved ones distressed and suffering. … I can understand why some prisoners felt they have to cut off from those they love for short periods or permanently. It becomes too painful. It’s where they can be hurt.’

(Davey, 2004)

Family support can be vital for all prisoners, but in particular for those who have mental health problems. PRT supports Anna Davey’s suggestion that prisons can more effectively meet the needs of prisoners for emotional support, and respond to families in a more consistent way by:

- Further development of Family Contact Development Officers
- Ensuring that families are kept well-informed
- Involving them in key processes such as sentence planning and suicide prevention
- Initiating a Family Relations Working Group, with a remit that parallels the work of Race Relations Management Teams, and
- Overall, conferring responsibility for family relations to a specific, accountable person, to co-ordinate the work with families.

6.6 Relationships with staff

Staff play an essential role in supporting the mental health of prisoners. Officers on the wing are the people who prisoners are most likely to interact with on a daily basis, are best able to identify vulnerability and anxiety, give support and guidance and defuse escalating problems. But a positive, active regime depends on sufficient staffing levels. The reverse side of this is that prison staff can fail to ameliorate the worst aspects of prison life and in fact exacerbate them by their attitude.
towards prison. Staff shortages and low morale can reduce the prison regime to a desperate warehousing function.

A recent report from HMP Wandsworth highlights the lack of respect given to prisoners and little evidence of positive engagement. A prisoner survey from HMP Belmarsh, carried out by the Prisons Inspectorate, found that 40 percent felt that staff treated them with a lack of respect.

‘There are a few staff who treat you as a human being but most will not even do a simple thing like get you a request form or free letter.’

(HMCIP, HMP Belmarsh, 2003, prisoner survey)

An indicator of morale in the service and the quality of management is sickness levels. The average sickness rate in 2003-4 was 13.3 per cent, far higher than for other parts of government (National Audit Office, 2004). Prison staff can suffer from stress and anxiety when they are expected to accept responsibility for mentally ill prisoners, duties for which they are not trained, resourced or supported. Many prisoners with mental health problems have in fact been excluded from psychiatric services in the community and yet, prison staff who are not trained in these matters have no choice but to cope with them. Staff are at risk of, and suffer from assaults by mentally ill prisoners. The Nurse and Ormsby study illustrates how the fear of safety is always present in their daily lives.

Staff shortages are mentioned in many reports as a reason why certain activities such as association and education are cancelled. Attendance by prison staff at safer custody meetings is important. But IMB reports from Reading and Long Lartin state that these meetings are not held regularly, or that the key people do not attend.

‘Various causes of stress - including reduced staffing levels, prison culture, prison management and fear of safety - were frequently described as interacting with each other and increasing overall stress levels … this was best described … As a “circle of stress” whereby low morale and staff shortages increased stress levels, which in turn increased staff sickness rates, reduced staffing levels, further lowering morale of remaining staff and led to more stress and sickness.’

(Nurse and Ormsby, 2003)

Prison can be a breeding ground for negative relationships and those between staff and prisoner can feed off each other, producing a cycle of negativity. Equally, caring staff can find that their work with prisoners becomes more rewarding.

‘The good ones enjoy their jobs a lot more than others because they’re being personable and we treat them with respect.’

(Nurse and Ormsby, 2003, citing a prisoner)

The problems above have not been helped by the very high turnover of prison governors. In the five years to March 04, just under a third of prisons (44) have had a four or more governors or acting governors in charge. The average tenure for prison governors in HM Prison Service is one year and nine months (Hansard, written answer, 19th January, 2004). The governors give leadership and can imbue a prison with a strong sense of purpose. They are key players in taking forward the partnership with the NHS. If they keep changing then obstacles to delivery will not be dealt with but are more likely to fester and grow.

Many staff do a good job against all the odds, treat prisoners with respect and humanity and they are to be applauded. But without proper supervision, support, training and leadership the culture of a prison can easily slide into destructive and negative attitudes towards prisoners which increase their vulnerability to poor mental health.
7. Prisoner-patient Involvement

Section Seven highlights the importance of consulting prisoners about the mental health care they receive. It sets out the key benefits of involving prison mental health care service users (‘prisoner-patients’); describes the different ways that the prisoners’ perspective can be taken into account, considers some of the barriers inherent in the prison setting that hinder service user involvement, and proposes some principles for developing the approach further.

7.1 Background

The Health Service and the Prison Service employ different images of the person, two profiles which have been characterised as ‘Patient or Prisoner’ (HMCIP, 1996). These roles symbolise the tension in the ways the two departments treat people in prison. The extent to which the person in prison has a say in decisions regarding their treatment is one barometer of these differences. Prisoners who receive medical treatment are by definition patients, or service users under the care of the NHS.

At the policy level, differences between HM Prison Service and Prison Health are acute. The Health and Social Care Act (2001) requires NHS organisations and agencies to consult service users and the public in planning healthcare services. In contrast, the only Prison Service directive on consulting prisoners, PSO 4480, is restrictive in tone, warning prison governors about the potential risks to security inherent in allowing prisoners to have a say.

‘Any associations allowed to operate in prisons must not compromise good order or discipline ... Examples of potentially inappropriate activities for associations to become involved in include: security issues, offending behaviour programmes, searching strategy, sentence planning, drug strategy, categorisation, transfers, etc. This list is not exhaustive.’

(HMPS, 2002)

Thus, PCTs are mandated by law to consult prisoners as service users, while prisons are not.

In practice, however, the worlds of healthcare and prison custody are not so far apart. The Health Service is still developing procedures and structures to enable it to meet the terms of the Health and Social Care Act, while many prisons already make use of prisoner councils, as described in a recent PRT report, ‘Having Their Say’ (PRT, 2004b). The vast majority of prisons enlist prisoner representatives on race relations management teams and other policy groups.

This section surveys a number of studies that inform the development of prisoner-patient involvement. The first part describes why it is so important. Then, the section will look in more detail at the specific question of consulting recipients of mental health services. The particular obstacles arising in prisons that hinder the development of prisoner-patient involvement will also be discussed.

7.2 The importance of involving prisoner-patients

‘We can no longer treat prisoners as passive recipients of healthcare. If the healthcare service is to provide an effective service, then prisoners need to play an active role.’

(Birmingham, 1997)

The second of the Inspectorate’s tests of a healthy prison, that prisoners are treated with respect, can find expression in the extent to which prisoners are consulted about their treatment and the
conditions in which they are held (HMCIP, 1999). But providing opportunities for prisoners to exercise a voice in mental health care requires resources. Therefore it is important that healthcare managers, PCTs, prison governors and others agree on the positive outcomes they expect to gain from the investment.

In 1999, the inquiry into the unit for personality disorders at Ashworth Hospital (the Ashworth Inquiry) highlighted benefits of user involvement in providing evidence about quality. Citing the advocacy service, the complaints procedures and the patient council, the Inquiry Report noted:

‘In theory, these present a mechanism by which important issues can be raised which otherwise might remain hidden; part of their justification is, then, that they are a means to monitor quality and address clinical and operational issues.’

(Ashworth Inquiry Committee, 1999)

Focusing on concerns identified by prisoners can enable the health services to deliver a more responsive service, better suited to the actual needs of prisoners who require mental health care. Another advantage of gaining user feedback is that it can help service providers in preparing forms, documentation, and reports to use language and writing styles that are accessible (Spiers et al., 2005).

A study by Robson et al. set out three broad benefits of user involvement:

- The service was encouraged to see users as stakeholders
- The process opened up communication
- Users were enabled to express their priorities and concerns.

(Robson, et al., 2003)

Defining prisoners as ‘stakeholders’ entails a change in the nature of the doctor-patient relationship. At the level of policy, PCTs in the process of developing in-reach work in prisons would gain much from involving prisoner representatives in planning because this would help the PCTs to focus their in-reach strategies. When the health and prison services systematically engage with prisoner-patients as stakeholders in decisions about policy, the prisoners’ feedback can alert managers to areas that require urgent attention.

Robson and colleagues observed that service user involvement was encouraged where users and staff could discuss differences and work together to try out possible solutions. They provided further detail about this aspect:

‘Good quality two-way communication between users and decision-makers benefited users and promoted change in organisations. An emphasis on dialogue highlighted that the views of both parties were equally valid.’

(Robson et al., 2003)

PRT’s report on prisoner councils found that a key benefit of consulting representative prisoner groups was that conflicts between the interests of managers and prisoners could be discussed and often resolved, leading to a more stable social order. The willingness of management to consult with prisoners contributed to the perceived legitimacy of the managers.

As a governor explained:

‘One value … is having a forum where you can discuss tensions that surface, a meeting that enables us to explain things directly and in detail. It aids communication. And, as a result, it prevents problems festering.’

(PRT, 2004b)

One gain that may be less obvious is that service users themselves benefit from taking responsibility for representing their peers. They can become more self-confident, better able to express their views, and gain increased empathy through their experiences of user involvement.
### 7.3 Defining ‘prisoner-patient involvement’

Research reveals variations in the implementation of service user involvement in the health services. Studies have shown that a lack of clarity about the purposes and processes limit their effectiveness. Some of the main questions to be answered in developing plans for service user involvement are:

- **Who** is defined as a service user?
- **What** is the nature of user involvement?
- **What are** the best methods to draw on their perspectives?
- **How much** user involvement is required?
- **What aspects of practice** should they focus on, and are any subjects ‘off-limits’? For example, can service users legitimately have a say in their own risk assessments?

Although light can be shed on these questions by turning to experience outside prisons, prisoner-patient involvement in mental health care in prisons is a new field. Therefore, these questions are offered as points to be considered by PCTs and healthcare managers as they begin to develop prisoner-patient participation in particular prison establishments. The use of the term, ‘prisoner-patient’ in preference to ‘service user’ highlights the gulf between prisoners and most recipients of health services. ‘Service user’ implies the free status of a consumer, engaging with health services voluntarily, whereas prison exerts a powerful influence on all the prisoner’s decision-making.

This is an example of important differences between healthcare outside and inside prison. These differences make it impossible to transplant service user involvement directly into prisons without adapting the concept to the prison world. A new approach is needed to develop consultative processes inside. The prisons’ legitimate concerns about security, the special requirements and limitations of confidentiality, and the negative impact of the environment on mental health are additional factors that require a tailor-made approach. Between them, PCTs, prisons, and prisoner representatives should consider which aspects of the service user model will work in prisons; which will not work; and which need special adaptations to fit into the prison setting.

In prisons, a broad definition of those who benefit from the health services could include people receiving (or assessed for) drug treatment, any prisoner with any mental health problem (including personality disorders), and families of prisoners. Alternatively, a very restricted interpretation could limit the pool to prisoners who are currently in contact with mental health in-reach services. However, there are two types of engagement with healthcare: long-term, chronic conditions as against short-term health problems; and both groups should be represented.

MIND recommends a definition that focuses on recipients of mental health services and excludes indirect beneficiaries:

> ‘By “users” we mean people who have themselves used any services (such as in-patient, out-patient or primary care) because they experience, or are thought by others to experience, mental distress or “mental illness”. Relatives and friends are therefore only users if they use services on account of their own distress.’

(MIND, 1993)

### 7.4 The nature of involvement

Research by the Centre for Institutional Studies explored how voluntary agencies worked to increase user involvement (Robson et al., 2003). Robson and his colleagues found that service users had different expectations of involvement.
Some users felt “involvement” was about influencing services to achieve improvement for all users. ... Others did not expect to become involved beyond their individual use of services.”

(Robson et al., 2003)

The nature of user involvement can be clarified by introducing a distinction between an individual’s input into his treatment, and the influence of a client group on the general service provided to all.

Three types of service user involvement can be envisaged:

1) Individual service users can be consulted about the treatment they are offered, so that they can play an active role in the decision-making process that determines the treatment they receive. This should be part of the process of gaining the consent of a patient to their treatment and referred to earlier.

2) Feedback from individuals can be collated to reveal patterns of ineffectiveness; for example, if services consult every service user to ensure that the information held on them is accurate, the service provider might be able to develop more systematic checks on its record-keeping.

3) Users can be consulted in groups, providing feedback about services to guide general improvements in the provision.

Confusing these roles is likely to reduce the effectiveness of prisoner-patient involvement. If a group is convened to discuss problems of communication between mental health practitioners and service users, the meeting will be undermined if a prisoner-patient dominates the discussion with his personal experience. Nonetheless, there are benefits from each of these three forms of feedback.

Involving patients requires a range of processes. For example, consultation, in the sense of inviting feedback to influence a policy change, differs from resolving complaints. Applying the usual NHS complaints processes in prisons will be complicated, given that the system differs from the prison complaints system. PCTs are now working to establish the Independent Complaints Advocacy Service (ICAS) in prisons. ICAS is gathering information about the obstacles to handling complaints in prisons, e.g. prisoners have restricted access to telephones. As with any new initiative, ICAS must be publicised in prisons, so that prisoners are aware of this option, and know how to begin the process.

Principles developed by MIND help to clarify the nature of user involvement. They capture the values, suggest methods for engaging users, and identify the needs of individuals who take responsibility for representing their peers.

MIND defined full user involvement as:

‘Equal citizenship; dignity and respect in mental health services; full information on treatments and rights; involvement in treatment and care; independent advocacy in every area; broad participation of users through equal opportunities employment and service delivery practices; involvement in planning, running and evaluation of services; policies to ensure it is safe to get involved; training of workers by users; practical commitment and resources for user involvement.’

(MIND, 1993)

Achieving these in prison presents a challenge for healthcare services and prison managers. The list shows that it is crucial that prisoner-patient involvement be based on explicit expectations and objectives. There can be little doubt that a thorough engagement with prisoner-patients in prison healthcare would also have a positive effect on prison regimes overall.
7.5 Methods of consulting service users

‘There is no magic formula for how to go about involving service users in research. As with user involvement in service delivery and planning, there are a variety of local and organisational circumstances that will help to determine the most appropriate strategy.’

(Faulkner and Morris, 2003)

Faulkner and Morris focused on the role of service users in research, but their observation is equally valid for eliciting user feedback on services. The culture, history, and requirements of prisons mean that prisoner-patient involvement must be defined against a very particular set of ‘organisational circumstances’.

In thinking about how prisons can develop methods of consulting prisoner-patients as mental health service users, two parallels are helpful. Special hospitals, such as Rampton, have run patient councils; and many prisons have consulted prisoners through wing forums and prisoner councils.

The patients’ council at Rampton Hospital was established in 1997, through a constitution agreed with the hospital. It has twelve members, including an elected chair and vice chair, with seats reserved for women, patients who have learning disabilities, and people from minority ethnic groups. Rampton managers are represented on the council, and special measures are used to encourage the participation of people who would find it difficult to read documents or speak in public. The constitution emphasises that council members have a duty to represent fairly the needs of their fellow patients (PRT, 2004b).

The Ashworth Inquiry also examined the mechanisms needed to gather patient feedback in special hospitals (Ashworth Inquiry, 1999). Their report lists three steps taken at Ashworth to enhance the opportunities for patients to exercise a voice. First, a patients’ advocacy service was established and run by the local Citizens Advice Bureau. Second, an efficient complaints procedure was introduced. Third, the patients’ council was set up, following the model of the Rampton patients’ council.

The National Consumer Council’s study, ‘User Power’, proposed four key steps for developing service user participation:

- Mobilise potential; Make participation meaningful; Build confidence and trust; and Remain accountable.

(Birchall and Simmons, 2004)

The first step refers to the need to recruit representatives. Birchall and Simmons advocated a direct and personal approach. Their report invited service providers to think about how they can encourage and empower the most marginalised of service users. This is crucial in prisons, where power hierarchies could result in representative groups stacked with prisoners who wield great influence within the prisoner community.

For participation in a service user group to be meaningful, Birchall and Simmons believed that the subjects covered need to be things that really matter to the participants. Further, representatives need to see evidence that their views count. For example, when a change of policy is announced, the input by the representative group needs to be acknowledged.

Any institution that exercises control over people must expect a degree of suspicion from the service users in the early stages of a representative group. Efforts must be made to establish rapport. One way in which the distrust can be addressed is to begin by setting out very clear parameters of the group’s role and functions. The service provider will not gain the trust of service users if it promises more than can be delivered.

Thus the final guideline suggested by Birchall and Simmons is to practice accountability. The PRT study observed that in some prisoner councils, minutes were kept, with action points for staff that
were then followed up in subsequent meetings. But accountability extends more widely. For example, cancelling a scheduled service user meeting, or a failure by senior managers to attend, can undermine the forum.

The study by Robson and his colleagues also discussed aspects of organisations that enhanced user input. User involvement benefited where:

- Managers were committed to user involvement
- There was a shared vision of a user-centred organisation
- Space was dedicated to enable users and staff to discuss differences, and to generate and try out ideas
- There was an open attitude to a full range of views
- Resources were allocated specifically for user involvement
- There was a willingness to take risks.

These attributes have obvious benefits in empowering patients to exercise their voice.

7.6 How much user involvement is required?

The voice of the service user can be used as a crucial input in planning services and monitoring their quality. PRT’s study on prisoner councils found that some prisons decided on which areas prisoners would have considerable input into aspects of the regime (e.g. choice of diet); other areas on which they would have input (e.g. arrangements for visits); and some about which they would have no opportunity to comment (e.g. drug searches or other security matters). But there were prisoner councils empowered to discuss any aspect of prison life, and PRT observed lively and constructive discussions about the work of drug detection dogs, cell searches, and risk assessment. The range of topics open to negotiation was partly related to the formal powers of the council: in prisons where senior managers allowed councils to make binding decisions, the range of topics was limited; in prisons where the council had no decision-making role, the prisoners were allowed to discuss a wider range of concerns.

Research by Langan and Lindow into patient involvement in mental health revealed a wide range in the extent to which service users were permitted to have a say (Langan and Lindow, 2004). Although there was some evidence of users who were able to influence the treatment they received, the general picture was that patients were restricted to accepting or rejecting what was given. Langan and Lindow found little evidence of the use of advocates, and in some cases, patients were not informed about possible options in the treatment they were given. They, too, found that in the relationship between the service provider and the service user, user involvement could mean merely commenting on treatment, not influencing it. Few of the professionals they interviewed discussed how to elicit input from hard to reach patients.

Langan and Lindow’s research provides further insights into the possible scope of service user involvement, as their study examined the extent to which mental health patients had a say in their own risk assessments. For some mental health service users, involving them in managing risk could be an empowering experience. It also built greater trust between the patient and professional; and enhanced a collaborative approach to managing risk. There was common ground between some patients and the professionals who had the duty of assessing risk:

‘Many service users were aware that they could pose a risk to other people when experiencing psychosis and they wanted help to reduce the chances of this happening.’

(Langan and Lindow, 2004)

They concluded that many mental health practitioners would welcome a framework for consulting service users in their assessment and management of risk.
Birchall and Simmons responded to the question about how much say service users should have with a set of standards that might be used to test mechanisms for involvement:

‘Our approach suggests there is enough participation when the following conditions are met:

• The people who participate are representative of service users, in terms of their interests, gender, age, ethnicity, and so on
• There is enough turnover in leadership positions, or sufficient scrutiny, to ensure that an oligarchy does not develop
• There is enough help and support for the most active members to ensure that they do not become burnt out and disillusioned.

(Birchall and Simmons, 2004)

7.7 Barriers preventing prisoner-patient engagement

In many prisons, the idea of prisoner-patient involvement is likely to face strong opposition. The nature of the punitive environment can profoundly hinder the development of patient involvement. The PSO on prisoner councils typifies the ways in which the traditional prison ethos labels all prisoners as potential threats to good order. Punitive values in prison lead to a perception that any exercise of responsibility by prisoners is risk laden.

Birchall and Simmons described concerns service providers had about user involvement. They used the phrase ‘the fragility of participation’ to signify the ways in which user involvement can be nullified or marginalised by the service provider.

New ideas in prisons are often subject to the status of ‘add-on’ provision; and therefore liable to be neglected in contrast to functions that are perceived to be ‘core’ duties. To be effective, mechanisms for prisoner-patient involvement need the full support of senior managers. Yet, there is some evidence that these are the people most likely to perceive that user feedback might be threatening or irrelevant.

A factor that contributes to the sensitivity of engaging these particular service users is the growth of a risk averse social climate, as described by Langan and Lindow:

‘Since the early 1990s, mental health service users have become increasingly defined in terms of risk and dangerousness, despite consistent research evidence that their contribution to violence in society is minimal. … The continued focus on risk means that there is a danger that people so defined will be excluded from decision-making about their lives.’

(Langan and Lindow, 2004)

Their observation applies with greater force in prisons.

The Ashworth Inquiry suggested that the voice of service users in Ashworth was perceived by some staff as a threat.

... we heard a considerable amount of disquiet over the new emphasis on patients’ rights ... Things had gone “too far” and staff were afraid of saying “no” to patients, lest they become the subject of a complaint. ... we are struck by a remark of Professor Sines. ... that whilst patients had been empowered over recent years, staff had become disempowered. It is vital that a better balance be struck between the “rights” of patients and those of managers and other staff to run the Hospital safely.

(Ashworth Inquiry Committee, 1999)

The balance of power is, if anything, even more important in prisons, where traditional policy and culture recommend that staff maintain control at all times.
The comment by the Ashworth Inquiry Committee implies that implementing user involvement inevitably requires a shift in power, taking it away from staff in order to give it to patients/prisoners. There would be some basis for this interpretation if the central purpose of prisoner-patient involvement were to hold staff (medical or custodial) accountable to prisoners for the way they are treated. But regardless of how prisoner-patient involvement is organised, whether through feedback from individuals, a service user council, or some other means, there is no need to conceive of it as a threat to staff.

If the development of prisoner-patient involvement were defined as taking power from prison staff to give it to prisoners, this would be adversarial thinking, which is likely to exacerbate tensions between the two groups. The essential question about prisoner-patient involvement is: how can it enable the prison to raise and address conflicts of interest that arise between healthcare managers, medical staff and prisoners? If these differences are ‘resolved’ by the professionals exerting their control over the situation, the likelihood is that their legitimate authority will be eroded, resistance to their rule will increase, and greater energy will have to be invested in security rather than care. If problems are worked through via open dialogue and compromise, the professionals will not get everything they want, but the service they provide will fit prisoners’ needs, and they will have a greater sense of ownership, and therefore a sense of personal responsibility in making the agreed solutions work.

Nonetheless, prisoners are conscious of the powerlessness of their position, and their status is likely to reduce their capacity to reflect the views of their peers. Even if the atmosphere is healthy and most staff support the idea of prisoner-patient involvement, prisons provide many opportunities for disaffected officers to apply informal punishments. A prisoner-patient who raises a common concern about the officers’ performance might find that he becomes the person who is regularly unlocked last of all, or that his mail goes missing, or that he is searched more frequently.

A more practical limitation is that, in some prisons, the turnover is high. In these establishments, members of a prisoner representation body will also have a high turnover, and the prison will be required constantly to recruit new representatives. Then, too, prison staff who are committed to developing forums for consulting prisoners may feel isolated from their peers, un-supported by their managers, and forced to balance their interest in empowering prisoners against other duties. When these individual officers or managers move on, it is often the case that their efforts are not matched by a successor. The challenge to the Prison Service is how to embed consultation with prisoners in day-to-day operations, so that it is not so dependent on individuals.

Birchall and Simmons’ report also acknowledged that service users are often lacking in confidence. Prisoner-patients often have limited reading and verbal skills, and may require particular kinds of support to enable them to fulfil the role of representing the interests of fellow recipients of NHS services. To promote service user involvement, service providers need to plan for extra support for service user representatives. Two practical examples of possible support are advocates, drawn from the voluntary sector in the local community; and specialised training in skills required to represent the interests of one’s own group, which prisons should provide (perhaps through the education departments) for the prisoner-patient spokesmen.

Finally, the organisational dilemmas in the transfer of responsibility to PCTs are likely to complicate the development of prisoner-patient groups. For example, who will be responsible for convening them - the prison or the healthcare manager? While the models in the community and the mental health field are clearly led by the health services, the commitment and co-operation of prison managers is vital.
Part three explores four key areas, involving specific policies in prisons: self harm; suicide prevention; the dangerous and severe personality disorder programme; and treatment for prisoners with a dual diagnosis. It discusses prison policies to reduce self harm in the context of the equivalence principle. It explores the impact of the social climate of prisons on the risk of self inflicted deaths. And it examines the possible problems that may arise in the DSPD programme.
8. Self Harm in Custody

This section examines the ways the Prison Service responds to prisoners who deliberately injure themselves. It is based on a comparison between an example of good practice in the health service and the traditional approach employed, until recently, in prisons. It will also explain the new policy in prisons, ‘Assessment, Care in Custody, and Teamwork’ or ACCT (see below). And it will assess this new strategy in the context of the guidelines promoted by the National Institute for Clinical Excellence (NICE).

8.1 Questions of definition

The ACCT approach will replace the method based on the use of the form F2052SH (which had been introduced in 1994). The process for using the F2052SH began when any staff member had a concern that a prisoner was at risk of harming him or herself, or attempting suicide. Prison Service Order 2700 instructed staff:

“In the event of any incident of self harm, or cause for concern that the prisoner may be at risk, open a F2052SH (where there is not one open already) and where there has been an incident of self harm also complete a F213SH self harm/attempted suicide form.’

(HMPS, PSO 2700)

The first matter for discussion is the question: what behaviour counts as self harm?

People can do actual damage to their bodies in innumerable ways; in the broadest sense, the misuse of certain drugs, many eating disorders or other compulsive behaviours are harmful to oneself, as is cigarette smoking and even gambling. PSO 2700 offered a detailed, though potentially misleading, description. Its first statement was broad, giving staff considerable discretion:

“Self harm” is any act where a prisoner deliberately harms themselves irrespective of the method, intent or severity of any injury.’

(PSO 2700)

The Order then excluded some forms from the definition:

“Anorexia, bulimia nervosa and food refusals should not be reported using this form.”

(PSO 2700)

In annex C, the order listed six specific types of self harming behaviour: hanging; cutting; overdose/poisoning; fire; jumps from a dangerous height; and swallowing foreign bodies.

Paragraph 3.1 requires prison staff to record any incident of self harm, “irrespective of the method, intent or severity ... ” It is important to respond to every act of self harm as an important event, and not to appear to trivialise any, but this broad definition may have confused some staff about when to record self harm. Despite the instruction to consider the full range of severity of injuries, some staff might have counted compulsive scratching or banging one’s fist against a wall, while others would not.

To what extent is self harm considered an attempt at suicide?

Some forms of self injury, such as self-poisoning and asphyxiation, carry higher risks of death than others. Conversely, repetitive self harm can be a way that distressed people cope with strong emotions, thus preventing suicide. However, it is no longer acceptable to react to every self harm incident as though the sufferer was attempting to take their own life.
The link with attempts at suicide also complicates the question of measuring the problem. Some forms of self harm may require immediate medical attention, but not be life-threatening - for example, a jump from a landing can lead to broken bones. Conversely, other self harming behaviour might not require medical attention to any injury yet constitute a serious threat to life - such as self-asphyxiation.

A number of questions can also be raised about what leads people to injure themselves deliberately.

Richard Pacitti, contributing to the NICE guidelines consultation, stated:

‘Self harm can be described as an expression of personal distress usually made in private by an individual who intends to injure themselves. It is commonly thought that people who self harm intend to commit suicide but this is not always the case. People may self harm as a way of obtaining relief from an unpleasant and otherwise overwhelming situation, emotional stress or even to stop themselves from committing suicide. Healthcare professionals sometimes find this hard to understand and people who self harm are often thought of as “attention seekers”.’

(NICE, 2004a)

The different definitions of deliberate self injury have a huge effect on estimates of its prevalence among prisoners. Most estimates of the extent of self harming behaviour in prisons depend on staff reports. Any self harm that is hidden from staff - intentionally or not - is not recorded. It is difficult to know how much is hidden. Thus the official estimates do not show accurately the extent of the problem.

8.2 Repetitive self harm

The word ‘repetitive’ distinguishes harming as a means of relieving strong emotions from parasuicide, or attempted suicide. The motivation for repetitive self harm is often to find a way to cope with psychological distress. Many people who have repeatedly harmed themselves describe the acute worthlessness, powerlessness, or filthiness they feel prior to their acts of self-injury. From their perspective, deliberate self injury fulfils many psychological needs, including punishment, control, cleansing, and, at least momentarily, relief.

The phenomenon of repetitive self harm rules out a simple view that self injury is inevitably a precursor to suicide. Repetitive self harm can persist for years, causing increasing injury without becoming intentionally suicidal behaviour. This report deals separately with self harm and self inflicted deaths in custody to maintain the distinction.

The Office for National Statistics survey, ‘Psychiatric Morbidity among Prisoners in England and Wales,’ (Singleton et al., 1998) applied the distinction between deliberate self injury and attempted suicide. The survey measured self-reported rates of suicide attempts; and the rates of self harm without suicidal intent. Seven per cent of sentenced men and 15 per cent of men held on remand had attempted suicide in the previous year (the rates for women were about double those for men). About six per cent of male prisoners said that they had engaged in deliberate self injury without suicidal intent during their current time in prison.

8.3 Previous prison policy

In theory, the use of the F2052SH would initiate a standard process of professional assessment, case management, and, as necessary, special measures including moving the person at risk to the healthcare centre.

However, there was widespread evidence that the process was not working as it should. As early as 1999 the Chief Inspector of Prisons conducted a survey of medical officers that showed that over a quarter of them felt they had had inadequate time in reception screening
to assess the person’s risk of suicide (HMCIP, Suicide is Everyone’s Concern: A Thematic Review, Appendix 3). The Chief Inspector’s review also found that over two-thirds of the 399 staff surveyed between 1996 and 1998 had not received suicide awareness training (HMCIP, 1999).

An independent study of the process in the West Midlands echoed the Chief Inspector’s finding about training. The report, by Morag McDonald and Stephanie Sexton, observed:

‘There is generally little understanding about the nature of [prisoners’] self harm amongst staff.’

(McDonald and Sexton, 2002)

They added:

‘The general attitude to self harm and suicide prevention appears to be one that assumes self harm is a precursor to suicide and that it is manipulative behaviour, to gain improved conditions or attention. Most staff regard attention-seeking behaviour negatively.’

(McDonald and Sexton, 2002)

One key flaw was the dual function of the F2052SH form. It was intended to record known acts of self harm and to register someone as at risk of attempting suicide. While many of the people who took their lives had previously injured themselves, this does not establish a causal link: self harm does not lead someone to attempt suicide.

The approach based on the F2052SH neglected the distinction between persistent self harm and attempted suicide. In practice, the use of the F2052SH form may have led to the unnecessary identification of many prisoners as at risk of suicide. At the same time, it would neglect the specific needs of those who injure themselves repeatedly.

A further drawback of the approach was that the response tended to emphasise the identification of, rather than care for, people at risk. A consequence was that staff may have been more concerned about accurately identifying prisoners at risk than they were with providing distressed prisoners with the care and support they needed. In addition, the use of the F2052SH worked against a whole prison response.

The Chief Inspector highlighted the fact that what matters in responding to self harm and suicidal thinking is how the person at risk is cared for:

‘Writing on the form is not what sees someone through a crisis. If the contents become clichéd and repetitive, the piece of paper becomes meaningless, and worse, staff quite wrongly feel they have done their job. This is not to argue against the role of the form, but to emphasise that it is not the most important feature of the strategy and it should not be relied on as the sole mechanism for intervention. The most important outcome of any process is that the prisoner concerned receives the help he/she needs to get through the crisis.’

(HMCIP, 1999)

8.4 A therapeutic response in the NHS

The crisis recovery unit (CRU) at the Bethlem Royal Hospital was founded to treat people who harm themselves repeatedly. Its philosophy and practice can be explored as an example of how self harm is managed in a medical, not a penal, institution.

The CRU is a therapeutic community, working with people who engage in repetitive self harm. A multidisciplinary staff team includes nurses, psychiatrists, a social worker, psychologist, and occupational therapist.
There are five key elements of the CRU’s approach:

- The residents’ personal responsibility for their behaviour
- Acceptance of short-term risk
- Supportive, non-judgmental staff attitudes
- The principle of permissiveness
- The CRU as a community.

A guide to the CRU states the two principles which underpin the unit’s work:

> Maximising residents’ long-term safety while at the same time giving them maximum responsibility is paramount. There are two therapeutic strategies which are central to this process: (a) retention of responsibility by residents and (b) calculated short-term risk tolerance by staff in the interests of longer term safety for residents.

(Crisis Recovery Unit, A)

Staff do not attempt to prevent residents from self harm by depriving them of the means to do so. The guiding philosophy is that residents must have a genuine choice of whether to harm themselves or not and that having this choice open to them empowers residents to decide for themselves to use alternative, healthier ways of managing stress.

How do the principles of retention of responsibility and short-term risk acceptance work in practice? The unit structures in negotiated care and support within which the resident can exercise responsibility. Residents are expected to learn to recognise when they need help; to express that need to their primary care staff; to take steps to prevent themselves from acting on the temptation (e.g., hand in potential self harm implements); and, in the aftermath of episodes of self harm, to discuss the incident openly with the staff. In the aftermath of any incident, residents are expected to learn about the things that lead to their self harming behaviour.

The CRU’s policy of tolerating self harm to some degree demonstrates to the resident that it is his responsibility to manage his behaviour. The short-term acceptance of risk of self harm by staff is considered essential to enabling the resident to make long-term improvements in handling emotional stress.

Rather than defining the resident as at risk of self harm, and then closely supervising them to prevent them from carrying out the self harm intention, the CRU identifies and supports the positive strengths of each resident, encouraging and empowering them to resist the temptation:

> Residents are assisted … to find alternatives, which may be: alternative means of expression, e.g. talking about feelings or ‘painting’ them. Postponement tactics, e.g. going for a walk. Making difficulties for themselves, e.g. handing blades in to staff. The use of the ‘healthier’ part of the individual to give wiser counsel, e.g. by pre-recorded tapes.

(Crowe and Bunclark, 2000)

Practicing tolerance is crucial to the CRU. People who harm themselves need to develop alternative ways of dealing with their emotions. A central part of this learning process must be to experiment with ways of expressing emotions and frustrations. Therefore, some of the modes of expression that residents try out will inevitably be uncomfortable for staff or the community.

> The unit’s environment has been created to allow specialized treatment for self-harming individuals, but also attempts to reflect the outside world. There is greater permissiveness (toleration of deviant behaviour) than in conventional units, allowing residents to express their disturbance, and this is possible only through the staff’s ability to contain, hold and work with the disturbance.

(Crowe and Bunclark, 2000)
The CRU builds a sense of community through daily meetings to make decisions about the running of the unit. Each person (staff or resident) is accountable to all other members of the community.

Living in the community brings benefits to the residents in developing social skills. In addition, the principle of ‘retention of responsibility’ applies both to individuals and to the residents as a group living together.

‘Group decision making through for example the daily community groups or weekly business groups provide residents, as well as staff, with a voice regarding the functioning of the unit. This voice may be the voice of criticism, an invaluable experience for residents who frequently resign themselves to acceptance and in a state of ‘learned helplessness’ often feel that it is not worthwhile even trying. However through participating within the decision making process residents may gain a realisation that indeed they can be effectual. But also skills of negotiation and discussion are developed with a need for consensus to be reached.’

(Crisis Recovery Unit, B)

Individuals are accountable to the community, but the community is also a key source of support. Residents hold the right to call an emergency meeting to explain the reasons for their personal crisis, or to share their struggle to think of positive and non-harmful ways of handling a situation. The residents’ problem-solving skills are recognised and enhanced, while at the same time, advice from community members demonstrates that staff do not hold all the answers.

Comparing the approach used by the crisis recovery unit to the Prison Service response to prisoners who self harm brings to light the gulf between healthcare practice in the community and in prison.

1) The CRU approach is a carefully integrated package: the community meetings, the staff to resident ratios, the policies of risk acceptance and patient responsibility, fit together to provide a whole therapeutic culture. Responding therapeutically to people who self harm cannot be pursued piecemeal.

2) The CRU is able to practice tolerance in its management of self harm in part because of clear boundaries. The CRU does not admit persons whose behaviour constitutes a serious risk to others (including people who engage in interpersonal violence or arson, and people with severe drug dependency or psychiatric problems). Further, although the CRU systematically tolerates self harm, staff draw the line at any form of self harm that is likely to cause a serious lasting injury (e.g., amputation of a limb) or constitute an immediate threat to life. In such a situation, staff would employ the methods of intensive supervision and the withdrawal of blades and other potential implements. Finally, the CRU makes it clear to residents that if the person becomes intentionally suicidal, then their continued placement on the unit is untenable.

3) The CRU are able to practise their principles of accepting short-term risk and encouraging patients to exercise responsibility, because of the quality of support which they, and the community of other patients, provide. If a prison wing cannot ensure a similar level of support, then it could be irresponsible to require a prisoner to take personal responsibility for his self harming behaviour.

It is clear that these principles could not be implemented in a prison environment (at least not without substantial changes). The way that staff at the CRU work with patients requires:

- The capacity to select people for admission based on clinical judgement: prisons must accept people sent by the courts
• Sufficient numbers of staff to give individual attention to each person’s emotional needs: prisons are constantly under pressure to reduce staffing levels, and their primary function is security, often to the neglect of well-being

• Consistent and substantial support and counselling for staff working with patients: a wide range of demands on training time for prison staff preclude giving priority to responding to distress and the risk of suicide

• Doing everything possible to develop the patients’ capacity for taking personal responsibility: prisons’ primary function of confining people prevents them from promoting responsibility.

None of these should be taken to undermine the duty of prisons to continue to pursue equivalence in responding to self harm. Rather, prison managers and healthcare managers need to consider how they can tackle these limitations in order to develop a more therapeutic and effective response. If the example set by specialist provision like the CRU is unrealistic for prisons, then what is the minimum that prisons can be expected to achieve by way of practice that is equivalent to treatment outside?

8.5 The Guidelines promoted by the National Institute for Clinical Excellence

In mid-2004, the National Institute for Clinical Excellence (NICE, 2004b) produced a comprehensive set of guidelines on the care of people who have self harmed. There are 12 key guidelines, covering the themes of respect for the patient’s choices, assessment of needs, assessment of risk, treatment, staff training, and interventions.

The guidelines were clearly prepared for NHS staff. However, the principle of equivalence, the guidelines’ focus on the needs and rights of patients who injure themselves, and the power invested in prison officers suggest that the guidelines are also relevant to the treatment of people who do so in prison.

In addition to these, the NICE guidelines recommend offering the patient an environment that is safe and supportive - and this aim is explicitly included in the ACCT response. Realistically, however, prisons are not safe environments and ensuring that the prisoner is as safe as possible is not the same as offering them an environment that, in the words of the guidelines, ‘minimises any stress’.

The NICE guidelines set a high standard for training:

‘Clinical and non-clinical staff who have contact with people who self harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self harmed.’

(NICE)

The guidelines make further recommendations regarding the quality of support for staff who work with people who self harm. For example:

‘Providing treatment and care for people who have self harmed is emotionally demanding and requires a high level of communication skills and support. All staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood.’

(NICE)

‘Staff working with people who self harm should have easy access to legal advice about issues relating to capacity and consent at all times.’

(NICE, 11)
8.6 ACCT in the Prison Service

A new strategy for responding to self harm and reducing suicide has been promoted by the Safer Custody Group, and it is based on solid research evidence, a painstaking analysis of the limitations of the F2052SH approach, and extensive piloting in prisons.

The following description is based on a Pocket Guide for Staff, published by the Safer Custody Group, "The ACCT Approach: Caring for People at Risk in Prison" (SCG, 2004/5).

The reference in the title to 'Care in Custody' signals a welcome shift in emphasis, so that the vital element is the care provided to prisoners in distress. Further, the central role of teamwork directly addresses the problem identified with the F2052SH by stressing the need for a co-operative and integrated response.

The Pocket Guide sets out a chart to trace the steps in caring for prisoners at risk:

- A staff member identifies a prisoner at risk and opens the ACCT plan
- The ACCT administrative support officer is informed and a log number is assigned
- The Unit Manager and night orderly officer are informed
- The Unit Manager draws up an 'Immediate Action Plan', which may involve special arrangements on normal location, or a move to the Healthcare Centre
- Within 24 hours, a trained assessor interviews the prisoner, consulting him or her about and discusses what the prisoner would like to happen
- Also within 24 hours, a case review is held and a case manager is appointed
- If mental health problems are identified, the prisoner is referred to healthcare
- A Care and Management Plan (CAREMAP) is agreed with the prisoner
- The situation is reviewed and changes in the prisoner's state are taken into account
- Staff continuously work with the person to build up the kind of support networks that will make it possible to close the ACCT plan
- If a decision is taken to close an ACCT plan, care continues to ensure that the person is safe.

The ACCT approach promises a wide range of improvements over the F2052SH process. A crucial difference is the assessment of the prisoner's needs (with the input of the prisoner) within 24 hours of the concern being raised. The guide places great emphasis on the need to involve the prisoner in each step of the process. For example, the person at risk is present and consulted in drawing up the care and management plan:

"Involve the person at risk. The way they are cared for should have their agreement."

(SCG, 2004/5)

The ACCT employs a problem-solving approach, thus recognising the link between the causes for the person's distress and the risk of self harm:

"Help the person to deal with problems that are causing them emotional pain. Involve other agencies as required. Do not try to solve problems for them. Involve them in considering the options open to them. If the problem can't be solved, help them to cope better."

(SCG, 2004/5)

ACCT recognises that deliberate self injury is an isolating experience and it therefore encourages prison staff to help the prisoner make links to others, possibly family, who can provide them with support. This networking function promotes a whole prison approach and respects the prisoner's choice of those he cares about.
The approach also requires staff to work with prisoners at risk to increase their sense of safety. The Pocket Guide discusses this aspect of the Caremap in detail:

> ‘Prisoners/trainees at risk should be cared for in a safe environment. This could be anywhere the person at risk feels safe, comfortable, and relaxed. This may mean remaining in his/her own cell with access to personal belongings. It may mean a shared cell. It may mean a “safer cell”. It is for the Case Review Team to make this decision. Location should increase staff interaction with the individual. Secluded or isolated accommodation must only be used as an absolute last resort, after alternatives have been considered.’

(SCG, 2004/5)

High proportions of prisoners regularly report to the prisons inspectorate that they do not feel safe. Perceptions of safety in prison relate to many factors, including: the actual risks of victimisation; the perceived level of risk; witnessed victimisation; types of victimisation directly experienced (e.g., insults and verbal abuse, or threats and assault); the degree of respect received from staff and other prisoners; the extent of stigmatisation; the extent of bullying; and the degree to which the person feels confidence in officers and other prisoners to intervene. Wider factors include anxieties the person may feel about their future, the amount of support they have, outside and inside the prison, and their previous experiences of custody.

But to what extent will full implementation of the ACCT approach help Prison Health to address the NICE guidelines? The ACCT strategy fulfils the spirit of at least three of the 12 NICE guidelines. ACCT involves the self harm sufferer in decisions; provides for risk assessment; and, through the ‘Caremap’, aims to ensure that, where relevant, a full mental health check is carried out.

The NICE guidelines point to a few areas in which the ACCT strategy requires further refinement. These are: encouraging people who injure themselves repeatedly in harm minimisation techniques; assessment and addressing the needs of people who self harm; and the training needs of staff.

An entire section is devoted to recommendations regarding advice to people who repeatedly self harm. These include education about harm minimisation techniques, the self-management of superficial injuries, and referring the person to relevant voluntary agencies for advice about alternative coping strategies.

Harm minimisation was not addressed when the F2052SH approach was initiated in 1994. PSO 2700 explicitly rules out a harm minimisation response:

> ‘It is not Prison Service policy to promote “safe self harming”’.

(PSO 2700, para 4.5)

Does ACCT promise an improvement? The Pocket Guide recognises, intermittently, the possibility of repeated self harm. For example, staff are told to be alert to signs of an ‘increase in the frequency or lethality of self harm’. The ‘Caremap’ is expected to include reference to ‘normal patterns of self harm’ by the prisoner. In addition, the Pocket Guide contrasts suicide attempts from self harm with no intention of dying. However, although harm minimisation is part of an overall therapeutic response to repetitive self harm, the ACCT Pocket Guide does not provide staff with any basis for applying its principles. In some ways, then, the ACCT approach repeats the problem the F2052SH form had of treating all self harm as a prelude to a suicide attempt.

The NICE guidelines also recommend a preliminary psychosocial assessment to measure the person’s mental capacity, level of distress, willingness to engage in treatment, and to check for mental illness. It is clear that this assessment is intended to form the basis of subsequent medical intervention. The ACCT strategy recognises a role for professional assessment of the person’s mental health. However, the ACCT approach places responsibility for ultimate decisions about a care plan on
the shoulders of the case manager (HMPS staff) and expects healthcare staff to provide:

... ‘relevant information about their patients to ACCT Assessors and Case Managers as part of their assessment.’

(SCG, 2004/5)

This distribution of responsibility suggests that the response to a person who self harms in prison will be decided primarily within the terms of prison operational requirements, rather than the therapeutic needs of the person who harms himself. This impression is given further weight by contrasting the assessment procedures in each document. This reveals a surprising omission from the ACCT plan.

The NICE guidelines set out a step-by-step process of responding to the health needs of people who self harm; and a key step is to assess the person’s needs. The guidelines fully recognise that psychosocial needs may drive self harming behaviour:

‘All people who have self harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.’

(NICE, 2004b)

In addition, NICE recommends a full risk assessment, to identify the extent to which the patient matches the demographic features associated with an increased risk of suicide, particularly, “depression, hopelessness, and continuing suicidal intent” (NICE, 6).

ACCT is dominated by a concern about risk. The Pocket Guide tells staff the signs to look for to identify who is at risk. The initial assessment of the prisoner - for which ACCT sets a 24 hour maximum delay - is intended to identify the level of risk. A case review is held within 24 hours of the initial assessment, and its purpose is to ‘agree the level of risk’ (Pocket Guide, 7). Further, the purpose of the subsequent case reviews is to take into account any factors that may have changed the level of risk.

The ACCT strategy focuses the efforts of staff on identifying, measuring and reducing risk, but it arguably neglects the needs of the person. The care and management plan includes a problem-solving component, and case reviews are expected, in part, to ask whether the problems have now been resolved that required staff to set in motion the ACCT plan. However, these do not place sufficient priority on identifying the key psychosocial needs that led to the self harm to meet the standard required by the NICE guideline.

The ACCT approach was intended in part to improve on the way the F2052SH focused attention on identifying people at risk, neglecting the care provided for them afterwards. ACCT marks a significant step forward, because it highlights the importance of teamwork, involves the patient in decisions, and encourages staff to interact, not merely observe, the person at risk. However, the ACCT Pocket Guide still lacks a solid framework within which follow-up care can be delivered.

The plan stipulates regular case reviews, to discuss progress made in resolving the person’s problems, but there is no structure or guidance dedicated to the means by which the person’s problems can be addressed. Staff and managers (and the person himself) are left to work out the practical steps to deal with the situation. In practice, the focus on risk and the absence of concrete methods of addressing prisoners’ problems suggest that the ACCT may not do enough to improve the care and support available for prisoners at risk of self harm.

The provision of high quality training and follow-up support for staff remain open questions about ACCT. It is clear that the first priority for the Prison Service is to provide the specialist training required by the ACCT assessors. A three-day course for them has been piloted. A basic course intended for all staff members who come into contact with prisoners lasts three hours. A source
estimated that training in ACCT requires a week for every prison. Given the other training
to the staff placed upon prisons, including race relations, control and restraint, and awareness of
mental health more broadly, it is unlikely that all prison staff in contact with prisoners will be fully
trained in ACCT in the near future.

Although it is encouraging that the ACCT support process has been jointly implemented by
NIMHE and HMIP, as it stands, the strategy faces a number of questions, which implementation
might, or might not, answer:

• To what extent is the new approach restricted to responding to immediate concerns of

the person, and neglectful of long-term, underlying problems?

• How will the care of prisoners who attempt suicide differ from that offered to people who

engage in repetitive self harm?

• Will healthcare staff receive specific training to enable them to fulfil their role in assessing

mental health needs?

• To what extent will PCTs provide the clinical follow-up that is recommended in the NICE

Guidelines for every person who commits self harm?

• Will the NHS press the Prison Service to recognise that harm minimisation is a

requirement of equivalence?
9. Self Inflicted Deaths: Suicide Prevention

‘When the state takes away a person’s liberty, it assumes full responsibility for protecting their human rights. The most fundamental of these is the right to life.’

(JCHR, 2004)

‘Extremely vulnerable people are entering custody with a history of mental illness, drug and alcohol problems and potential for taking their own lives. These highly vulnerable people are being held within a structure glaringly ill-suited to meet even their basic needs.’

Jean Corston, Chair, JCHR, (quoted in Guardian, 01/01/05)

A self-inflicted death often reflects a crisis of desperation. When that death occurs while the person is being held in prison, questions need to be asked about whether the treatment or conditions contributed to that despair; and about whether the imprisonment of the victim was justifiable.

Knowledge of the risks of self-inflicted deaths in custody goes back at least 120 years. In the 1880s a study indicated that the risk was highest during the first few weeks of prison, and particularly among first-time prisoners and prisoners on remand.

A Prison Service standing order from 1933 stated:

‘It appears:

that persons under remand or awaiting trial are more liable to commit suicide than those who have received sentence

that prisoners in prison for the first time are more liable than others to commit suicide

that persons who are guilty of violence to others are specially prone to commit violence on themselves

that the motives for suicide are generally fear, depression, passion, unsoundness of mind, after effects of drink, and remorse

(HMCIP, 1999)

Jenny Shaw et al (Shaw, 2003) analysed data on 172 self-inflicted deaths in prison custody from 1999-2000 (five of these occurred while in the custody of escort services). This study found that:

- 19 (11%) ... occurred within 24 hours of reception into prison; 55 (32%) occurred within seven days
- 85 (49%) individuals were on remand
- 19 (11%) were on a vulnerable persons unit
- 109 (63%) were located in single cells (this includes 9% who were in a segregation unit); of those in double cells, the cellmate was absent in around a half

(Shaw, 2003)

As the comparison with a study from the 1880s implies, the Prison Service has been aware that the risk is highest in the first few weeks of custody, and that remand status constitutes a particular risk factor for over 100 years, without any discernible effect on the capability of prisons to prevent self-inflicted deaths. This raises deep issues about the extent to which prison policies - even those closely based on the best research evidence - can change the prison environment so that it becomes a place of safety.

3 This section follows Prison Service policy in using the phrase ‘self-inflicted death’ rather than suicide. Whether a self-inflicted death was suicide or not is legally decided by a Coroner. About one in three self-inflicted deaths in custody are eventually defined as ‘misadventure’.
The Joint Committee on Human Rights, in their recent session on deaths in custody, reached a similar view:

‘Detentions of already very vulnerable people confront an ill-resourced and overcrowded prison service with a formidable task in ensuring prisoners’ safety. Ensuring prisoner safety is a fundamental responsibility of the state under Article 2. It is difficult to see how this is being upheld when the state continues the bad practice of sending such vulnerable people to prison for minor offences. Indeed, this represents a systemic failure to positively promote and enforce the human rights of these people and grave failure by the state to fulfil its positive obligations under the ECHR.’

(JCHR, 2005)

A recently published review of suicides in male prisons over the last 25 years found that men in prison are five times more likely to kill themselves than men in the community. Boys aged 15-17 are even more likely, 18 times more likely to kill themselves in prison than young men of that age in the community.

This section:

first considers the evidence about the extent of the problem of self-inflicted deaths in prisons;
second, presents further evidence about the factors that appear to contribute to the high number of self-inflicted deaths;
third, examines policies for prevention, in light of the research; and
fourth, explores the analyses of other bodies, including the Chief Inspector of Prisons, Parliament, and the Mental Health Act Commission.

9.1 Extent of the problem

According to Inquest, the charity that works with families of people who have died in custody, the number of prisoners who have suffered self-inflicted deaths while in custody during the past five calendar years is as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Self-inflicted deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>82</td>
</tr>
<tr>
<td>2001</td>
<td>73</td>
</tr>
<tr>
<td>2002</td>
<td>96</td>
</tr>
<tr>
<td>2003</td>
<td>94</td>
</tr>
<tr>
<td>2004</td>
<td>95</td>
</tr>
</tbody>
</table>

The total in these five years was 440 people.

Annual totals do not take into account the changing prison population. It is useful to analyse the prevalence of self-inflicted deaths as an annual rate in relation to the population:

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate per 100K prisoners</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>125.3</td>
</tr>
<tr>
<td>2001</td>
<td>110.1</td>
</tr>
<tr>
<td>2002</td>
<td>134.16</td>
</tr>
<tr>
<td>2003</td>
<td>128.7 (forecasted)</td>
</tr>
</tbody>
</table>

(SCG 2004)

The Prison Service target for reducing deaths in custody is expressed as a rate per 100,000 prisoners. The target rate changes over time, but in 2000 it was 135.7, and in 2003 it was 114.6. The three-year rate to the end of February, 2005 was 127.6.
Swings in the rate show short-term fluctuations. Rises or falls over a short period of a few months should not be used as a reflection on the extent to which changes in the prisons result in reductions. The Safer Custody Group recommends three-year periods for comparison.

A high number of deaths in one prison might not mean that that establishment is doing anything different from any other. Although, following a series of deaths, the prison itself becomes a more vulnerable institution in which further deaths could occur. The personal characteristics of prisoners as they were outside - termed ‘Imported vulnerability’ - also contribute to the risk of self-inflicted death or suicidal thinking.

**9.2 Risk factors - personal characteristics**

A majority of people who suffered a self-inflicted death in prison share a combination of personal characteristics. The Shaw study discovered that of the 172 people who killed themselves in custody during 1999-2000:

- 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.

(Shaw, 2003)

Almost three quarters of the prisoners who took their lives in prison in the years 1999-2000 had at least one psychiatric diagnosis on reception into prison. The prevalence of mental health and drug problems among this group is a powerful demonstration that prisons are being misused by courts to hold people whose basic problem is poor mental health, when the provision for them outside is inadequate. This takes on added significance when the legal reasoning for the decision so often includes the consideration that the person before the court is in need of a ‘place of safety’.

In the light of prison suicides, the legal fiction that defines prisons as ‘a place of safety’ constitutes shocking evidence that courts are out of touch with reality. Vulnerable people face an increased risk of suicide by being sent to prison.

As the risk is highest in the first few weeks, prisons that receive large numbers of prisoners each week - the large local prisons with a remand function - would be expected to experience a higher number of self-inflicted deaths than long-term sentenced prisons, where the number of new prisoners in one week is much lower. Similarly, a prison where the personal characteristics of most of the population put them at much greater risk would expect to endure a higher number of self-inflicted deaths than a prison with a ‘safer’ population.

It is a mistake, however, to assume that personal characteristics can fully explain self-inflicted deaths in custody. The regime and treatment the person receives in prison are more important factors.

**9.3 Risk factors: the social climate of prisons**

Alison Liebling and her colleagues at the Prison Research Centre in Cambridge analysed aspects of the regime, treatment or culture of prisons to identify those that could influence the risk of self-inflicted deaths.

The Cambridge study established that the prevalence of self-inflicted deaths could be correlated to general levels of distress among everyone in the particular prison. Prisons in which there are high general levels of distress are ones in which it is more likely that self-inflicted deaths will occur.
Prison is an inherently distressing experience. However, the Cambridge study demonstrated that prisons can do far more to reduce the stress prisoners experience. Liebling identified aspects of the prison culture that could either relieve or exacerbate general levels of distress. The two main areas were personal safety and the extent of caring and fairness prisoners received from staff.

‘Human beings need fairness and respect: that is, they need to know that actions and decisions taken in relation to them are morally justifiable and to be in environments that treat them with dignity. Demeaning and careless treatment causes distress.’

(Liebling, 2005a)

Liebling concluded that some prisons had considerable success in meeting prisoners’ needs for respect and safety, and therefore substantially reduced the level of risk of self-inflicted death. This conclusion reflects a balance between theories of imported vulnerability and social climate:

‘High vulnerability prisoners were significantly less distressed when they were in prisons where they spent less time locked in a cell, they had employment in the prison, association was less frequently cancelled, they were doing offending behaviour courses and they had regular and good quality contact with their families.’

(Liebling, 2005b)

Liebling and her colleagues found that the perception of safety, or, in their words, ‘trust in the environment’ led to lower levels of distress. Perceived safety can include the degree to which prisoners feel that staff are caring or intimidating, the levels of victimisation from other prisoners, and a lack of information given to prisoners.

‘Prisoners often said that … what made them feel safe was “having someone to talk to”.’

Perhaps the most revealing implication of this comment is that too often, safety is conceived of narrowly, in terms of being protected from other prisoners. The need to talk to others strongly suggests that some prisoners - perhaps those most at risk of suicidal thinking - may also sense that they are a danger to themselves.

9.4 The damaging effects of imprisonment

The work by Liebling and her colleagues put the spotlight on the moral climate of prisons. But there are also mundane, practical consequences of being sent to prison that may have an effect on an individual’s emotional well-being. Some of these factors form a bridge between theories of imported vulnerability and the influence of the prison environment, because they arise from the ways prisons fracture family relations and destroy the person’s networks of social support.

In their evidence to the JCHR, the Royal College of Psychiatrists listed some of the traumatic effects on persons as they enter prison:

‘it is still not possible within a prison environment to provide the same level of exercise, and fresh air, for example, that is available elsewhere. The risks to mental health … remain high. Separation from family and friends, entry into an alien environment, sudden withdrawal from drugs and alcohol, an uncertain future, loss of job and income, the rupture of many social relationships and supports, all induce mental distress and disorder.’

(RCPsych, in JCHR, 2004-5: Ev 186)

Their evidence closely matches the typical experience of someone sent to prison on remand, although they did not mention whether a person’s legal status could affect their level of distress. However, it seems likely that a person’s feelings of uncertainty would be exacerbated while they are on remand.
Sophie Corlett, policy director of MIND, suggested that the stresses of prison life have harmful effects, even on those who are mentally healthy:

‘From the evidence it appears that [people with serious mental health problems] become more ill and it would appear that people who have less severe mental health problems develop more severe mental health problems. Prison appears to be a good greenhouse for developing mental health problems.’

(JCHR, 2004-5, italics added)

The JCHR report bluntly described the harmful impact of prison custody on mental health:

‘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.’

(JCHR, 2005)

9.5 Population pressures

The role of overcrowding is largely neglected by the focus on staff-prisoner relationships and by the personal characteristics approach. Whether overcrowding influences the risk of self-inflicted deaths in custody is the subject of much debate. Overcrowding has diverse causes and consequences, and it is difficult to establish a direct link between overcrowded prisons and increased rates of self-inflicted deaths.

However, between January 2005 and the end of September 2005, 48 of the 60 (four out of five) self-inflicted deaths in custody occurred in prisons that were above their Certified Normal Accommodation. During this period, half of the prisons in the system were above their CNA. Prisoners who took their own lives were disproportionately likely to do so in an overcrowded prison.

PRT has put on record its view that overcrowding increases the risk of self-inflicted death:

‘10 of the 20 establishments with the highest incidence of self-inflicted deaths are also in the top 20 for turnover of the population.’

(PRT, 2005)

Some of the inherent effects of overcrowding are clearly related to the risk factors identified by others, for example the number of people passing through a prison. Prisons with high turnover tend to:

- Hold people on remand
- 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 to these, it is likely that 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 to get to know prisoners personally or to give them caring attention. Officers are also limited in their ability to gather information about individuals which could help to identify who is at particular risk of suicide. This problem has been exacerbated in recent years by a deliberate policy pursued by a pressurised Prison Service headquarters to reduce the number of staff active on a wing at any time. The so-called ‘performance improvement process’ requires prison management to cut costs, and the primary target for ‘savings’ is the reduction of staff numbers.
In prisons that are required to deal with a high turnover, it is much harder to acknowledge the person’s dignity or permit their development. The demands on local prisons also mean that they are less able to meet the minimum standards of treatment that the whole prisoner community needs in order to feel less distressed.

In their briefing to parliament, the Prisons Research Centre team was blunt about what they found in the 12 local prisons:

“We witnessed major deficiencies in facilities and procedures at most prisons. The regimes in general in many of these establishments were impoverished. Mean levels of distress among prisoners were extremely high. Reception areas were extremely busy, often cramped, and lacking privacy. Attitudes ranged from respectful and considerate at [some prisons] to firm at others and cynical and dismissive at others.’

(Liebling, 2005b)

The Joint Committee on Human Rights also drew a direct link between overcrowding and an increased risk of self-inflicted deaths:

“The overcrowding of the prison system due to this over-reliance 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.’

(JCHR)

9.6 Strategies for prevention

Official policy advocates a whole prison approach to prevention. There are, however, two contrasting ways that prisons can try to prevent suicide: a whole prison approach is one. The other is to focus on at-risk prisoners, with measures including observation by staff and removal of the prisoner to a ‘safe cell’. The former engages all staff and all prisoners in working together to create a healthy prison, characterised by decency and a mission to meet the needs of all prisoners; the latter requires staff to use the F2052SH form (or ACCT) to record incidents of self-harm that are taken to indicate a risk of suicidal intent.

The balance between these two differs from one prison to another. In general, however, evidence suggests that too much emphasis is placed on the identification of at-risk prisoners.

Writing of the attempts in the 1980s to sharpen the tools to identify those at risk, Barry Goldson and Deborah Coles remarked:

“The primary emphasis … retained focus on the medical/psychiatric and procedural. Prisoners assessed as suicidal and/or at risk of self-harm, were conceptualised as pathological. The “solution” was found primarily in more rigorously applied processes of assessment and monitoring. There was little official attention paid to the “social” dimensions of death, harm and damage in penal custody; the pain of confinement; the corrosive impact of conditions and treatment and the intrinsic deleterious nature of the prison environment itself.’

(INQUEST, 2005)

Identifying prisoners at risk

Regarding the performance of prisons in identifying prisoners at risk, the Shaw study found that:

- 40 (25%) had an open F2052SH at the time of death (indicating recognition of risk)
- At final contact with health care staff, risk of self-harm/suicide was thought to be low or absent in 141 (93%) cases.

A mechanism for identifying prisoners at risk of attempting suicide which is only 25 per cent accurate is clearly unreliable. Looking at the demographic composition of the prison population

4 The F2052SH is the form used to register prisoners perceived to be at risk of self-inflicted harm or death. The Prison Service is currently replacing it with a new document, the Assessment Care in Custody and Teamwork for (ACCT).
and the known risk factors for attempted suicide, it is not difficult to see why. The odds against correct identification are extremely high.

In a given year, just over one in 100 prisoners will take their own life. Thus, on a virtual wing of 100 prisoners, prison officers would be required to decide which one prisoner should be watched. But most of those 100 prisoners match the characteristics of someone at risk. The Social Exclusion Unit report, ‘Reducing re-offending by ex-prisoners’, showed the composition of the prison population:

- 72 per cent of male sentenced prisoners suffer from two or more mental disorders
- 66 per cent of male sentenced prisoners self-reported drug misuse in the year before they entered custody
- 20 per cent of male sentenced prisoners had previously been admitted to a psychiatric hospital
- 20 per cent of male sentenced prisoners had previously attempted suicide.

In short, almost three quarters of prisoners have at least one of the identifying characteristics of people at risk of suicide.

But the task of identification is still more complex. Suicidal thinking is periodic: people enter a time of crisis, which may be short and linked to an event, and many are able to pass through this crisis and regain their equilibrium. Thus, in addition to keeping an eye on new prisoners, wing officers are required to bear in mind that people who have been incarcerated for months or years can also become more susceptible to suicidal thinking. While self-inflicted deaths occur at a disproportionate rate in the first few weeks of custody, it is also true that a person’s susceptibility to suicidal thoughts can rise and fall and rise again during a period of imprisonment.

The conclusion that trying to identify which prisoners are most at risk is not the most effective means of preventing suicide has been given added support by Dr Jenny Shaw. Her review of research studies going back to the mid-1980s concluded that, “those at risk of suicide were difficult to identify from the general prison population, who shared many of the risk factors” (Shaw, 2000).

It is crucial that prisons do everything in their power to reduce the risk of a suicide under their care. Clearly, part of that is the responsibility to be alert to signs that an individual is particularly at risk. But the emphasis on identifying risk has led to an excessive reliance on accurately targeting specific individuals possibly to the detriment of broader changes to the social climate that could have a more significant impact.

It is a matter of balance. Paralleling reports by the Chief Inspector of Prisons, the Cambridge research has demonstrated a widespread failure to treat people with care and respect in ways that reduce their distress. Redressing this problem should be the priority for all prisons, as reliance on the targeted approach, in the absence of improvements in prison culture, is unlikely to reduce the risk of self-inflicted death.

It remains to be seen whether the implementation of the ACCT approach will set a healthier balance between identification and care.

Juliet Lyon, director of Prison Reform Trust, stated in her evidence to the JCHR Inquiry into deaths in custody:

“The Prison Service has a culture of observation and control. It is a disciplined service. If it feels that someone is at risk of suicide, than a form is raised and that person is observed and the time in between observation is reduced if the person is seen to be very much at risk. This was a culture that, years ago, pertained in psychiatric hospitals and was done away probably in the late 1960s and early 1970s when there was a realisation that actually what people needed was to be near somebody,
to have some comfort, to have a person to talk to and to have contact. ... The culture itself is not conducive to looking after people who are at risk of suicide.’

(Juliet Lyon, cited in JCHR, 2005, Part II: Ev4).

Listeners

The Listeners scheme is based on the work of Samaritans in the community, and indeed Listeners are selected, trained and supported by Samaritans. There are other projects that provide peer support to prisoners - the Insiders scheme is one example - but Listeners schemes are explicitly focussed on working with prisoners who are distressed and considering self harm or suicide.

The first Listeners scheme was established by Samaritans in HMP Swansea in 1991. There are now 118 Listener schemes in HMPS establishments.

The idea is described in a Prison Service guide to good practice:

‘The Listener scheme is a system whereby selected prisoners are trained and supported by Samaritans, using their same guidelines, to listen in complete confidence to their fellow prisoners who may be in crisis, feel suicidal or who need a confidential sympathetic ear. The objectives of such a scheme are to assist in preventing suicide, reducing self-harm and generally to help alleviate the feelings of those in distress. Samaritans are involved in selecting, training and supporting Listeners in almost all the schemes in operation.’

(HMPS, 2002)

Volunteer prisoners are chosen for their abilities to maintain confidences, to be non-judgmental, to listen and communicate, and to emphasise, regardless of personal feelings about the ‘caller’. Once trained by Samaritans from the outside community, the Listener is supported by a more experienced Listener inside, and meets regularly with Samaritans to talk about, and learn from, their experience.

Contacts can be referred to a Listener in a variety of ways, the main two being self-referral, by approaching a Listener directly; or asking a member of staff, who then contacts a Listener and facilitates the meeting.

Setting up a scheme has a number of practical requirements. For example, volunteers must agree to serve as a Listener for at least six months after being trained, and therefore governors are asked to make efforts to ensure that Listeners are not transferred out of the prison. Samaritans have regular access to the Listeners, and Listeners must attend regular meetings with Samaritans (which can sometimes conflict with visits, education, or other prison activities). The nature of the work means that volunteer Listeners need ongoing support. It also requires all staff to recognise that all prisoners - regardless of their status, the nature of their offence, or their location - have the right of free access to Listeners at any time.

The schemes work best when the prisoners maintain ownership, rather than management solely by prison staff. The extent to which Listeners are encouraged to direct the schemes - e.g. choosing means of publicity, deciding on referral systems, and responding to any complaints - is a good measure of the level of the prison’s commitment to the scheme.

The requirement of a well-run scheme that is most challenging to the ethos of traditional prison management is the rule of complete confidentiality.

The Prison Service guide stated:

‘Listeners should not be asked to reveal details received while acting in that capacity including, for example, possession of a weapon. Listeners who cannot keep to this rule should not continue in the role.’

(HMPS, 2002)
Some prison officers still find this rule difficult to accept. The guide suggests that their attitude might reflect a concern for security - as, for example, a Listener who is told by a ‘caller’ that he has a weapon is bound by the rule not to reveal this information. Equally, officers might believe that details about a person’s level of risk could help them better to prevent self-harm or suicide.

The reason for the rule is that it is essential to build trust with people who might otherwise decide not to disclose their distress to anyone. Sceptical prison staff need to accept that the suspicion that a Listener might pass information to an officer (without the consent of the caller) would completely undermine the work.

The trust that confidentiality can inspire depends on a very clear statement of any exceptions to the rule. The Listener scheme has two, and they are worth quoting in full:

> ‘Volunteers will not accept a confidence which contravenes the Prevention of Terrorism (Temporary Provisions) Act 1989.

> Volunteers will call for help, without consent, where a caller has begun to commit suicide and has reached a condition where it is clear that they are fully unable to make their own decisions.’

(HMPS, 2002)

The importance of the rule is strengthened by the detailed way the HMPS guide considers the practical implications.

> ‘Although Listeners can be used as part of a prisoner’s support or care plan, it is not appropriate for them under any circumstances to make an entry in a prisoner’s F2052SH [or ACCT] because the content of their befriending is confidential.’

(HMPS, 2002)

9.7 Investigating deaths in custody

A death in custody inevitably raises the need to examine the circumstances behind the death, and in particular, whether any aspect of the treatment the person experienced could have contributed.

Liberty has stated that government has a duty, under Article 2, to ensure that every death in custody is fully investigated:

> ‘The state must be presumed to have failed if a person dies in its custody. Therefore there needs to be a thorough investigation of any death, because any fault in the system for protecting the right to life could very well lead to other loss of life. The state has failed in its role not only if it does not investigate the death properly but also where criminal offences have been committed, if it does not prosecute those responsible.’

(Liberty 2003a)

Liberty summarised the requirements of Article 2 of the ECHR for such investigations:

> It must be independent from those implicated in the events.

> It must be capable of leading to a determination of whether the state is responsible for the death.

> It must be prompt.

> It must contain sufficient public scrutiny and involve the next of kin in the investigative proceedings.

(Liberty 2003b)
Before 2004, investigations into deaths in custody were conducted by the Prison Service, in addition to the coroner's inquest. In 2004, the government assigned the Prisons and Probation Ombudsman the duty of investigating self-inflicted deaths in custody.

Stephen Shaw, Prisons and Probation Ombudsman, said:

"In taking on the daunting responsibility of investigating deaths in custody, I have three main aims. First, to enhance public confidence when someone has died while in the hands of the state. Second, to involve and to provide answers for bereaved relatives. Third, to contribute to the efforts of the Prison Service and others to reduce the numbers of self-inflicted and other avoidable deaths."

(Home Office Press Release, 2004)

In its first year, the fatal incident investigations team initiated an investigation into 204 incidents (including deaths in probation approved premises, immigration detention centres, and deaths after release) (Bradley, 2005: 6). In this section, the second and third of these aims are taken as themes of the duties of the state to provide explanations in the aftermath of any death in custody.

The interests of bereaved families

The ombudsman's responsibility can be defined by reference to human rights law. The Joint House Committee on Human Rights summarised the implication of Article 2 of the ECHR:

"The next of kin of the deceased must be involved in the inquiry to the extent necessary to safeguard his or her legitimate interests."

(JCHR, 2004)

Although this defines the extent of the families' rights, the terms are perhaps too broad to ensure that bereaved families receive answers to their questions about the death of a relative in custody. The JCHR heard evidence from bereaved families about a lack of information, insensitive treatment in informing families, and continued obstruction of families' attempts to gain information.

INQUEST, in a recent publication, quoted a bereaved parent (whose experience related to the system of internal investigations, before the Prisons and Probation Ombudsman took on the new role):

"The death of my son has had an enormous impact on me, his brother and the rest of our family. Nothing can ever be the same again and I still feel a slow burn of anger and an overwhelming sense of injustice that will not go away. The inquest gave us some more information but did not fulfil our expectations. In many ways it led to more uncertainty and after it was over I felt as if there was no one else left to listen."

(INQUEST, 2005)

In November, 1994, Christopher Edwards was killed in HMP Chelmsford by his cellmate. Both prisoners clearly had mental health problems, and neither, arguably, should have been in prison. For the next eight years, Christopher's parents, Audrey and Paul Edwards, had to fight determined resistance by authorities to find out what had led up to the death of their son. Although Christopher's death was not self-inflicted, their search for explanations revealed the inadequacy of the systems for responding to the needs of bereaved families.
John Wadham, then director of Liberty, wrote about the ways in which officials blocked the Edwards family’s attempts to learn what led up to Christopher’s death:

‘The death of a loved one is tragic but to have to fight to find out the truth which happens in many cases where the authorities are responsible is not acceptable. To have to struggle for every scrap of information and to be presented by structures such as the police complaints system and the inquests which do not work is an insult to relatives.’

(in Edwards, 2002)

Their experience of delays and obstructions also took place before the ombudsman’s office was handed responsibility for investigating deaths in custody. However, the current situation suggests that bereaved families are still not receiving the quality of support to which they are entitled. The JCHR heard evidence of long delays in coroner’s inquiries, which are often over a year. Liberty stated that the average time between a death in custody and the start of an inquest is between one year and 18 months (Liberty, 2003: 44). PRT has learned of a number of inquests that are taking place as much as four years after a death in custody.

According to Audrey Edwards, the inquiries and investigations that took place over the eight years did not begin to address her interests. Indeed, the system of investigating the facts seriously neglected the Edwards’ family’s legitimate interests in learning the truth of what happened and in working out how something positive could come from their son’s death. She stated:

‘It came to me in retrospect that the inquiry could - and should - have been an instrument of reconciliation instead of the divisive experience it actually was. Sadly it did not seek from the outset to be a means to achieve mutual understanding between ourselves and the public agencies whose performance was under review.’

(Edward, 2002)

In the aftermath of each death in custody, it might be hoped that the search for explanations might reveal factors that could be addressed, so that future deaths might be prevented. Unfortunately, some investigations appear to reveal that the problem is not that the Prison Service needs to develop new polices: some deaths in custody have occurred because the Prison Service has failed to implement reasonable steps to treat people with dignity.

The ombudsman was asked by the then Home Secretary to investigate the six deaths of women in HMP Styal. In her response to his findings, Deborah Coles, co-director of INQUEST, stated:

‘The Home Office minister and prison service management need to explain to the families of the six women who died between August 2002 and August 2003 why they failed to take urgent action to address the systemic failings identified in the previous Inspectorate report of 2002.’

(INQUEST, 2005)

To what extent, therefore, is it realistic for the ombudsman to hope that the investigations into deaths by his office will help to prevent what he terms, ‘avoidable deaths’?

Learning lessons

The ombudsman’s team do not see their function as allocating blame in the aftermath of a death. Rather the emphasis is on drawing out the possible lessons from each death. By gathering detailed information about the circumstances that led up to a death in custody, the team should be able to contribute to evolving good practice.

The ombudsman’s team therefore face a potential conflict between the aim to provide explanations without blame and the interests of families (in some circumstances) to learn about failings that contributed to the death.
But how well can investigations into deaths in custody contribute to developing more effective means of preventing deaths in future? To summarise the findings of a number of inquiries, there has been:

- A lack of training of staff in the management of people at risk of self-harm or suicide
- Inadequate staffing levels
- Poor communication between health and disciplinary staff
- A continuing practice of locating vulnerable prisoners in segregation units.

These are not problems of a poorly conceived policy; nor are they - as they are often presented in official statements about deaths in custody - very rare circumstances brought about by a situation of extreme pressure. Rather, these are the conditions that are typical of many, if not most local prison establishments. They are persistent operational failings, problems that are no sooner addressed in one place with a quick cash injection, than they arise in a different prison, with the same fatal consequences.

The fact that this combination of neglect is far more typical than is officially acknowledged raises a profound question about the way the ombudsman’s role has been defined. The investigation structure is carefully designed to restrict the ombudsman’s discretion.

His role is restricted to the operations of prison and probation (and immigration holding centres). However, this report has shown that a key contribution to many deaths in custody is the inappropriate over-use of custody to detain people who have serious mental health problems. The inability of the ombudsman officially to comment on the effects of the courts’ misuse of prison requires him to look for lessons on a case-by-case basis, with the possibility that the wider picture will be neglected.

INQUEST has highlighted four basic flaws in the current system of inquests and investigations by coroners and the Prisons and Probation Ombudsman:

- Not sufficiently independent (no statutory basis)
- Not timely
- Ombudsman has no power to compel witnesses to provide evidence
- Insufficient attention to the needs of bereaved families.

In place of the current arrangements, INQUEST has called upon government to establish a standing commission on custodial deaths. This, INQUEST believes, would have sufficient independence, the power to demand evidence, and resources to ensure that identified failings of the state would be rectified. The terms of reference for the Commission would centre on collecting, analysing and disseminating data and research on the causal factors contributing to deaths in custody.

The government has published a draft bill on corporate manslaughter and PRT was one of the organisations to respond to the consultation process. It is important to consider how the concept of corporate manslaughter specifically relates to the position of prisoners, who are extraordinarily dependent on prison managers and staff for basic human needs.

As it stands, it would appear from the wording of the bill that duties of care that arise out of the exercise of custodial powers would not be covered by the offence. If investigations suggest that “management failure” did, in all probability, bring about the death of an inmate, then it is difficult to understand why the offence should be less relevant than in any other sphere of service delivery. The various tests set out under “management failure by senior managers” and “gross breach and statutory criteria” would still apply, providing a transparent framework, with necessary safeguards. PRT maintains that the offence of ‘corporate manslaughter’ should cover duties of care that arise out of the exercise of custodial powers.
10. The Dangerous and Severe Personality Disorder Programme

10.1 Background

Personality disorders are associated with a significant burden to the individual, their families and society as a whole (Moran, 2002). The ONS 1997 survey findings reveal that 64 per cent of male sentenced prisoners and 50 per cent of female sentenced prisoners had at least one personality disorder. These rates are 12 times higher than men in the general population and 14 times higher than women (SEU, 2002).

However, these rates disguise a number of questions about the definition of a personality disorder. For example, anti social personality disorder (ASPD) specifically emphasises antisocial behaviour and so it is not surprising that the prison population will usually have a high prevalence of ASPD (see below).

Defining the concept of personality disorder suffers from circularity. It is difficult to separate the definition of the condition from the grounds for diagnosis in an individual. Despite over two decades of extensive research, psychiatrists and psychologists remain divided as to how these disorders should be conceptualised. It is only possible to make meaningful statements about the epidemiology and management of a health problem on the basis of an agreed definition (Moran, 2002).

Given the confusion and debates over the terms, it is predictable that there would be a lack of consistency in working with people who have personality disorders. It has been recognised by the government and some professionals that this group of people have been failed by treatment which falls far short of the seven standards in the National Standards Framework (DoH, 1999). People with personality disorders tend to make heavy demands on services which are often ill equipped to deal with them. The DoH report ‘Personality Disorders; No longer a diagnosis of exclusion’ (2003) brought this neglected and isolated area of mental health into focus for the first time.

There is considerable stigma attached to the diagnosis with users feeling labelled both by society and professionals. According to Professor Eddie Kane, a member of the Department of Health and Home Office expert advisory group on personality disorder, the exclusion experienced by those with personality disorders is active, rather than just by default. Twenty-eight per cent of specialist Mental Health Trusts provide no service. In a survey, 17 per cent of Trusts claimed that they had no people with personality disorders in their area. Dedicated services were very limited.

‘One of the characteristics of this group is that they evoke high levels of anxiety in carers, relatives and professionals. They tend to have relatively frequent, often escalating, contact across a spectrum of services including mental health, social services, A& E, GPs and the criminal justice system.’

(DoH, 2003)

There are a range of treatment interventions for personality disorders, including psychological treatment and drug therapy, although clinicians are sceptical about their effectiveness. The DoH (2003) indicated some guarded optimism about therapeutic interventions with the proviso that more research is needed.

In general, the consensus on treatment is that a combination of psychological treatments, reinforced by drug therapy at critical times, is most likely to be effective. Part of the benefit which individuals who are personality disordered derive from their treatment comes from being involved in therapeutic interventions which are well structured, with a clear focus, and theoretically coherent to both therapist and patient. Treatment needs to be relatively long term, integrated into other services available to the patient, and with a clear treatment alliance between therapist and patient (Bateman and Tyrer, 2002).
This confirms the views of service users, captured by a focus group, for the preparation of this DoH report, which identified the most helpful characteristics of a personality disorder service were those which could make people feel respected, valued and hopeful. Amongst these were early intervention before crisis point, accepting, reliable and consistent, clear and negotiated treatment contacts, appropriate follow up and continuing care, and involving patients as experts. Unhelpful features of services which made people into ‘career psychiatric patients’ were, amongst others, office hours only, lack of continuity of staff, staff not interested in causes of behaviour, withdrawal of contact used as a sanction and dismissive or pessimistic attitudes (Haigh, 2002).

There are interventions which have been developed specifically to address offending behaviour such as: enhanced thinking skills, dialectical behaviour therapy, anger/violence management, sex offender treatment programmes, and forensic psychoanalytic psychotherapy. These are described by Craissati et al. (2002) in their review of research (see DoH, 2003).

10.2 Prevalence of personality disorder in prison

As stated above, the prison population show a high prevalence of some categories of personality disorder. This is not very surprising as criminal behaviour is one of the diagnostic tests for ASPD. The survey by Singleton et al. (1998) found that the prevalence of any personality disorder was 78 per cent for men on remand and 64 per cent for male sentenced. ASPD had the highest prevalence of any category of personality disorder, with 63 per cent of male remands and 49 per cent of sentenced prisoners.

People with personality disorders are likely to also suffer from associated mental illness such as depression, anxiety disorders and substance misuse and dependence (Moran, 2002). Moran points to two ways in which the association between psychiatric illness and personality disorders can be complicated: firstly because the presence of a psychiatric illness may bias the assessment of personality leading to an erroneous diagnosis of personality disorder and secondly, because the diagnostic criteria for some personality disorders and some psychiatric illnesses overlap, resulting in false co-morbidity. In addition, Reich and Green (1991) suggest in early research that those with personality disorder are also more likely to have a poorer response to treatment for an associated psychiatric illness such as depression and anxiety. These factors are likely to be compounded by the prison environment.

10.3 Prison mental health services

It is perhaps not surprising that prisoners with personality disorder are more likely than others to experience disciplinary procedures, and more periods of segregation (Singleton et al., 1998).

The prison environment poses particular challenges, over and above those identified elsewhere in this report, in providing mental health services for this group. Prison staff may view them as: violent, emotionally unstable, cunning, manipulative, insincere, or lacking in feeling. Health care staff, both prison and NHS, are unlikely to have the resources and skills to deal with the complex problems of prisoners suffering from personality disorders with associated psychiatric illnesses. The result is that these prisoners are likely to face a destructive cycle of rejection and coercive crisis interventions. These will follow manifestations of their illness involving other prisoners and staff (for example, discipline problems) or themselves (self harm and attempted suicide).

What specialist provision is there for people with personality disorder within the prison system? Three prisons have an established specialised therapeutic community regime, geared for offenders with personality disorders. The first is at Grendon with 210 beds. Grendon only accepts prisoners who have chosen to go there. Prisoners need to be motivated to change and willing to participate in often very demanding group work. The focus of much of the work is upon disordered relationships, and exploring the past and present. By forming reparative relationships with staff and other prisoners over a period of time prisoners can learn how to live more constructively, and how to break the cycle of being abused and abuse.
A second prison with a therapeutic regime is HMP Dovegate where the therapeutic community is a discrete facility located on the same site as the main prison with an operating capacity of 200 of which 15 per cent must be Category B prisoners. HMP Blundeston also has a therapeutic wing, which was pioneered by prison officers.

Like the Crisis Recovery Unit (see above, section 8) a key feature of therapeutic units is that they encourage personal responsibility. Taking responsibility for their actions is an essential part of treatment for people with personality disorders at the Henderson Hospital, an NHS facility. Adrian Feeney listed some of the principles of therapeutic communities:

- The voluntary nature of the programme
- The sanction of discharge if the patient does not engage
- A clear hierarchy and set of roles, which promote responsibility for one’s own actions and an understanding of the actions of others
- A limited period of treatment, which ensures good throughput and prevents therapeutic stagnation.

(Feeney, 2003)

Some of these features, strictly upheld in prisons like Grendon, Dovegate, and Blundeston, could serve as measures of the approach to be taken in the two new DSPD units. For example, Grendon maintains a principle of permissiveness: that a person must be free to make mistakes in order to learn from them.

One of the enduring problems experienced by people in these therapeutic communities is their return to mainstream prisons. This transition, from a therapeutic setting to the prison environment, can cause them considerable difficulties. Accounts from an ex-prisoner explain that in order to survive in the prison environment it is essential not to expose vulnerability, to be macho and strong. It is exactly these responses that the prisoner with personality disorders, going to a therapeutic community has to break down in order to benefit from the regime and learn new ways of interacting with people. Returning to prison, he needs to relearn and return to his old responses in order to survive.

Some prisoners with personality disorders may be transferred from prison to provision such as Arnold Lodge. This is a forensic residential personality disorder unit within a medium secure unit and transfers would be done under the Mental Health Act section 47/49. There is a comprehensive pre-admission assessment so that only suitable prisoners can be admitted for a maximum period of two years. There are three stages: A three month assessment period, a 15 month intensive treatment period and finally a six month period of rehabilitation and preparation for discharge either back to the community or to prison to finish a sentence. Prisoners can also be transferred to high secure hospitals such as Rampton and Broadmoor. All transfers to hospital are subject to considerable delay.

PRT has heard from a former prisoner that the after care support which patients returning to the community might expect to receive is not routinely available for those returning to prison. Representatives from the prison are often not sent to attend a CPA meeting. There is a risk that much of the rehabilitative work by many professionals and the prisoner themselves is undermined as they re-enter the prison environment.

It is welcome that the DoH is supporting better services for this excluded group but we have noted that this work starts from a low base. Developing general services for personality disorders will stem from eleven ‘model’ services and networks, two of which are service user led, a huge step forward in service planning. New emphasis on training and providing a ‘skills escalator’ for non-specialist health staff and non-health staff should enable the housing officer, for example, who faces the difficult client with personality disorders, to cope better and be less likely to exclude and reject. Similarly the development of the ‘Capabilities Framework’ on the NIMHE website and materials at the NHS University will hopefully allow more staff to feel able to cope with this demanding client group.
But how, and to what extent, will the development of general services for people with personality disorders find their way into the prisons where the overwhelming majority suffer from some type of personality disorders and the culture is that of containment and crisis? Prison staff should, in theory, be able to benefit from these resources, but we have seen elsewhere in the report that accessing material in the prison environment can be problematic. Training and support in this area needs to be adequate, consistent, accessible, and timely if it is to have any chance of effecting front line services for prisoners with personality disorders.

10.4 The programme for dangerous and severe personality disorder

The origins of the DSPD programme can be found in a statement to the House of Commons in 1999 by the then home secretary, Jack Straw. He drew attention to a perceived gap in legal protection afforded society from acts of serious violence. He pointed out that ‘those who are capable of committing acts of a serious sexual or violent nature’ could be dealt with either through criminal law or detention under the Mental Health Act. He argued that some who pose a serious risk can slip through the net, if their condition is deemed ‘untreatable’. He concluded that the current arrangements left society unprotected from dangerous individuals:

’Society cannot rely on a lottery in which, through no fault of the courts, some dangerous, severely personality disordered people are sent for a limited time to prison or to hospital, while others remain in the community, or return to it, with no interventions whatever.’

(Straw, 1999)

In this statement, Straw explicitly voiced the motivations which led the government in 1999 to commit itself to the development of a programme specifically for people who are defined as having a dangerous severe personality disorder. It was to protect society from individuals who could not otherwise be detained because their condition was deemed ‘untreatable’. Straw did not mention that detaining someone because of what they might do in future, preventative detention, is a dubious practice in natural justice.

The dangerous severe personality disorder programme (DSPD) was jointly developed by the Home Office, DoH and the Prison Service, with the dual aim of providing better public protection and improving mental health. But the validity of the work rests on the assumption that there is a robust association between violence and personality disorder.

Inevitably much of the interest has focused on the category of dangerous severe personality disorder (DSPD). The numbers of people who meet the criteria are small: around 2,000 - 2,400. Most of them are in prison rather than hospital (Hadjipavlou, 2004). This is where the bulk of the funding will be spent, with new buildings and facilities but it is also where issues of concern are more likely to arise. The DSPD programme has planned pilot capacity for 92 places at HMP Whitemoor (open since 2002 and currently holding around 44 prisoners) and HMP Frankland with a planned capacity of 80 places (opened May 2004 and holding around 23 prisoners). Broadmoor and Rampton NHS Hospitals are each planned to take 70 men each.

High security provision of 300 new places for (DSPD) patients for assessment and treatment is to fulfil a government manifesto pledge. Those deemed suitable for admission for treatment in a DSPD pilot unit will have had an assessment that indicates that firstly, they are more likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover: secondly, that they have a severe disorder of personality and thirdly, their offending is linked to personality disorder (Hadjipavlou, 2004). We have noted above that two prisons, Frankland and Whitemoor, with potentially 170 places are part of this programme.
10.5 Concerns about the DSPD programme

Plans for the Programme are refreshingly transparent, and the procedures and regimes reflect careful thought and planning. However, areas of concern about the DSPD programme have been voiced by lawyers, psychiatrists, social policy analysts and media commentators. In summary, these are concerned with civil liberties, (the use of preventative long term detention) the use of language (DSPD is a term of politics rather than medicine), the lack of knowledge about treatment models, and the use of the prison system to treat/contain mentally ill people, in the prison system. The focus in this report is on those concerns directly relevant to the way the programme operates within the prison system, for offenders serving sentences.

An underlying question is whether the DSPD Programme represents a sensible balance of resources for mental healthcare in prison. The budget for the programme, which targets an estimated 200-300 people (not all of whom are in prison) was £126 million over three years. The DSPD Programme will cost about £180,000 per person per year (Batty, 2002). In contrast, a scoping exercise about costs of healthcare in prison led to £122.5 million being transferred to the DoH for 2002-3 (Ladyman, 2004b). In 2000, it was estimated that about half of the prison healthcare budget was spent on mental health (PRT, 2003). A rough average, based on a prison population of 75,000, suggests that this budget represents an annual expenditure on prison mental health care of approximately £817 per person. This suggests that mental health services will be woefully under-funded for the majority of people in prison, and that the investment in the DSPD Programme is a serious distortion of equitable service provision.

Definition and assessment

A seminar by the Royal College of Psychiatrists in 2003 made the following observation

‘There is an apparent discontinuity in policy for offenders with personality disorder in that the DoH Guidance is entitled ‘Not a Diagnosis of Exclusion’ but for certain offenders, the diagnosis is changed to dangerous and severe, making their management within forensic psychiatry services rather different from those in the rest of the service.’

(RPsych, 2003)

The definition of DSPD is vague and contentious. The circularity in the definition is cause for concern.

The Mental Health Alliance voiced scepticism about the definition:

‘There is a lack of scientific validity for personality disorder, and especially for DSPD … Many people are currently misdiagnosed with personality disorder.’

(Mental Health, 2004)

The Mental Health Act commission were outspoken about the inherent ambiguity of the label:

‘The problems of re-defining patients as having personality disorder (whatever that might be, given the problems of case definition, diagnostic categorisation and epidemiology) only serves to underline the difficulties inherent in using such classification and the potential for their misuse.’

(MHAC)

An ambiguous definition complicates the practice of assessment. Moran (2002) pointed out that there is no consensus of how to assess personality disorders. Clinical and research methods for diagnosing can diverge with a level of agreement between schedules which is ‘generally very poor’.
An unreliable basis for assessment is only the beginning of practical problems facing the new DSPD units. The new segregation PSO 1700 suggests that anyone on segregation for three months or more should be considered for assessment for a close supervision centre (CSC) or DSPD unit. Prisoners can be held in segregation units for a variety of reasons, including undiagnosed acute mental health problems. Therefore, extended time spent in a segregation unit is a dubious criterion for assessing suitability for transfer to a DSPD unit. The assessment criteria are also influenced by non-clinical factors such as whether a prisoner has a fixed term sentence or on a life sentence. Guidance says that determinate sentenced high risk prisoners, who present the most serious and immediate threat to public protection, are likely to be given priority by DSPD Units. For those on life sentence, it is their tariff and length of time to possible release which are likely to be influence an admission assessment.

Consent

The Planning and Delivery Guide of the DSPD High Secure Services (July 2004) states that:

‘Not all prisoners/patients admitted to units will have been referred on a voluntary basis, It is to be expected that willingness to participate in assessment or treatment will be a continuum... units will not generally be required to seek the formal consent of prisoners/patients before they are admitted to a Unit for Assessment. ... However, units should ensure, as far as practicably possible, that individuals admitted are made fully aware of what assessment, and in due course, if selected, treatment will involve.’

(DSPD Planning and Delivery Guide, 2004)

Prisoners treated within the Prison Service DSPD units (Franklin and Whitemoor) cannot be treated under the MHA 1983 as prison is not a hospital for the purposes of the Act. So the position is that:

... ‘in the prison based units, while the placement itself can be involuntary, prisoners will continue to have a legal right not to participate in treatment.’

(DSPD Planning and Delivery Guide, 2004)

How are choices being presented to prisoners who have been selected for assessment and treatment? We have noted that their consent is not needed for the assessment process. Are they likely to be viewed negatively for refusing treatment following assessment or, as importantly, do they believe they will be penalised in some way? Those determinate sentence prisoners who are most likely to be selected, are more likely to resist treatment because of the possibility that they will be sectioned and readmitted to hospital after their sentence ends. Those on life sentence will have less priority, but are perhaps more likely to feel they can get benefit from the treatment.

Those sent to DSPD pilots run in hospitals settings will, in contrast, come within the MHA. This allows for compulsion but also has safeguards for patients such as independent oversight of care and due process by the Mental Health Act commissioners.

However, it has been widely recognised that if patients are to benefit from the service they need to be voluntarily engaged, involved and actively participating. The difficulties of achieving this against a penal backdrop must be very challenging.

Prisoners must be informed of their referral but do not have to give consent. Prisoners are to be notified of the referral and given a copy of the referral form but as yet they are not able to make representations to the referral panel of the prison unit. It has been suggested that solicitors ought to be able to get a copy of the referral form from the DSPD unit.
Confidentiality and consent to use data

The formal guidelines for the DSPD service say that:

'It is not envisaged that units seek the formal consent of individual patient/prisoners before utilising data (anonymised as appropriate) for the purposes of research and evaluation. ... however units should nevertheless take steps to ensure that patients/prisoners are made aware of the nature of the research, the type of personal data required, how it will be used and the extent to which it will be anonymised'  

(DSPD Guidelines, 2004)

If this lack of consent for use of personal data for research and evaluation is of a different standard from that experienced by any other patients undergoing treatment then it should be challenged.

Complaints procedure

Complaints made within DSPD units in a health setting will be investigated in accordance with the NHS complaints procedure. In prisons the situation is different. Although non-clinical complaints, which cannot be resolved locally, can be referred to the Prisons Ombudsman - for clinical complaints, the DSPD guidance suggests that the prisoner should be offered the option of having the matter referred for external peer review. The review would offer non-binding advice on the basis and resolution of a complaint to both the complainant and the unit.

This seems an unsatisfactory and biased arrangement. Prisoners should be able to use the same complaints process to those in the DSPD units in health, namely, the NHS complaints procedure.

Aftercare

The most difficult dilemma that is likely to arise in providing aftercare is the challenge of dealing with the stigma that results from the use of the label. Dr David James was quoted in an article by David Batty, providing evidence from similar programmes in the US and Canada:

'Inmates who have completed equivalent schemes in the US and Canada have found no community programmes will have them because of concerns over risk. They become pariahs, even if deemed to have responded well to treatment, so there’s a danger of accumulating more and more people in prison and special hospitals.'

(Batty, the Guardian, 2002)

There must be concerns for the after care of prisoners who complete the programme of treatment. Guidance says that priority will be given to determinate sentenced prisoners. If they are considered no longer dangerous will they be allowed back into the community? Will the services be there to continue to support them in the long term? If they are not treatable or still have time left to run on their prison sentence how will their passage back to prison be eased? What will be put in place to prevent the work undertaken being undermined by the prison environment?

Adrian Feeney has suggested that the DSPD programme will inevitably fail to meet the healthcare standards concerning discrimination:

'Detention in the DSPD service will carry with it a heavy burden of stigma, which will run counter to Standard 1 of the National Service Framework, that “health and social services should combat discrimination against individuals and groups with mental health problems and promote their social inclusion”.'

(Feeney, 2003)
11. Dual diagnosis

‘Dual diagnosis is a label they give you, but even at my most buoyant I think I’ve got more than two problems.’

(Service User, cited in Rethink and Turning Point, 2004)

11.1 The extent of dual diagnosis

The term ‘dual diagnosis’ refers to people who suffer from a combination of drug misuse and mental health problems. Relevant drugs include: cannabis, cocaine, opiates (heroin, methadone) and amphetamines, but also alcohol and misused prescribed medications. Mental health problems can also be widely defined, and include, for example, anxiety, sleeplessness, or paranoia.

Among people who have mental health problems, drug misuse (and therefore dual diagnosis) is common. For example, a literature review by Crawford reported:

In a sample of 204 patients with bipolar affective disorder, past substance abuse was evident in 34 per cent ... This was most often alcoholism (82 per cent), cocaine (30 per cent), marijuana (29 per cent), sedative-hypnotic (21 per cent) and opiate abuse (13 per cent).

(Crawford, 2001)

The National Forensic Mental Health Forum estimated that between a third and half of people in the general population who have a severe mental illness also have problems related to substance misuse (DoH, Dual Diagnosis Good Practice Guide).

The numbers of prisoners who suffer from dual diagnosis is much higher than the general public. The SEU Report stated that 60-70 per cent of people in prison had misused drugs prior to imprisonment; and over 70 per cent of prisoners suffer from at least two mental disorders (SEU, 2002). In more detail, Tony Bullock reported that 89 per cent of a sample of prisoners had misused cannabis in the 12 months prior to imprisonment and 44 per cent said they had misused heroin. The majority of heroin users were poly-drug users, as 72 per cent of them had also used crack, and most of them had also used cannabis (Bullock, 2000).

If the Bullock sample can represent the prison population, three-quarters of whom had at least one mental health illness, then:

- Two thirds of the prison population could be said to have both a mental health problem and recent misuse of cannabis
- One-third of all prisoners could be said to have both a mental health problem and recent misuse of heroin.

A PRT briefing (2004) reported that 63 per cent of sentenced male prisoners admitted to hazardous drinking before coming to prison. The briefing stated that half of them were severely dependent on alcohol. Thus, roughly one quarter of the sentenced prison population could be said to have at least one mental health problem co-existing with severe alcohol dependency.

The ONS study found that 79 per cent of the male remand prisoners who were drug dependent also had two or more mental health problems (Singleton et al., 1998).

These estimates, based on recent research into patterns of drug and alcohol misuse by offenders, show that dual diagnosis affects an alarming proportion of the prison population. Yet policies and programmes tailored specifically to this problem are lacking.

11.2 The varied nature of dual diagnosis

It is important to note that there is a small group of people who have severe problems with both (e.g. acute schizophrenia and dependence on heroin). Crawford found that, contrary to
expectations, serious mental health problems did not mean that the person was less likely to benefit from integrated treatment.

A much larger group have some degree of problem with both. The Dual Diagnosis Good Practice Guide provides a helpful chart, giving examples of possible combinations:

**The scope of co-existent psychiatric and substance misuse disorders**

<table>
<thead>
<tr>
<th>Severity of mental illness</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Dependent drinker who experiences increasing anxiety</td>
<td>Individual with schizophrenia who misuses cannabis on a daily basis to compensate for social isolation</td>
</tr>
<tr>
<td>High</td>
<td>Recreational misuser of ‘dance drugs’ who has begun to struggle with low mood after weekend use</td>
<td>Individual with bi-polar disorder whose occasional binge drinking and experimental misuse of other substances de-stabilises their mental health</td>
</tr>
</tbody>
</table>

(DoH, page 8 - adapted)

The DoH toolkit explained that the links between the two conditions are varied. A person can suffer from a serious mental health problem and then begin to misuse drugs; or, substance misuse can lead to psychological problems; or, withdrawal from substance dependence can lead to or exacerbate mental illness; or the misuse of drugs can alter, or mask, underlying mental health problems.

**11.3 Appropriate treatment**

A psychiatrist is quoted in the toolkit produced by Rethink and Turning Point:

‘People with a dual diagnosis are, in effect, a kind of mental health underclass. They find that their needs are not severe enough to meet the criteria of any single agency, so they can fall just below the threshold of all “helping” services. For example, they may have mild ideas of suspicion but may not be clearly psychotic. They may have been to prison but not long enough to be followed up by probation. They may have been squatting with friends, but not technically homeless. There may be no clear reason why social services should allocate a social worker. As a result, they have a dreadful quality of life, even though they may have six or seven major problems, they may receive either no help, or just bits and bobs of help without clear co-ordination.’

(Rethink and Turning Point, 2004)

Dual diagnosis is often neglected, as programmes and budgets are targeted at the problems of drug misuse or mental health in isolation from each other. Drug treatment programmes are often ill-equipped to address mental health problems; mental health treatment is often unable to work with drug dependency. Therefore the consequence for these prisoners is that they are excluded.

The Social Exclusion report (2002) cited an example:

“We can’t help him because he has a mental health problem. But they won’t help him with his mental health until we’ve sorted out his drug problem.”

(Prison based drugs worker, cited in SEU, 2002)
Similarly, a 1999 literature review conducted at the University of Reading found evidence that people who had mental illness appeared to be more likely either not to be admitted or to be discharged early from mental health facilities (Badger, et al, 1999).

Integrated treatment is widely advocated. A key feature of this is that professionals are well trained in both drug treatment and mental healthcare. It should be noted that this recommendation requires a higher standard of care than merely co-ordinating the work of professionals from both sectors.

People who have mental illness may suffer from more than one problem; and people who misuse drugs or alcohol often use a variety of drugs. Thus, the group of prisoners who come under dual diagnosis is extremely varied, and programmes to address the problem need to be flexible, to address individual needs.

Crawford’s literature review found that a lack of understanding of dual diagnosis can contribute to neglect:

“Staff attitudes are sometimes negative towards patients with dual diagnosis. If they are able to understand that what had been viewed as “bad behaviour” is as a result of neurocognitive impairment it may lead to greater empathy.”

(Crawford, 2001)

Dual diagnosis highlights the conflicts between the treatment culture of medicine and the punitive ethos of the prison. Although the Prison Service has invested in expanded drug treatment programmes, its policy of responding to drug misuse is fundamentally punitive. The drugs strategy is based on the mandatory drug testing programme, under which one in ten prisoners, randomly selected each month, are tested for illicit drugs. Prisoners who are found positive are punished and can be placed on a targeted programme of frequent testing.

This report cannot trace the full debate over the effectiveness of MDT in curbing drug misuse. However, with respect to dual diagnosis in particular, Mary McMurran has cited the view that punishment is poorly suited as a reaction to drug misuse among people who have mental health problems:

McMurran cited a study by Mueser, Bellack and Blanchard to contend that:

“it is conceptually unsound, and very possibly damaging, to treat substance abusing people who are mentally ill using the confrontational tactics employed by some addictions services.”

(McMurran)

In a previous publication, PRT drew attention to the particular problem of mental illness and alcohol dependency:

“Dual diagnosis requires further development and greater prominence. Although the pathways document gives thought to those with drug treatment and mental health needs, given the prevalence, more attention needs to be paid to this issue. An important omission is alcohol and hazardous drinking which should be addressed in this document. The Prison Service currently lacks an alcohol strategy or good practice guide which, given the association with violent crime and public order offences, should be addressed without delay.”

(Alcohol and Re-offending - Who Cares?, PRT Briefing, Jan 2004)
Part four explores the issues for a selection of special groups in prisons who are particularly vulnerable to mental health problems, and who may have complex needs and hence difficulties within the prison system over and above other mentally ill offenders. Their numbers within the prison system may be small so they can be overlooked even though they are likely to be over-represented within the prison population. These groups are people:

- With learning disabilities, including those with autistic spectrum disorders
- Who are Deaf and have hearing loss
- Asylum seekers
- The elderly
- Black and Minority Ethnic prisoners.
12. Learning Disabled Prisoners

12.1 Background

The DoH document, ‘Valuing People’, suggests that learning disability includes the presence of:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence an IQ under 70):
- a reduced ability to cope independently i.e. impaired social functioning; and
- these two factors started before adulthood, with lasting effect on development.

This definition covers adults with autism who also have learning disabilities but not those in the higher level autistic spectrum disorder such as Asperger’s Syndrome. The DoH estimate that there are around 210,000 people with a severe and profound learning disabilities and those with mild/moderate learning disabilities stands at around 1.2 million.

People with learning disabilities no longer reside in large institutions on the outskirts of towns. They live in a range of provision from living with parents (an increasingly elderly population), staffed group homes, semi independent living (some supervision from visiting staff) and independent living. As a result of these more independent life styles they are more likely to come into contact with the criminal justice system:

'We have people moving into independent living who then become very vulnerable to exploitation and who are encouraged to participate in criminal activities to enhance the perception of themselves within their non learning disabled peer groups...... Recently the needs of our client group have started to change in that there are many more of them ending up in prison, having been left to carry the can or due to inappropriate sexual behaviour or through a need to supply themselves with drugs.'

(Email from social worker working with learning disabled clients, Nov 04)

The Reed report (1992) recommended that those with intellectual disabilities should be diverted from custody into the health and social care system. Few areas, such as North Derbyshire have developed a comprehensive local forensic service for people with learning disabilities. It ensures that people with learning disabilities who present a risk to themselves and others can have their needs met locally. As a result, diversion from custody is more likely to be achievable. Unfortunately, this type of provision is not widely available within the United Kingdom.

Learning disabled offenders may face a higher than average risk of being sent, inappropriately, into custody. Along with the general failure to divert people with mental health problems from custody (described earlier), this group faced additional difficulties and barriers:

- Their disability may simply not be recognised and services that could assist are not notified at the pre-custody stage
- Their disability may be recognised but falls outside the core business of service providers in mental health, housing and criminal justice. The cut off for learning disability is accepted as an IQ below 70, however significant proportion of community teams for people with learning disability exclude people with an IQ above 60 and these are the people who are more likely to come before the courts. Many offenders may be in the borderline range of intellectual functioning and still be accepted as suffering from mental impairment as defined under the Mental Health Act 1983
- It may be recognised that the offender falls within the MHA but it is not possible to make any suitable arrangements for him, such as a place in a secure unit and so he must be sent to prison and await a transfer from there after a considerable period of time, possibly years
• The offender is deemed not to fall within the MHA, his housing and living arrangements have broken down possibly because of his behaviour, and no alternative support is forthcoming from health or social services.

A study by Lyall et al. (1995) in one health district found that there were few established links between the criminal justice agencies and other services and that the experience and attitudes of staff in the different agencies:

...‘both hindered the recognition of the presence of a possible learning disability and also prevented referrals across agencies.’

(Lyall et al., 1995)

Their experience is likely to be just as valid ten years later.

Prison can, of course, become the outcome when the learning disabled offender is given a community order which, like many other non learning disabled offenders, they do not adhere to. However they may be in breach because they need more support to meet the requirements of the order. The Scottish Executive study reports on how criminal justice social workers questioned the extent to which this group retained or understood information about their responsibilities and the commitments being placed on them (Myers, 2004). This was in relation to developing release plans but it would surely apply to community orders as well. The offender with learning disabilities who is repeatedly returned to court for non-compliance will eventually be sent to prison, unless some specialist intervention and support is forthcoming. It is arguable that without essential support and a proper understanding of their intellectual disabilities, they have been set up to fail when they are given community orders by the court.

Myers’ important study in Scotland, ‘On the Borderline’, highlights how adults with learning disabilities who require security to keep themselves and other safe are not recognised as a group requiring a specific policy.

‘The policy framework in which they exist is parallel rather than cross cutting so that this group can easily fall between different service stools: between health, social care and criminal justice pathways: between mental health and learning disabilities services: between “mainstream” and “forensic services”.’

(Myers, 2004)

With an increasing public and political concern with offending behaviour, the widening of the criminal justice net and the lack of a spectrum of care for people with learning disabilities there is an increasing likelihood that more people with learning disabilities will fail to be diverted at an early stage and find their way to the prison system.

12. 2 Numbers of people with learning disabilities in prison

It is difficult to estimate the number of people with learning disability within the prison population. The ONS survey (Singleton et al., 1998) found that 11 per cent of men on remand had an IQ of 70 or less, as did five per cent of sentenced prisoners. This was measured by the Quick Test, a brief intelligence test of perceptual-verbal performance. Other studies have given a range for the remand prisoners from two to five per cent (Woods and Mason, 1998: Holland et al., 2002). For sentenced prisoners, the prevalence rate can vary widely from 0.4 per cent of adult males in England and Wales (Gunn et al., 1991) to 28.8 per cent in Ireland (Murphy et al., 1999).

Myers’ study in Scotland had a sample of forty nine people for whom case recording forms were completed who had learning disabilities and/or autistic spectrum disorder and who were in secure forensic or other specialist settings. None of this group were in prison (about 18 per cent of the total sample were in a punitive rather than therapeutic environment).
Myers pointed out that the numbers of people formally identified as being learning disabled is an underestimate, as prison staff may know, or believe, that certain prisoners have a learning disability and/or ASD but these prisoners have never been formally assessed. Myers concludes that it is not possible accurately to determine prevalence rates. This needs to be urgently done in England and Wales so that policy makers and service providers can adequately address the yawning gap in current provision.

However, most commentators agree that there is a much larger group of men close to disability range who are psychologically very vulnerable (Murphy, 1995).

In a later study, McBrien commented:

‘One of the most prevalent vulnerable groups among offenders comprises those who do not have an intellectual disability as formally defined but have much lower cognitive and adaptive abilities than do either the general population or the offending population.’

(McBrien, 2003)

Given that the DoH definition includes factors over and above IQ measurement, such as impaired social functioning, and hence vulnerability, there is a strong argument that those on the borderline of formal assessment should be included in this discussion.

### 12.3 Prevalence of mental illness among people with learning disabilities

People with learning disabilities face a higher prevalence of mental illness than the general population. This has been recognised by the DoH document ‘Valuing People’. The Myers study bears this out as just under half of her sample experienced mental health problems. But her prison population had a far higher incidence of mental illness: it was eighty eight percent, mainly suffering depression. In the group in prison, two thirds were known to have been patients in a psychiatric unit. Just under half of the sample had communication problems, with the prison group showing a slightly higher incidence at just over half. The majority of these cases were perceived to be due to cognitive impairment or speech related with the additional problem of hearing impairment being noted in several cases. The report will discuss hearing loss in the next section.

The ONS study (Singleton et al., 1998) showed that offenders with low intellectual functioning were related to both the presence of personality disorder and increased odds of being assessed as having psychotic disorders. The odds ratio for risk factors of an offender with a Quick Test under 25 or below (roughly comparable to an IQ of 70 or below) having a personality disorder was 1.45. For probable psychosis, the odds ratio (2.87) for risk factors associated with low intellectual functioning were the highest for those with a quick test of under 25.

### 12.4 The DoH and mental health services in prison

The DoH document, ‘Valuing People’ has just one paragraph relating to people with learning disabilities in prison. It makes disturbing reading:

‘Prisoners with learning disabilities present a wide range of issues. The Prison Service seeks to identify their individual needs for education and health care within the framework of addressing their sentence requirements. Prison establishments have to balance the resources needed to deliver this level of care with the many other demands of prisoner management.’

(DoH, 2001)

There is an implicit attitude in this text suggesting that a very vulnerable group, many of whom are in the prison system because of the failure of services in the community, are now to be excluded from the Department of Health’s responsibility.
What is the likely outcome for a person with learning disabilities and a mental health problem in the prison system? How does the Prison Service seek to establish the complex needs of this group of people? How does the ‘balancing of resources to meet the needs of prisoners with learning disabilities as against the majority of offenders’ affect the learning disabled offenders’ access to programmes to address their offending behaviour and re-enter society with a reduced risk of re-offending?

For any prisoner, initial screening is vital to identify health care needs, including those relating to mental health. To date, there is no recognised tool to assist prison health care officials to identify offenders with learning disabilities in the initial reception screening of prisoners. An offender mental health care pathway has been developed by Prison Health and the DoH with Sheffield University to assist all relevant agencies in delivering better health care to the offender population. (DoH, 2005)

This document, which acts primarily as an implementation tool and checklist, is a welcome development, but it does not adequately highlight the needs of those who are learning disabled. It lists ‘learning disabilities specialists’ in the template of “professionals involved”. But several important preconditions need to be in place first. The possibility of a learning disability needs to be identified as the offender first arrives in the prison system so that a more formal assessment can be carried out by specialist professionals. But then those professionals need to be available to make that assessment and the resulting specialist services or resources for prison health staff to use, need to be accessible so the needs of the offender are met. Unfortunately these conditions are unlikely to be met. The evidence is that the learning disabled offender can fall between services in the community and this can happen even more so in prison. Many non-forensic services will not accept referrals of people without a formal learning disability and forensic services will often exclude those with borderline learning disabilities.

12.5 The prison environment

The difficulties that a person with learning disability can expect to encounter within the prison system stem from their risks that they pose to themselves and the risks they face in their environment from other people. Those on the borderline of disability may be labelled as a ‘difficult’ prisoner by prison staff because their disability has not been recognised. There may have considerable problems in understanding the rules and regulations and adapting their behaviour to meet the requirements. After all, their disability means that they have difficulties in understanding new information and learning new skills. Prison for all prisoners is a new, demanding and harsh environment, where the ability to comprehend the rules and nuances of the social environment are very important to survival. In prison it is risky to stand out as ‘odd’ or different. This makes people with a learning disability or ASD particularly vulnerable. Being victimised, ostracised or ridiculed by others is not uncommon. But there are other ways in which they risk being exploited by other prisoners, for example, being blamed for other prisoners’ wrong doing. Sexually inappropriate behaviour can make an offender vulnerable. The nature of their disability prevents some of these offenders from consistently behaving in an appropriate way. This then makes them very vulnerable in a prison culture where sex offenders are stigmatised and are treated harshly by other inmates and sometimes staff as well.

During their daily life in the prison people with learning disabilities are likely to find it harder than mainstream offenders to secure work. They will probably spend longer time in their cells than others for their own protection:

‘Both (people with learning disabilities) get bullied - their behaviour probably leads to that. For example, X becomes an object of fun... he only knows how to deal with it up to a point, then he doesn’t know how to deal with it, which means being up behind his locked door for long periods. It helps to keep him out of trouble, but it doesn’t provide treatment or support for him.’

(Myers, 2004)
12.6 Lack of access to treatment programmes, the Human Rights Act and the Disability Discrimination Act

A learning disability makes it difficult, if not impossible, for these offenders to engage in programmes set up by the prison to deal with re-offending. Cooper (1995) argued that people with learning disability (including borderline intellectual functioning) are over-represented among sexual offenders. Yet, programmes dealing with sex offenders often specifically exclude those of below average intelligence (Duggan, 2002). In addition:

‘Professionals in both criminal justice and mental health settings are expected (and often mandated) to offer treatments that reduce recidivism in learning disabled sex offenders. At the present time they cannot base their choice of intervention on randomised trial evidence … until better evidence is forthcoming, clinicians will have to continue to base practice on clinical experience and evidence from the non-learning disabled population…the courts, recipients of care and carers should be informed of the basis on which an intervention is given.’

(Ashman, 2002)

The result is that these offenders are either excluded from treatment programmes, which could effect their length of sentence, or they are required to participate in programmes which are designed for non-learning disabled and so are, in effect, being set up to fail.

‘A child with learning disabilities commits a very serious crime thirteen years ago. It is acknowledged by all agencies concerned that he has mild learning disabilities, however no hospital bed is offered. He receives a discretionary life sentence. Because of his learning disability he is excluded from participation in offence related programmes and hence remains in prison long after his tariff. Aged 26, he is transferred to a secure learning disability service where he can work on his offending and gain life skills prior to discharge into the community. This young man has spent half his life incarcerated without access to treatment.’

(Email from Dr Lorna Duggan. St Andrews Hospital 3 Nov 04)

Learning disabled prisoners may be vulnerable to abuses of their human rights. Unlike other prisoners, they are unable to participate in therapeutic and rehabilitative programmes within prisons, because there is a lack of appropriate programmes. We have seen from the case study quoted earlier that this can result in their being unable to participate in offence related programmes and so remain in prison longer that their original tariff. In order to bring a case before the ECHR they would need to work through the remedies available to them in the UK courts. It seems likely that learning disabled prisoners (like Deaf prisoners described in the next section), their advocates and agencies working on their behalf will need to be more litigious in order to get much needed improvements in provision. Will the proposed new Single Commission for Equality and Human Rights be able to promote much needed change in this area?

The Disability Discrimination Act good practice guidance sets out reasonable steps to enable and facilitate the use of services by disabled people. The (DDA) makes it clear that services should ‘provide a reasonable alternative method of make the service in question available to the disabled person’.

The DDA provides for three stages of the legal process. Stage one is to have adequate policies in place. This has been done by way of Prison Service order 2855, issued in 1999 and updated in 2003, which covers the management of prisoners with physical, sensory or mental disabilities. The Prison Service standard states:
‘The Prison Service will ensure that prisoners with physical, sensory and mental disabilities are able, as far as practicable, to participate equally in prison life.’

(PSO 2855)

A duty is placed on governors of prisons to ensure that a local policy is in place to prevent discrimination on the grounds of disability. Stage two is to provide auxiliary aids or services or to offer a reasonable alternative method of providing the service. Stage three relates to removal of physical barriers and needs to be in place by 2004.

12.7 Conclusion

Prison was perceived by prison based professionals interviewed by Myers’ study (2004) as an inappropriate environment for people with learning disabilities and/or ASD. It was felt that prison had neither the resources nor the expertise to meet the needs of this group. There were clear limits as to what the prisons could provide with the result that these offenders spent long periods of time in their cells.

Without specialist care, the mental health needs of this vulnerable group are unlikely to be treated and indeed are likely to deteriorate as they face the stress of a prison regime they are not equipped to cope with, combined with a vulnerability to bullying and victimisation. Segregation and isolation are hardly a valid health care intervention, but that is how many prisons cope with their complex needs.

The Scottish Executive study concluded that unless the services needed by this group are in place, appropriate, and in balance, some people with learning disabilities may become …

‘Entrapped within a secure environment while others may find themselves on a revolving door between community and custody.’

(Myers, 2004)

There needs to be a wide ranging review of learning disability in prison and a change in policy and practice. The Prison Reform Trust has been commissioned to undertake a major project on learning disabilities in prison.
13. Deaf Prisoners

13.1 Background

The vast majority of deaf people, often mainly older people, who develop hearing impairment in later life, will still use speech as their main means of communication. A much smaller group are of all ages, have a unique cultural identity and use British Sign Language (BSL) as their first language. They are known as the ‘Deaf community’. This section of the report focuses on prisoners from the Deaf community. However, the larger group of deaf prisoners, who are ageing, also require special support for their hearing loss, in addition to the other needs for physical and mental health that arise from their age (see later in the report).

Estimates of numbers of Deaf people in the general population whose preferred language is BSL is between 50,000 and 75,000 (BSMHD, 1998). Those who have hearing loss, as a consequence of age, number over eight million (RNID 1998).

Mental health services for Deaf people in the community should meet the National Service Framework for mental health services, but it has been widely recognised by the government and professionals that service provision falls far short of these standards for the majority of Deaf people.

Daniel Joseph was a profoundly Deaf young man who suffered from a severe mental illness. In 1998 he killed one woman and seriously assaulted another. The resulting inquiry (Merton, Sutton and Wandsworth Health Authority, Lambeth, Southwark and Lewisham Health Authority, 2000) into his care and treatment highlighted the lack of a national strategy for mental health for Deaf people and concluded that services were not organised around the needs of the patients, as envisaged by the NHS Plan (DoH, 2000). The Department of Health consulted widely on the future organisation of services in a document entitled ‘Sign of the Times’ (2002) to take into account their needs.

As expertise in working and communicating with Deaf people in the mental health service is very localised and can be patchy, it is not surprising that Deaf people who enter the criminal justice system suffer major disadvantage. This was the opinion of the review of the Department of Health and Social Services for mentally disordered offenders in 1993 under the chairmanship of Dr Reed, and it is equally true now.

The Courts Service issued an information pack for staff members in October 2003 to use to enable them to comply with Part 111 of the Disability Discrimination Act, 1995. The pack gives some guidance to staff as to how to deal with hearing impaired users at various stages of the process; at the public counter, and during the hearing. It needs to be implemented and monitored. Staff need to be fully aware of it as do the Deaf people coming before the courts and their advocates and families. There remains among practitioners considerable concern about a serious lack of awareness of Deaf people’s needs, little knowledge about poor verbal skills and lack of clarity about the use of interpreters. The Trial Issues Group (TIG) developed some detailed guidance on the use of interpreters. Courts are basically responsible for securing attendance of accredited interpreters for defendants under the Prosecution of Offences Act 1985 S.19 (3) (b) but the situation is complex. The charity, Sign, the National Charity for Mental Health and Deafness works with Deaf offenders. Sign has described its experience of working in courts:

“We have been involved with quite a few court cases recently. We have only come across one judge who has been absolutely clear that it is the court’s responsibility to arrange interpreters. All too often the advocacy partner arrives to find that there is no interpreter. This leads to either lots of frantic scribbling on paper, or postponement.”

(Sign Charity, email 04)
A research project carried out by Durham University revealed that sign language court interpreters are often not qualified interpreters, or have specialist legal interpreting training. The study found that this highly skilled task is often poorly understood by other participants in court proceedings (Brennan, 2004).

Early research that suggested that Deaf defendants were more likely to receive custodial sentences or no sentence at all, rather than alternative such as probation, community or supervision orders has been disproved in a later study by Young et al. (2001). But there remains a central question about the training of both probation officers and magistrates in considering this sentencing option for Deaf people. Supported housing is costly and scarce and commissioning suitable packages of care has the additional hurdle of securing funding. Deaf people represent a specialised, low incidence group needing cross departmental arrangements to meet their complex needs. The lack of linguistically appropriate disposals for deaf mentally ill offenders may account for their twelve times higher prevalence in the high-security hospital population than in the general population (Young, et al., 2000). It is probable that structural circumstances around available provision, rather than psychopathology, accounts for this prevalence.

**13.2 Numbers of Deaf people in the prison population**

There is no official Home Office policy on keeping statistics on Deaf prisoners in England and Wales. Surveys that have been carried out do not make a distinction between deafness as hearing loss and deafness associated with use of sign language and cultural identity. Thus, official figures ‘need to be treated with some caution’ (Young et al. 2000). The UK literature review by Young et al. of Deaf people with mental health needs in the criminal justice system, suggested that at any one time there are likely to be between 63 and 100 Deaf prisoners in England and Wales. This figure is similar to that given by the minister for state for health, Ms Winterton in a response to a parliamentary question in April 2004. The DoH estimated that 0.1 per cent of the prison population would have some degree of hearing loss (that is currently 750). But there are likely to be between fifty and a hundred prisoners who are profoundly Deaf.

Studies of prevalence carried out by the Birmingham Deaf Prison Project in 2004 and the prison scoping exercise by Apha Hospitals and BST Mental Health NHS Trust and Rampton Hospital Nottingham NHS in 2005 show lower figures, but the responses to the scoping exercise illustrate how the prison system fails to cope with the needs of Deaf prisoners and questions the reliability of surveys which rely on prison staff who have no or little deaf and mental health awareness. These issues are discussed further in section 13.5

**13.3 Prevalence of mental illness in Deaf people**

Members of the Deaf community, like any other, encounter mental health problems but are more at risk of being misdiagnosed and wrongly treated because of problems in use of BSL and a general lack of deaf awareness by practitioners (Ridgeway, 1997).

The DoH report, ‘Sign of the Times’, draws attention to the fact that people who are Deaf are at high risk of social exclusion and that this effects both their mental health and access into appropriate mental health services. Ridgeway (1997) has shown how positive self esteem, so important to maintaining good mental health, can be much harder if social exclusion is the norm. Assessing the prevalence of mental health problems for adults who are Deaf is very problematic. As the BSMHD states:

*Deaf adults (in the general population) share the overall prevalence rate for psychotic disorders but are more likely to be diagnosed as having a personality disorder, or behavioural or adjustment problems. This is probably a consequence of being Deaf in a hearing world rather than an innate predisposition.*
'Co-Morbidity is higher in Deaf people with mental health problems. They are more likely to have learning difficulties (though this may be a feature of limited educational opportunity – a case of being disabled by the learning environment, rather than being learning disabled) and organic syndromes.

'Deaf People are no less likely than hearing people to suffer from common mental health problems, like depression and anxiety states.'

(BMHSD, 1998)

But within prison, the position is different. Deaf prisoners are more likely than their hearing peers to have mental health difficulties while in prison because of the way their communication needs compound their isolation and stress of prison life (Ackerman, 1998). The usual experience for Deaf prisoners in the UK is:

... ‘an experience of severe communication deprivation within an enclosed and isolated environment. Consequently, circumstances such as these are unlikely to be supportive of good mental health among Deaf prisoners. However, no reliable evidence currently exists to substantiate this assumption.’

(Young, et al., 2000)

Three main therapeutic and emotional issues were discussed by deaf and hard of hearing paroles and prisoners in a study by Rene-Aliston (1997): frustration, fear and isolation. Frustration arose at the lack of communication between themselves and others during the criminal justice proceedings. Their isolation and boredom were exacerbated by the lack of signing peers in the prison and lack of captioned television. Fear built from the sense of isolation and frustration and their inability to communicate with those around them and there was fear of mistreatment by officers and fear of the unknown (Rene-Aliston, 1997).

This then is a population characterised by high levels of psychological distress (Ridgeway, 1997), barriers to effective communication, poor access to appropriate services, misdiagnosis and mistreatment. A study of forensic referrals to the three specialist psychiatric units for deaf people in the UK found that of the 431 relevant cases they looked at from over 5,000 referrals, 60 per cent of the group would have benefited from a specialist deaf service at some time in the assessment/treatment process (Young, et al., 2001).

13.4 The DoH position and mental health services in prison

The DoH response to the plight of Deaf prisoners is contained in their consultation paper, ‘A Sign of the Times’ (2002). This important document seeks to improve mental health services for Deaf people in the community. It describes some of the key issues relating to their ability to access appropriate mental health care, makes recommendations for service development to develop the National Service Framework approach, and recommends the development of a national forensic strategy. In particular, the consultation paper recommends that:

• Research is undertaken to identify the number of prisoners who are Deaf and their mental health needs
• The needs assessments carried out by individual prisons should be used
• The best way of providing In-reach support to Deaf prisoners needs to be explored.

The prison scoping exercise, funded by the DoH, starts the research process. But it has highlighted the scale of the problem and indicates the urgency of the situation. This report has noted that it is not unusual for health needs assessment documents to state that their data are collected from incomplete sources (unpublished Phd study in one English region). Health needs assessment often contradict the ‘toolkit’ instructions prepared by Prison Health and the DoH to assist in their preparation and can contain anecdotal evidence, information from prescription record and poorly kept paper records. In-reach teams are, as described elsewhere in the report, ‘firefighting’ with
huge caseloads and inadequate resources. To support In-reach staff in this highly specialised area will require major input from specialists who work with Deaf people. Additional funding would be required, so that investment in support for In-reach staff to work with Deaf prisoners does not reduce the funding in other high priority areas. One option, which would need to be fully discussed with Deaf prisoners, would be to locate them, and specialised services, in a few prisons.

The DoH ‘Sign of the Times’ recommendations seem unlikely to produce the necessary changes in any reasonable time frame, unless there is greater political will to address the needs of this very disadvantaged group. Research is urgently needed to rectify the chronic lack of knowledge on the Deaf prisoner population and their needs. At a minimum, compliance with stage two and three of the Disability Discrimination Act by all prison establishments needs to actioned as a matter of urgency.

The DoH document presents a bleak picture:

> ‘Deaf people in prison are likely to experience enormous difficulty in having their mental health needs met. It is probable that communication problems in this setting will generate mental distress and add to that present prior to imprisonment. Not only is the prison health service unlikely to be in a position to carry out mental health assessment, the mental health service local to the prison will probably be in the same position.’

(DoH, A Sign of the Times, 2002)

Within the prison mental health care system misdiagnosis is likely when there is reliance on initial clinical impressions rather than detailed diagnostic assessment. The 1999 Prison Census (Monteiro and Cook) shows that only 11 prisons had used a forensic assessment for Deaf prisoners with 29 prisons having had no forensic assessment. However, visiting forensic mental health professions rarely have access to interpreters. Without the necessary additional specialist training, experience and necessary communication skills, they are unlikely to be to deal with issues related to the forensic aspects of mental health and deafness.

13.5 The prison environment

Dr Monteiro, Consultant Psychiatrist from Alpha Hospitals, has described Deaf prisoners as:

> ‘...suffering “double jeopardy”: of being in custody and their plight seriously effected by isolation, and the lack of any meaningful communication within the prison.’

(Dr Monteiro, letter to PRT, 19th August 04)

The prison scoping exercise (O’Rourke, 2005) shed light on the inability of the prison system to cope with, or even to identify, many deaf prisoners. Some prison staff did not appear to be able to recognise deaf prisoners, even when prompted by a request for a hearing aid, which would require battery changes. No check was made on the number of deaf prisoners within establishments. The survey received two questionnaires from the same establishment giving completely different information. This was not an isolated case. Some of the answers themselves were inconsistent:

> ‘one respondent stated that a prisoner did not need a mental health assessment, but then went on to say that they suffered from severe depression.’

(O’Rourke, 2005)

Other typical day to day problems encountered by Deaf prisoners include:

- Lack of deaf awareness among prison officers and fellow prisoners, for example, they think that the prisoner is ignoring them when they call his name, or a deaf prisoner touching someone on the shoulder (very common in the deaf community) which can be considered as threatening
Increased isolation because there are few, if any, other people who can communicate with them
Some of the prison systems are based on noise (e.g., getting up, entering a cell) therefore, a deaf inmate will not hear that someone has banged on their door
No interpreters for every day things and for training
Problems with access to the outside world - no minicom.

(Email from Sign, 27th Sep 04)

Their isolation is further compounded by the inaccessibility of the usual distraction from the tedium of prison such as watching television and being in telephone contact with friends and relatives (Fiskin, 1994) An HM Prison Service survey in 1996 revealed that no prison had Teletext television that could broadcast subtitles programmes and only three had a loop system that assists in amplification for hearing-aid users. Research in this area has not been undertaken since by the Prison Service.

In the 1999 Prison Census (Monteiro and Cook, 1999) 138 prisons were contacted with a total number of returns of 62 per cent (86). There were identified responses from 58 prisons. Over 50 prisons responded that they held prisoners who were Deaf or hard of hearing. Of these, 14 held prisoners who were profoundly Deaf, 28 had partially Deaf prisoners, seven identified themselves as having prisoners with minimal hearing loss and the position of four prisons was unrecorded.

The small numbers of Deaf prisoners spread quite widely within the prison establishment presents a serious challenge in ensuring these prisoners get some access to facilities that they need, such as interpreters, staff who can understand sign language, minicom, and accessible written signage to make prison procedures and rules more available. The prison scoping exercise by O’Rourke found that prison staff reported that a lack of funding reduced their capability to provide facilities for deaf people. Equipment such as induction loops was sometimes lacking, even in healthcare units. Contrasts emerged between prisons, such that a deaf individual in one prison had all his needs met well, while in another prison, eleven deaf and hard of hearing prisoners endured ‘very poor facilities’.

The 1999 prison census further showed that 25 of the 58 prisons who provided an identified response did not record what means of communication they used with Deaf prisoners. Fourteen prisons did not use sign language, four used gestures and only nine used sign language. More recently, Paul Goggins, then Home Office minister for prisons, responded to a parliamentary question in September 03 that ‘more staff in prisons are being trained in basic BSL skills and a small number of staff are more highly qualified and experienced signers’. O’Rourke (2005) found that common themes were that too few staff could use sign language; interpreters were not provided; and there were no proper assessments of deaf prisoners. There were also more widespread difficulties reported in communicating with deaf prisoners.

Clustering or grouping these prisoners would seem a sensible and humane way forward. The DoH has attempted to get Deaf prisoners in a small cluster of prisons but the prison authorities have had problems facilitating the solution, in part because of internal requirements (sentence planning and security); but also because families of such prisoners want that person kept locally to maintain contact with them (conversation with DoH official 29th June 2004).

Given these constraints it is hard to understand a situation within a prison where, when there is more than one deaf prisoner, they are discouraged from socialising. A possible explanation is that because this group can communicate between themselves and cannot be understood by staff, staff have concerns that there may be a security threat. This has led to a situation where Deaf prisoners are allowed to be together for group offending work (when an interpreter is available), but can then be separated at socialising time (conversation with Dr Monteiro 18 August 04).

The following case history from Sign graphically illustrates many of the issues the report has highlighted.
S was sentenced to life, with a minimum of 16 years. He eventually serviced 24 years, half of that in solitary confinement under Rule 43. He is now in the community on parole.

In prison, he complained of hearing noises. This was misdiagnosed as schizophrenia resulting in S being considered dangerous and violent. Certainly he was angry at his treatment and this inevitably boiled over in the occasional outbursts. He was kept in straight jackets, suffered intolerable isolation and subjected to excessive bullying and aggressive treatment by both prison staff and other inmates. His current Probation Officer, who happened to be his Probation Officer for the first six years of S’s imprisonment confirms this account of his treatment.

Twelve years later, S was diagnosed as having tinnitus. Anyone suffering from this disabling condition will know that the noise can make people desperate. Soldiers returning from the 1st world War, for example, often committed suicide rather than suffer intolerable ringing noises associated with their gunfire induced tinnitus.

With treatment, hearing aids and more understanding, S’s behaviour and progress greatly improved. Indeed he is a gentle, sensitive, caring man who amazingly does not show anger or resentment about his treatment in prison. He could not complete some of the mandatory courses for lifers, was moved far too often and seen as a being a difficult prisoner. Even at his final parole hearing, S was discriminated against when the Lifer governor refused to let S use the interpreter who was present at the hearing. Fortunately the parole board accepted the good reports on S.

(Steve Powell, Chief Executive of Sign, email Feb 05)

A service user whose experiences were described in the prison scoping study found a lack of awareness of the particular needs of Deaf people among prison managers. If this is representative of prison managers, it is unsurprising that their needs are not addressed at the wing staff level:

‘Whenever there was any trouble and I went to the governor, I was unable to communicate, as the governor sat too far away and it was difficult to lip read. I recall an occasion when a person from the Home Office visited me and wore very dark glasses and had no interpreter.’

(Service user, quoted in O’Rourke, 2005)

13.6 Lack of access to treatment programmes, the Human Rights Act and the Disability Discrimination Act

Like learning disabled prisoners discussed in the earlier section, Deaf prisoners can be similarly disadvantaged in the obstacles to therapeutic and rehabilitative programmes, including, for example, sex offender treatment, anger management, and enhanced thinking skills. Most Deaf prisoners will be unable to participate in these programmes, without access to interpreters. This can result in them being unable to meet the requirements of the Parole Board and so spend longer terms in prison than hearing offenders. Deaf sex offenders in prison who do not suffer from a mental disorder under the MHA 1983, cannot access sex offender treatment programmes available to those Deaf offenders who are serving their sentences in the community, or attend day hospital or specialist facility at, for example, the Denmark Unit part of the Bolton, Salford and Trafford Mental Health Services NHS Trust. Again this results in their being unable to address the difficulties that caused them to offend.

Deaf prisoners are likely to be vulnerable to abuses of their human rights. Some may not have been given the reasons for the deprivation of their liberty in a language they can understand, in
breach of Article 5 (2). It is not known if the lack of access to treatment programmes constitutes a breach of human rights but the injustice of their situation is apparent, cases brought before the ECHR need to work through the remedies available to them in the UK courts. It seems likely that Deaf prisoners, their advocates and agencies working on their behalf will need to be more litigious in order to get much needed improvements in provision.

A rights based approach can be seen in the implementation of the ADA (Americans with Disabilities Act) which has significantly affected the way in which correctional facilities must deal with inmates who are deaf and hard of hearing. The ADA requires the provision of special services and accommodations for the deaf that includes signing interpreters for religious activities, educational programmes, medical consultations, parole hearings, and mental health counselling (Twerky-Glasner, 2003).

The UK has the Disability Discrimination Act (DDA, 1995) and part 111 covers access to goods and services. It makes clear that services should 'provide a reasonable alternative method of make the service in question available to the disabled person'. The Act actually uses the example of providing a sign language interpreter (Section 21.4).

The Disability Discrimination Act code of practice (2002) informs service providers that they have to take reasonable steps to enable and facilitate the use of services by disabled people. Since October 1999, there should be auxiliary aids or services or reasonable alternative methods of providing the service. The gap in services for Deaf prisoners who are often without any means of communication other than gesture or writing requires that implementation of this important legislation needs to be much more rigorous. Will the proposed new single commission for equality and human rights be able to promote much needed change in this area?

One former prisoner has retold recent experiences:

‘There is supposed to be a form to note down your disability, but I never saw it. I asked for written information but was told that we haven’t any, …I was feeling suicidal on the first night, but unlike other prisoners, I couldn’t contact the Samaritans. Once I asked another inmate who I trusted to make a call for me, but you weren’t allowed to use someone else’s phonecard’.

(Llewelyn Foster, Ex Offender)

The Prison Service has introduced disability liaison officers (a welcome start) but in order to do the job effectively these staff need to have the right equipment (for example, minicomms for Deaf prisoners) and this is not always the case. They also need support and to be able to meet with other colleagues so that a body of experience and knowledge can be built up in this challenging area. They also need to become more pro-active in identifying disabilities among prisoners. One respondent to the prison scoping study, a disability liaison officer, observed that officers were unlikely to recognise a disability unless the prisoner explicitly reported it to them (O’Rourke, 2005).
14. Older Prisoners

14.1 Background and prevalence of older men in prison

The typical prison has been designed to hold and control offenders who are young and fit but now increasing numbers of prisoners over 60 are being held there.

The increase in the elderly prison population is not explained by demographic changes nor by a possible ‘elderly crime wave’. The significant rise in the number of male prisoners aged over 60 is not matched by a corresponding rise in the number of men convicted by the courts for indictable offences (PRT, 2003). The increases are due to harsher sentencing policies which have resulted in the courts sending a larger proportion of criminals aged over 60 to prison to serve longer sentences. This has particularly been the case in relation to sex offenders and drug traffickers. The courts are also tending to imprison those older offenders whose crime most challenge society’s age-related stereotypes.

The number of older people under sentence in the prison population has risen more than twice over the last decade - with the 60 and over population growing faster than the 50 - 59 year olds. In 2000 there were just over 4,000 people over 50 in the prison population under sentence (PRT, 2003). There are about 1,700 prisoners aged 60 or over (HMCIP, No problems, old and quiet, 2004). The proportion of prisoners over 60 in the prison population has more than doubled form one per cent in 1990 to 2.3 per cent in 2000. Nearly all the increase in the older prisoner population is accounted for by older men. In this group minority ethnic groups are heavily over-represented (PRT, 2003).

The life population has been increasing steadily since 1990. By the end of November 2001 there were twice as many prisoners serving life sentences as there had been in 1990. Older prisoners are more likely to be serving long sentences than younger prisoners and 20 per cent of all older prisoners under sentence are lifers - compared to nine per cent in the prison population as a whole (PRT, 2003).

14.2 Prevalence of mental health problems in older prisoners

The major study of the psychological health of older prisoners carried out by Fazel et al. showed that, personality disorders aside, psychological distress is more prevalent in older prisoners than younger prisoners (Fazel, et al., 2001). They found that 45 per cent of the most commonly recorded major illnesses were psychiatric and they uncovered significant unrecognised depression amongst older prisoners.

14.3 The position of the DoH and prison mental health services

The DoH National Service Framework (NSF) for the care of older prisoners (2001) specifically refers to the ‘wide range of health and social care needs, both while in prison and on release’. Standard seven of the NSF states that ‘older people who have mental health problems have access to integrated mental health service, provided by the NHS... to ensure effective diagnosis, treatment and support (DoH, 1999). However, the DoH and Prison Service strategy for developing and modernising mental health in prisons (2001) does not specifically mention older prisoners.

The prisons inspectorate’s thematic review ‘No Problems, Old and Quiet: Older Prisoners in England and Wales’ found that older prisoner being discharged from prison into the community did not appear to be subject to the single assessment process which is meant to identify their specific needs as recommended in the NSF standard noted above. The review makes clear that the acknowledged need for partnership between the NHS and Prison Service to meet health and social care needs in not yet happening (HMCIP, No problems, old and quiet, 2004).
The detailed findings of the prisons inspectorate into the mental health care for older prisoners are troubling. The acknowledged levels of mental health disorder do not appear to be picked up in clinical records that the inspectorate examined.

‘Mental Health Issues were mentioned in only 23% of male prisoners’ records; and in the great majority (43%) of cases, this referred to depression or reactive depression as a result of trial or imprisonment.’

(HMCIP, No problems, old and quiet, 2004)

The Chief Inspector gained the impression that the mental health services in prisons were, mainly aimed at the ‘more vocal, younger prison population’ (HMCIP, No problems, old and quiet, 2004). Prisons have other priorities and older prisoners who do not draw attention to themselves risk being ignored. The Chief Inspector concluded that a lack of awareness and other priorities may result in ‘older prisoners’ mental health issues being unidentified and unaddressed’ (HMCIP, No problems, old and quiet, 2004).

Only two prison healthcare centres (at Dartmoor and Frankland) had an agreement with or access to a consultant in older person’s medicine (HMCIP, No problems, old and quiet, 2004). None of the prisons that the inspectorate visited had specific mental health protocols for older people, despite the NSF strategy that all health systems should have such protocols in place by April 2004.

The Department of Health in response to the HMCIP’s report has said that it recognised the issues raised and plans to develop a policy for older prisoners. The Chief Inspector has called on the National Offender Management Service and the Department of Health to introduce a nationwide strategy for assessing and providing for elderly inmates’ needs. This has been supported by a range of agencies including New Bridge, Nacro, The Howard League for Penal Reform, the Centre for Policy on Ageing, Age Concern, and Prison Reform Trust. The Home Office has no plans to put in place a separate national strategy for elderly prisoners (Hansard, written answers May 1 2003).

14.4 The prison environment

The nature of the social environment in prison makes it even harder to grow old in prison rather than in the community (Wilson and Vito, 1986). In prison, there is a premium on physical strength and endurance and so older prisoner are likely to have a heightened sense of vulnerability in prison.

‘There is evidence that older prisoners are more affected by all that is unpleasant and de-personalising in prison life and likely therefore to suffer rapid deterioration of mental health.’

(Silverman & Vega, 1990; PRT, 2003)

Around 30 per cent of elderly prisoners interviewed by the prisons inspectorate in 2004 did not feel safe.

Some of the findings by the Chief Inspector’s report ‘No Problems, Old and Quiet: Older Prisoners in England and Wales’ were those of a prisoner in a wheelchair being able to bath only once a month, prisoners with incontinence struggling with night sanitation, inmates with mobility problems being allocated to upper bunk beds - and sometimes falling out. Her inspection team found that prison staff were reluctant to push wheelchairs and that some prisoners were helped by fellow inmates, but often had to pay for the help in kind with chocolate or tobacco.

The chronic disabling illnesses which can affect older people and prisoners are not the subject of this report. But the prison service inability to cater for the complex personal physical and mental needs of the 83 per cent of older prisoner with these conditions (OPCS, 1994; Fazel et al, 2001) are likely to cause additional psychological distress and vulnerability.
15. Prisoners Holding Foreign Nationalities

15.1 Background

There has been an increase of 152 per cent in foreign national prisoners in the last ten years compared to a 55 per cent increase in British nationals. Four out of ten sentenced men from foreign nationalities have committed drug offences while for sentenced women the figure is eight out of ten. The majority are serving sentences of over four years.

The routine practice of holding asylum seekers in prison who have not committed a criminal offence ended at the beginning of 2002, although the Home Office reserves the right to hold asylum seekers in prison on a case by case basis for reasons of security and control (Hansard, 30th January 2004).

The coming into force of the Asylum and Immigration Act, in September 2004, brought a new risk of imprisonment for asylum seekers. It introduced new criminal offences, such as that of not possessing (without 'reasonable excuse') a valid document showing identity and nationality when first interviewed by an immigration officer after arriving in the UK (Refugee Council briefing paper 2004). It is not clear yet how many will be sent to prison as a result, but a Guardian report (18, March 05) estimated that there had been 134 convictions.

15.2 Numbers of foreign national prisoners

The Prison Service does not have a complete, accurate picture of the number of foreign national prisoners. The national status of many prisoners has not been recorded or has been recorded inaccurately. At the end of January 2004, 1,200 people in prison were recorded as being of 'unknown nationality'. Officials estimate that the overall figure may well underestimate the actual foreign national prisoner population by between 10 and 20 per cent.

There are just over 9,000 foreign national prisoners (defined as anyone without a UK passport) which is about one in eight of the overall prison population.

As a result of the policy change in January 2004 the number of asylum detainees (held solely under Immigration Act Powers) in prison has fallen dramatically. There were 125 persons detained in the UK prison establishments solely under Immigration Act powers in the first quarter of 2005 (Home Office, 2005). It is not clear how many of these (if any) served their sentence and were awaiting deportation or made a request for asylum during their sentence and were awaiting a decision. We have noted above that the Asylum and Immigration Act 2004 will lead to an increase in these figures.

15.3 The prevalence of mental health problems in prisoners holding foreign nationalities

Foreign national prisoners have particular vulnerabilities to mental health problems. Isolation from family and culture and the stress of being in a foreign country and criminal justice system undoubtedly increase vulnerability to depression and poor mental health (Paton and Jenkins 2002).

A health needs assessment of 500 immigration detainees in HMP Liverpool was carried out in 2002 by Dr E Coffey and Dr E Church. The report was commissioned because it was recognised that detainees were likely to have distinctive health problems and needs. It was decided that, despite the minister’s announcement that detainees would be withdrawn from prison, there was benefit in continuing with the study because it would provide planning guidance for services in other detention centres. Also some detainees could be transferred to the prison population following closure of a detention centre. The study takes on fresh importance with the changes to the Asylum and Immigration Act 2004 (see above).
The study found that language barriers led to difficulty in assessing health problems, in particular mental health problems. Detainees had signs of old injuries and described having been tortured. Psychological health problems were very common, with high levels of stress, anxiety and frustration. Detainees were shocked and confused to be in prison, fearful about the future, and worried about their families. They all complained about the time they were locked in their cells, with little to occupy themselves, except to think about their problems. Many could not speak English and the use of interpreters was described as ‘occasional’... Eleven of the 500 male detainees had harmed themselves whilst detained in prison and, of these, three were serious attempts at hanging (Coffey, 2002).

This study’s findings on the psychological health problems, illustrated by interviews with detainees and staff, are sobering.

’Sometimes we feel we are not human. We are not human. Sometimes you feel there is nothing.’

(Detainee interview from Coffey, 2002)

‘They complain of headaches constantly, stomach pains constantly and one of the nurses put it in a nutshell. She said it was stress, total stress with them because they are in an environment they did not expect to be in.’

(Staff interview from Coffey, 2002)

Past experiences of torture were explored by the study.

‘I have had several people when you say to them: “How did you come by this?” they say: “Electricity.” You see scars like electric prods have been used on people in this area and then you start to realise why they are coming over here to get away from that.’

Staff mentioned that some detainees were fearful of what will happen to them in prison here because of their experience in prison in their own country.

‘One black lad in here genuinely thought that we were going to beat him up everyday... he thought if he saw more than two uniforms around him that they would take him out of the cell and they would beat him......he had had a very bad experience before and kept having flashbacks. He had been badly beaten, put in a dark dungeon for months upon end, let out for a few days and put back in again.’

(Extracts from Interviews, Coffey, 2002)

Foreign national prisoners who enter the prison system because they have a criminal conviction, for example for drug offences, may not have been tortured and abused prior to coming, like asylum seekers, but they are likely to be unusually fearful not only of staff but of the system because they do not understand it.

15.4 The prison environment

A recent report (Singh Bhui, 2004) identified the impact of the prison environment, as it exacerbates the stress and difficulties faced by those holding foreign nationality, thus increasing their vulnerability to poor mental health. A lack of information about the legal system, prison rules, and procedures, can give them particular problems over and above those for other inmates. Problems relating to detention and immigration can lead to some remaining in jail having completed their sentence because, “They are awaiting a decision from the Home Office, or because arrangements have not been made for their removal” (Singh Bhui, 2004). Language barriers can make all other problems much worse.
‘Respondents to the Wandsworth surveys regularly mention the frustration of being misunderstood by staff, of having little to read in their own language, of missing out on basic provisions (e.g. showers, association and groups) on a daily basis because they have not understood staff instructions or questions...poor communication between staff and prisoners clearly has implications for risk of self-harm assessment.’

(Singh Bhui, 2004)

A recent prison survey found that nearly 90 per cent of prisons holding foreign nationals are not making regular use of the translation service available because it was too expensive (Punter, 2003).

Foreign national prisoners are often ill prepared for release because their lack of understanding of English precludes them from pre-release provision. Deportation orders can be served with little prior notice so that there can be little time to inform relatives, or organise travel. Being ineligible for discharge grants adds to the difficulties they face with resettlement (Singh Bhui, 2004).

A lack of respect and/or racism from prison staff can add to the problems already identified and make the prison environment for foreign nationals even more hostile and threatening. The Singh Bhui report built on a survey of foreign national prisoners. One question concerned the main problems they faced in prison. In response, many simply stated racism or discrimination:

‘... most important is: some of the officers treating inmates like animal. Some of them swearing like fuck off, fucking, bastard. If they say five words, one of them bad word.’

(Foreign national prisoner 2001, in Singh Bhui, 2004)

15.5 The DoH and mental health services in prison

Every prison establishment should have a foreign national prisoner strategy that seeks to meet their needs, no matter how many or few there are in that prison. With regard to mental health, the initial assessment process needs to make sure that interpreters are available and cultural sensitivities are understood. Ideally, health workers experienced in working with asylum seekers or people from different cultures should provide care. Confidential one to one mental health support needs to be accessible as does more specialised psychiatric support. Urgent action should be taken to ensure that they are not left in prison having served their sentence. The flow of information between the prison Immigration services needs to be improved so that deportation happens in a timely way.

The Prison Service does not have a dedicated policy or strategy for foreign national prisoners, although PSO 4630, which refers to immigration detainees has been updated. PRT recently published a report by Hindpal Singh Bhui (2004) which called for a national strategy specifically for this group of prisoners. His report shows that a widespread feeling is isolation and a lack of official support. These prisoners are also likely to have special difficulties in accessing appropriate and accessible primary and secondary mental health care without strategic planning and extra resources. His report specifically calls on prisons to measure the extent of self harming among these prisoners and to take special steps if the evidence shows that they are more vulnerable. While some prisons have appointed staff as foreign national prisoner co-ordinators or have brought in specialist immigration advisers, the Prison Service has not given priority to increasing resources or providing services specifically for foreign national prisoners.
16. Black and Minority Ethnic prisoners

16.1 BME representation in the prison population

Home Office statistics on the number of prisoners received into custody under sentence show that men from Black Minority Ethnic (BME) groups are over-represented in prison. In 2002, almost 86,000 men were received into custody under sentence. Over 15,000 - 18 per cent - were recorded as Black, South Asian or Chinese or other. At the end of February 2003, prisoners from BME groups comprised 25 per cent of the total prison population. At this time, only one in eleven in the general population (nine per cent) came from minority ethnic groups.

The problem is getting worse. The number of men from BME groups sent to prison is rising much faster than white prisoners. In the past ten years, while the number of white men sentenced to custody increased by 65 per cent, their BME counterparts showed an increase of 176 per cent from 5,557 in 1993 to 15,359 in 2002.

Twenty-nine per cent of the male BME prisoners received into prison under sentence in 2002 held foreign nationalities. The 2003 figures show that among prisoners holding British nationality, 12 per cent were Black and 3 per cent, South Asian. (Source: Select Committee on Home Affairs 1st report)

Every stage of the criminal justice process shows a disproportionate representation of people from BME groups. The Institute for Race Relations stated in 2002 that Black people are four times as likely to be arrested as white people and less likely to be granted bail than their white counterparts (IRR, 2002). The IRR also reported that Black people are six times more likely than white people to be imprisoned (all other factors being equal) (IRR 2002).

Another way to make the same point is to compare the incarceration rates of different racial groups, based on the number of prisoners per 100,000 in the general population. In 1996, there were 146 white prisoners for every 100,000; the rate for South Asian prisoners was 121; for Chinese and other racial groups, it was 325. The rate of Black prisoners per 100,000 was 1,162. By the year 2000, the rate for white prisoners had risen to 188, but the rate for Black prisoners was 1,615 and for Black Africans in particular, it was 1,704 (CRE, 2003).

16.2 Scale of mental health problems among BME prisoners

In addition to being over-represented in prisons, there are also high numbers of people from BME groups in secure forensic psychiatric facilities. Jeremy Coid and colleagues analysed data gathered by the Office for National Statistics’ study of prisoners’ psychiatric morbidity. They showed that fewer than expected prisoners from BME groups were suffering from a probable psychosis. Prisoners from BME groups were also less likely than white prisoners to have attempted suicide or committed self-harm in prison. Coid added that BME prisoners were less likely to have previously received psychiatric treatment, endured childhood traumas, or had stressful prison experiences.

Coid and his colleagues also examined health care records. They found that fewer BME than white prisoners had been prescribed psychotropic medication while in prison; and fewer were recorded as having engaged in self-harm, or the misuse of drugs or alcohol. (See also the section on dual diagnosis in this report).

Coid also discussed the interface between prisoners from BME groups and mental health professionals working in prisons. Fewer Black prisoners reported having received mental health treatment at some time while in custody. It is possible that professionals recognise psychiatric
problems less often among BME than white prisoners. Or, that BME prisoners are more reluctant to disclose their concerns about their mental health to the (largely white) mental health staff in prisons.

A combination of three factors might suggest a full explanation for why Coid found lower rates of serious psychiatric problems among BME groups: a lower rate of serious mental health problems; racially imbalanced assessments by staff; and reluctance on the part of BME prisoners to engage with psychiatric professionals in prisons. Hence these factors may reflect the deeply complicated question of the relations BME people in general have with the psychiatric services, and the way in which mental disorder is defined. Indeed, Coid stated:

“There is direct evidence from local studies that among people with obvious mental illness, Black offenders have an increased risk of being processed by the police into the criminal justice system … Thus there may be a specific failure to recognise mental illness or to act upon its recognition at the remand stage.”

(Coid, et al., 2002b)

16.3 Particular issues for BME prisoners

“Coming to mental health services was like the last straw. You come to services dis-empowered already, they strip you of your dignity. You become the dregs of society.”

(cited in Keating)

Research by the Sainsbury Centre has explored the sometimes tense relations between psychiatric professionals and Black and minority ethnic communities. A study by Frank Keating identified a cycle of fear: Black people delay seeking help out of distrust of the mental health services; and the services tend to react to Black people who have mental health problems with coercive control.

Keating’s research is presented here because it shows a wider social problem which may shed light on obstacles hindering the provision of mental health care to BME prisoners. His work built, in part, on a study of attitudes among psychiatry professionals that reported a tendency to perceive Black patients as more aggressive and dangerous. Yet Keating found that professionals were reticent about race:

“There seemed to be a fear of talking about issues of “race” and culture in a safe and honest manner. There was an air of secrecy about these issues.”

(Keating)

Speaking to service users, Keating also found widespread fears:

“A major source of fear for service users was their perceptions about past, mostly negative experiences of MH care. … Participants perceived that the way services respond to them mirrors some of the controlling and oppressive dimensions of other institutions in their lives: for example, exclusion from schools, or contact with police and the criminal justice system.”

(Keating)

The fears of service users were two-fold: they had negative associations with the terms ‘mental illness’ and negative previous experience of mental health services, which they viewed as coercive and controlling. Black people viewed services as insensitive to their needs and intended more as a means of control than care. The cycles of fear that Keating found take shape as Black service users would suspect that the purposes of intervention are more about control than care; and service providers would interpret the Black person’s resistance as a threat that requires a greater degree of control.
The next step in the coercive process links the health controls of psychiatric treatment with the punitive controls of the criminal justice process. A Black person who has mental health problems and is drawn into the criminal justice sphere becomes subject to the powerful controls of both mental health and prisons, a combination that tends to confirm the Black person’s sense that the service provided is a controlling, rather than a caring influence.

Keating wrote:

‘Black people are more likely than their white counterparts to be subjected to more restrictive and punitive forms of treatment.’

(Keating)

Developing and strengthening the role of prisoner-patient involvement (see above, Section 9) provides one solution to this particular cycle of suspicion and coercion. Keating’s study suggested that people from BME communities who might be taken under the care of mental health facilities should be engaged in dialogue to further mutual understanding:

‘It is clear that progress will only be made in breaking “circles of fear” if there is a systematic change in the experience of service users at each point in the care pathway.…..There should be concerted efforts to bridge the schism between black communities and mental health services. This can be achieved by taking services to communities rather than waiting until late in the crisis for people to access care. There should be more community-based crisis services which communities can access in a timely fashion.’

(Keating)

In prisons, an equivalent to the community mental health workers taking their services to the Black community is the role of mental health in-reach workers. If in-reach staff are not in an environment where it is acceptable to discuss confusion about cultural differences, and even personal prejudices, openly, then it is likely that they will replicate the problems experienced by mental health professionals in the outside community.

Guidelines intended to promote mental health services to minority ethnic groups propose that any approach must include prior consultation:

‘Mental health promotion practice should be inclusive, it should value diversity, support appropriate methods of consultation, development and evaluation with all members of the local community.’

(Mentality, 2003)

The guidelines included recommendations specifically intended to promote improved mental health services to Black and minority ethnic people in prison, including:

• Effective mental health awareness training for prison staff to develop competencies and confidence to identify anyone showing signs of stress and anxiety and offer appropriate support
• Make available counselling and other support groups - access to NHS Direct could help individual prisoners identify appropriate help and useful organisations
• ‘Listener’ schemes that operate in most prisons, where prisoners are trained by local Samaritans branches
• Give prisoners as much personal autonomy as possible to promote mental health and prepare prisoners for taking individual responsibility again on release
• Contact with families and friends to provide support and contact with the outside world.
• Projects addressing substance misuse, including alcohol
• Staff need information about their own mental well being and stress management, and awareness that they can contribute to prisoners’ health and well being.

(Mentality, 2003)
16.4 Coercive controls

The Keating research suggested that Black people’s experience of services was that the services that were supposed to provide care were more likely to exercise social control; Black people were also more likely to feel that their mental health problems had been defined as crimes, to bring them under the authority of criminal justice agencies.

There is a parallel within prisons, in the strong evidence that Black prisoners are more likely than white prisoners to be subject to prison discipline. The Inquiry into the death of Zahid Mubarek has brought into the public domain concerns about the exercise of authority by prison staff which possibly shows racial bias. The Hounslow Racial Equality Council conducted focus groups among BME prisoners in HMYOI Feltham. The Council reported that:

‘Black inmates felt that they were being stereotyped as being violent and aggressive, and therefore more likely to be blamed for bullying compared to their white counterparts.’

(cited in Black Information Link, 2004)

In support of their impressions, the council investigated and found that Black young prisoners in the institution were three times as likely to be placed on a ‘stage one’ bullying classification as white prisoners. Black prisoners were also twice as likely as white prisoners to have been subjected to physical restraint (Control and Restraint).

The independent investigation into Zahid Mubarek’s death by the Commission for Racial Equality also found strong evidence of a tendency, among prison staff, to react to Black prisoners by recourse to prison discipline.

‘Black male prisoners were more likely … to be charged with disciplinary offences than white male prisoners; once charged, were more likely to be found guilty than white prisoners (particularly for offences involving violence or ‘disrespect’); and once found guilty received more punishments per offence than white prisoners, even for similar types of offence.’

(CRE, 2003)

The CRE reported that the pattern had persisted, at least since 1991. However, although these data show that Black prisoners are more likely than white prisoners to be subjected to prison disciplinary procedures, research does not provide an explanation for the difference. Thus, although one hypothesis might be that prison staff are more likely to interpret emotional crises among Black prisoners as threatening and therefore matters for discipline, this is only a hypothesis.

There are also concerns about risks in the use of control and restraint techniques (C&R). In the years 1999-2003 there was not a single death in prison while the person was under C & R. However, the JCHR heard serious concerns about C & R being used in a discriminatory fashion by the police and NHS staff.

‘The MHAC (Mental Health Act Commission) told us that 28% of restraint-related deaths in the last seven years had been of ethnic minority patients, in contrast to an ethnic minority population of 5-6%.’

(JCHR, 2005)

The JCHR recognised that the low numbers involved made it difficult to establish conclusive evidence of racial discrimination in the application of C & R. However, it recommended that training be provided to minimise the possibility of racial bias:

‘Race equality schemes under the Race Relations (Amendment) Act need to provide for measures to prevent discrimination in the use of restraint. We emphasise the need for training of all staff who may be involved in control and restraint, to include cultural awareness in its use. … Such training should be to national standards and delivered by accredited trainers.’

(JCHR, 2005)
Although this recommendation was intended mainly for police officers, it is not clear that Prison Service training in the use of C & R includes cultural awareness.

**16.5 Conclusions**

There is conclusive evidence that Black people suffer institutionalised disadvantage in their contact with mental health services in the community. To what extent is this carried over to their experience of mental healthcare in custody?

In response to the McPherson Inquiry, the Metropolitan Police accepted that the force was institutionally racist. Shortly afterwards, Martin Narey, at that time the director general of the Prison Service, accepted that the Prison Service was also institutionally racist. The inquiry into the death of Zahid Mubarek, by the Commission for Racial Equality, found 20 structural failings within the Prison Service that contributed to the death of Zahid Mubarek. A public inquiry, chaired by Lord Justice Keith, is now examining the role that racial bias played in the murder, and the wider impact of racial bias in the Prison Service as a whole.

It would be premature to pre-empt the findings of the current inquiry. But the evidence already considered in this section leads to hypotheses about the possible influence of institutional racism in the mental health treatment of BME prisoners.

First, to be clear about institutional racism, it does not mean that individual officers are racists. The Prison Service has strong policies about staff recruitment and their membership in racist organisations, but these do not address the core problems of institutional racism. The concept, as defined by Lord McPherson, refers to an organisational culture, basic structures and established procedures, which place minority groups at a disadvantage.

Institutional racism emerges in processes. The challenge for the Prison Service is to identify processes that produce outcomes in which BME prisoners are disadvantaged. The Prison Service must then analyse these processes to determine the mechanisms by which the needs of BME prisoners are overlooked. Some of the key processes that might be singled out for further investigation are prison discipline (adjudications); the use of segregation; access to healthcare (and specifically to qualified psychiatric attention); anti-bullying programmes; and access to education.

There is powerful evidence that Black prisoners in general are more likely than their white counterparts to be subjected to disciplinary measures. There is further evidence that cultural misunderstandings subject Black prisoners to dubious discretionary decisions about control programmes, most notably, anti-bullying programmes. These facts suggest that institutional racism in the field of prison mental health might lead some officers to misinterpret the behaviour of Black prisoners who have mental health problems, and react to it as deliberate rule-breaking. To what extent do prison officers enforce disciplinary measures against Black prisoners whose behaviour reflects undetected mental health problems? This is an area that requires a substantial piece of qualitative research.

A key question for the new in-reach services is what they might do differently, in order to improve the cycle of fear (discussed above) and encourage more trusting relationships with BME prisoners. In-reach services will need to be pro-active to counter-act the mutual distrust identified by Keating. Otherwise, they could be accused of reinforcing institutional racism if their services fail to reach BME prisoners who have mental health needs.
PART FIVE: CONCLUSIONS AND RECOMMENDATIONS
PART ONE: Keeping Mentally Ill Offenders Out of Prison

1. Developing a national framework
   - Court diversion should be an objective against which the performance of all chief executives of mental health trusts is judged.
   - The National Institute of Mental Health (NIMHE) should build on the work of Nacro and provide a comprehensive implementation guide for mental health services for offenders, commencing with police stations.
   - The mental health needs of offenders and defendants should be considered at all stages of the criminal justice pathway. The National Service Framework needs to support diversion and liaison services for mentally ill offenders by suggesting a model of service and including this in its performance assessment and programme monitoring.
   - The service level agreement, drafted by the Department of Health (DoH) and the National Offender Management Service (NOMS), should be expedited to ensure that courts have timely mental health reports on defendants for whom they are needed.

2. Securing adequate and sustainable funding
   - The long term cost effectiveness of providing supportive community services, as opposed to emergency services and prison, should be investigated by the NAO and considered by the Treasury.
   - Court diversion and liaison services dealing with police, court and prison should be a mandatory, not optional, part of all PCTs’ local delivery plans. (All PCTs are likely to have a police station.)
   - All health service commissioners should conduct a comprehensive mental health needs assessment for people from their area who come into contact with the criminal justice system.
   - Social Services and the NHS should provide matched funding for integrated health and social services for this group, based on comprehensive needs assessments.
   - Use of health and social care legislation, such as the Health and Social Care Act 2001 section 46 & 47, should be considered to bring in those authorities not engaged with the process of partnership arrangements.
   - NOMS new health and offender partnerships need to encourage/facilitate implementation of the National Service Framework for mentally ill offenders at the beginning of the criminal justice pathway.

3. Resolving tensions between the health route and the criminal justice route
   - Use of the term ‘mentally disordered offender’ should only be used for violent and dangerous offenders who are mentally ill.
   - The health gains from early intervention and investment in good local services need to be publicly acknowledged by politicians and professionals. The link with crime reduction needs to be made in a responsible way.
   - There should be joint resources and budgets for health services and the criminal justice system to facilitate joint working. Shared standards and outcomes for health and criminal justice teams should be introduced.
   - In its inspections, the Healthcare Commission should ensure that court diversion and liaison services are integral to local psychiatric services.

4. Improving the criminal justice process
   - It should be unlawful to send to prison an offender or defendant for whom there is clinical evidence that they require hospital care.
• The Judicial Studies Board and Magistrates Support Training and Development Committee need to be aware of, and focus on, concerns about mentally ill offenders.
• On the advice of the Sentencing Guidelines Council, the sentencing framework needs to take into account intellectual capacity and the restrictions on courts to give mental health orders despite clear medical evidence.
• The local criminal justice boards need to take into account the effectiveness of providing diversion and liaison services in reducing crime. Home Office research by Dr David James should be widely disseminated.
• The protocol established by the Wessex Consortium, Forensic Project Team should be used to establish a standard proforma for all courts. This can be downloaded from the internet: www.hants.gov.uk/wessexconsortium/CourtProtocol.pdf
• Schemes such as the Northamptonshire floating support scheme (working with Revolving Doors) the Unmore Unit in Oxford (day care support for mentally ill offenders on bail), and Elliot House in Birmingham (a psychiatric bail hostel) should be replicated widely.
• Transport arrangements to take mentally ill offenders to hospital under the MHA 1983 need to be clarified and improved in the new bill. Contracts for escort arrangements need to accommodate mentally ill offenders being taken to hospital from the court.
• appropriate adults schemes, which provide links to diversion and liaison services, such as the advocacy and appropriate adults service in Portsmouth, should be widely replicated.

5. Providing improved mental health provision

• The mental health bill must resolve the current limitation by which the courts cannot insist on mental health orders, even when there is clear medical evidence of need, due to failure to locate a bed in the required time limit (28 days).
• Investment in early diagnosis and intervention services which do not exclude/stigmatise users.
• Systematic consultation with users of services to tailor provision to specific needs.
• NHS training for all doctors should include the prison context. Specialist training schemes in general practice, public health medicine and psychiatry should include prison placements. The reluctance of general psychiatry to accept these patients needs to be addressed.
• Regional prison mental health forums, under the umbrella of NIMHE development centres, need to address the ineffectiveness of diversion and liaison services at the beginning of the criminal justice process.
• Tension between new NICE guidelines on managing disturbed psychiatric patients and zero tolerance NHS policies need to be resolved.
• System failures need to be addressed (NIMHE Forensic MH Services’ Case for Change’ 2000).

6. Better integrated services

• The National Health in Criminal Justice programme board needs to identify barriers to good practice and prioritise their removal.
• The pilot project in South East London, with the aims of:
  - creating a new care pathway
  - monitoring and regulating movements of mentally ill offenders and
  - establishing a permanent structure for cross-agency interventions needs to be supported and its lessons widely disseminated.
• The detailed interagency work as exemplified by the Youth Offending Teams needs to be replicated for adult offenders.
• Urgent work on protocols around information exchange, and clarity about confidentiality issues so that agencies can work more effectively together and make use of the CD-ROM supplied by DoH.
PART TWO: Delivery of Care

1. Awareness and attitude
   • The public needs better information about why increased funding for mentally ill offenders is necessary. Agencies need to articulate better to them and the media how good care contributes to good public health and safer communities for all.
   • DoH and deans of medical schools should encourage prison experience/ working for all new trainees.
   • Public health debates need to positively highlight the role of mental health promotion and treatment.
   • PCTs need to be influenced to recognise the benefits of direct work with prisoners who will be returning to their communities.

2. Policy
   • Evidence needs to be extracted from current data sets (e.g., ONS) and be extrapolated to local community scenarios so meaningful contrasts can be made about equivalence and the need for good services.
   • A new psychiatric morbidity study of the prison population should be conducted by ONS.
   • The criteria for security and its relationship to mental health problems need to be examined and a shared understanding developed between practitioners.
   • Ideological differences between criminal justice agencies and mental health practitioners need to be worked through in a constructive way.
   • Mental health services provided along the criminal justice pathway need to be part of mainstream delivery of mental health services with identical NSF standards and reporting requirements.

3. Institutional arrangements
   • National Offender Management Service (NOMS) and the regional offices need to ensure that health care is built into the offender's plan.
   • Funding packages should be attached to individual offenders to give providers an incentive to provide early hospital care (if needed) and the Care Programme Approach (CPA).
   • NHS services need to be given incentives to accept mentally ill prisoners in a more timely way.
   • The CPA must apply to all prisoners with mental health problems and attention needs to be given to the information systems required for the necessary transfer of CPA information between prisons and community mental health services.
   • Target setting needs to take into account local information, initiatives and priorities. They should be regularly reviewed by independent agencies to ensure they lead to real improvement in services.
   • Before the final handover to the PCTs of prison health care in 2006, lines of responsibility and accountability must be clarified so that they are transparent and understood by all participants. Clinical governance and audit need to be built into the system.
   • Inspection arrangements for prison mental health care need to be independent and robust, and involve visiting prisons and talking to offenders on a regular and ad hoc basis.
   • The use of segregation and seclusion should be investigated and DoH guidance (1999) followed.
   • The use of control and restraint and the training of prison staff in procedures need to be actively monitored by an independent agency.
   • Special arrangements should be made for offenders who are waiting for transfer to NHS care.
4. Operational issues

- PCTs and prison health staff must give greater attention to improving the integration of their services.
- Attendance by all key professionals at care plan meetings needs to be prioritised. Relatives and carers need to be encouraged to attend and their input should be welcomed.
- Local problems which prevent training opportunities being realised need to be resolved.
- Incentives should be provided to identify local relationships and solutions and to improve communications systems and data collection.

Prisoner- Patient involvement

1. Awareness and Attitude

- Prison staff given training and support to understand the potential of actively supporting the user voice.
- In setting up forums for prisoner-patient involvement, prisons and PCTs need to stress that involvement is voluntary. The patients’ freedom to choose to take part requires particular attention in a prison environment.

2. Policy

- Research is needed to assess how actively involving prisoners can help governors achieve targets (i.e., reducing re-offending and levels of violence).
- Alternative models of user involvement should be trialled to develop the NHS model within the special environment of prisons.
- Prisons and PCTs must work together to develop prisoner-patient involvement and to ensure that the structure is integrated into their joint working arrangements.
- Representation of prisoner-patients must promote and monitor diversity and equality.

3. Institutional arrangements

- Under leadership of NIMHE, decisions should be made about prisoner-patient involvement to distinguish aims which are non-negotiable, those that are negotiable, and those which are achievable.
- Leadership of PCT on the health agenda in prisons needs to be robust and unequivocal. Lines of communication and accountability need to be transparent.
- Decisions, documents and policies should be communicated in readily accessible language to prisoner-patients, and support must be provided if necessary to aid understanding.
- Section 11 of the Health and Social Care Act 2001 and documents such as ‘Getting over the wall: how the NHS is improving the patients’ experience’ need to be developed in the prison environment.
- Monitoring by PCTs with prison staff of the encroachment of security issues and prison procedures onto clinical care issues needs to be robust.
- PCTs need to support much stronger and more dynamic partnerships with agencies and interest groups outside prisons. The structure should engage relevant agencies from the voluntary sector to facilitate the representative’s role.
- Advocacy schemes such as that developed by Bristol Mind should be replicated.
- Monitoring and inspection by agencies such as the Prisons Inspectorate, the Independent Monitoring Board, and the Health Care Commission should routinely take account of the user perspective and voice.

4. Operational issues

- The contribution of prison officers who facilitate the user voice needs to be recognised by the prison and outside agencies such as NIMHE. Prisoners themselves could put forward particular officers for recognition.
Conclusions and Recommendations

- Build on the model of prisoner councils to provide a framework for getting prisoner views. Support the development of different models of user feedback. The work of the Prisons Inspectorate in this regard needs to be built on. The results need to be public documents, transparent and used to develop and improve services.
- Voluntary organisations need to be involved in training and supporting prisoners to have a strong voice.
- Developing the prisoner-patient voice and perspective needs to be part of performance review for prison governors.
- Prisoner-patients should receive feedback on the impact of their involvement. For example, minutes of meetings should be publicised and action points should be followed up. Prisoner-patients should also be enabled to give feedback about the meetings to other prisoners.
- Explicit terms must be set to ensure that prisoner-patient representatives who provide input are not victimised for giving their views. In particular, input should not be used either in prison disciplinary proceedings or in clinical treatment. Measures will need to be developed to protect prisoner representatives from negative consequences of engagement, either from staff or other prisoners.
PART THREE: Areas for Key Prison Service Policies in Responding to Particular Mental Health Needs

Self harm

1. Awareness and attitude
   • The NICE guidelines on the management of self harm should apply in prison.
   • Prison staff given more understanding of the need for care to be focused on good personal contact rather than just process. Personal officer schemes need to be remunerated in those prisons where they have ceased to function effectively.

2. Policy
   • ACCT modified to reflect more than immediate risk and concerns. There needs to be guidance on how to address long term underlying problems and psychosocial needs.
   • Prison governors and healthcare managers need to develop some strategies and guidance about self harm, based on harm minimisation.
   • Staff need guidance for those who repeatedly injure themselves.
   • A solid policy framework for the delivery of follow up care should be devised.
   • Structure and guidance given to staff on how to respond to underlying problems and psychosocial needs.
   • Involvement of service users must be established.

3. Institutional arrangements
   • Partnership arrangements with community agencies who have specialist experience in this area.
   • Oversight by PCTs on provision of clinical supervision and support for staff.

4. Operational issues
   • Awareness training for all staff about why people deliberately injure themselves.
   • Specialist training and follow up support for staff who actively deal with the issues, in particular for wing staff.
   • Full risk assessment for those who self harm, to identify whether there is an increased risk of suicide.
   • Priority to listening to what prisoners who self injure say they need to reduce distress.

Self Inflicted Deaths

1. Awareness and attitude
   • Greater focus on the importance of reducing levels of distress by treating prisoners with humanity and dignity.
   • Change in culture to reflect the need for those at risk of suicide to have personal contact and comfort.

2. Policy
   • ACCT needs to reach prisons faster and more intensively, so that responding to the needs of potentially suicidal prisoners becomes embedded in the routine operations of prisons.
   • Care and comfort for those at risk prioritised equally with the identification of those at risk.
   • Involvement of service users and, where possible, their families.
3. **Institutional arrangements**
   - Following the recommendation by INQUEST, government should establish an Independent Standing Commission on deaths in custody.
   - The new draft bill on corporate manslaughter should include deaths due to mismanagement within the prison system.

4. **Operational issues**
   - Better focus on care and personal contact.
   - All suicide prevention warning recommendations by the Prisons Inspectorate should be implemented as a matter of urgency and followed through by area managers.
   - Improved attention to concerns of relatives about risk to offenders of self inflicted deaths.
   - Governors to give priority to improved contact and more consideration to relatives in the aftermath of a self inflicted death.

**Personality Disorders**

1. **Awareness and attitude**
   - Stigma of personality disorders recognised and addressed by dissemination of the wider community personality disorder programme (DoH: “Personality Disorder: No Longer a Diagnosis of Exclusion”) within the prison system.

2. **Policy**
   - Involvement of service users prioritised.
   - Equivalence with the broader NHS for offenders involved with the DSPD programme regarding complaints and consent to use their personal (anonymised) data for research and evaluation.
   - Clarification for DSPD users about consent for referral to the programme and subsequent involvement.
   - Admission criteria to DSPD programme reviewed to address the current emphasis given to non-clinical reasons (i.e. whether prisoner is on a fixed term sentence).

3. **Institutional arrangements**
   - Partnership arrangements with the new general services for personality disorders so expertise is spread into the prison system.
   - Address the anomaly of prisoners returning from therapeutic regimes outside the prison service, such as Arnold Lodge, to mainstream prison to complete prison sentences where much of good work established can be lost.
   - Funding and support for programme of advocacy for DSPD users.
   - Review of community provision to address the lack of suitable aftercare.

4. **Operational issues**
   - Staff training and support to understand and recognise personality disorder and guidance on how to manage offenders with these traits.
   - Review of PSO 1700, recognising that offenders can be on segregation for periods of time because of untreated mental health problems.
   - Practitioners supervised to recognise untreated mental illness alongside personality disorder.
   - CPA fully supported by all prison and health care staff when offender returns to normal location.
Dual Diagnosis

1. Attitude and Awareness
   - All staff who work with prisoners need training and awareness in ways in which mental illness may manifest itself as so called bad behaviour so that their response is therapeutic rather than punitive.

2. Policy
   - Development of an integrated policy for mental illness and substance misuse.
   - Development and implementation of prison policy on alcohol and hazardous drinking.
   - Application to prisons of the treatment effectiveness agenda developed and overseen by the National Treatment Agency (NTA) to improve the response to prisoners with a dual diagnosis and their resettlement needs.

3. Institutional arrangements
   - Partnership arrangements to make best use of expertise of professionals highly trained in both drug treatment and mental health care.

4. Operational issues
   - Modification of the punitive approach of the mandatory drug testing programme to take account of possible damage to users who have associated mental health problems.
   - Involvement of voluntary agencies to facilitate support groups for prisoners.
Learning Disability

1. Awareness and Attitude
   • All staff working in the criminal justice system given awareness training about offenders who have a learning disability, in particular those who have a borderline diagnosis.

2. Policy
   • Streaming of fragmented policy for community and forensic services so offenders who are borderline learning disabled are not excluded from appropriate community services.
   • Review of the use of the prison system as a criminal justice disposal for learning disabled offenders.
   • Implementation of the Disability Discrimination Act.
   • Review of the use of segregation to manage learning disabled offenders.
   • Involvement of service users and development of advocacy work.

3. Institutional Arrangements
   • Better awareness by the courts that offender treatment and offending behaviour programmes are not normally available for offenders with learning disability.
   • Review by PCTs of how effectively community services operate for this group.
   • Improved links between criminal justice agencies and local community teams and more effective referral systems.
   • Partnership arrangements to provide specialist psychiatric input for learning disabled offender.
   • Funding to develop offence related programmes for learning disabled offenders so they are able to participate and address their offending behaviour.

4. Operational issues
   • Training in awareness of learning disabilities for all prison staff.
   • Improved identification of prisoners with learning disability as they enter the system.
   • Systems developed to quantify the numbers of offenders with learning disability within the prison system.
   • Training to develop skills of health care staff to provide mental health care for learning disabled offenders.
   • Initiate a buddy /mentoring for learning disabled offenders to help cope with prison life.
   • Funding for advocacy schemes for learning disabled offenders.

Deaf prisoners and those with hearing loss

1. Attitude and Awareness
   • All staff working in the criminal justice system given awareness training on offenders who are Deaf or have a hearing loss. In addition, training and understanding of guidance issued by the courts and local arrangements to ensure compliance with Part 111 of the Disability Discrimination Act 1995.
2. **Policy**

- Consideration should be given by the Prison Service to concentrating Deaf prisoners in a limited number of sites so that specialist services could more readily be developed for them in prison. This needs to be done with the co-operation and agreement of prisoners and their families.

- Deaf prisoners should not be prevented from having free association with other Deaf prisoners unless there are specific and overwhelming reasons why this should not be allowed to happen.

- Research needs to be commissioned to rectify the chronic lack of knowledge on the Deaf prisoner population and their needs so that humane policies can be developed.

- Involvement of service users.

3. **Institutional arrangements**

- Partnership arrangements need to be made for adequate interpreter provision or direct access to appropriate professionals who can communicate using British Sign Language so that Deaf prisoners can have access to mental health services.

- PCTs and Prison Health need to be evaluating the existing health needs assessments for this group and if needed carry out new assessments.

- Partnerships with specialist agencies such as Sign so that advocacy and support services can be offered to all Deaf offenders.

4. **Operational issues**

- Screening for deafness on entry to prison. A simple question or sign during the reception period could be used.*

- Standardised Prison Service directive for all establishments regarding technical aids such as minicomms and induction loops.*

- Mandatory basic deaf awareness training for prison officers.*

- Mandatory British Sign Language, deaf awareness training, mental health and deafness training for disability and diversity officers.*

- Remove barriers for Deaf offenders’ ability to participate in offence related programmes.

(* drawn from O’Rourke, 2005: Draft prison scoping exercise)

**Prisoners holding foreign nationalities**

1. **Attitude and awareness**

- Cultural awareness and sensitivities about the likely experiences of foreign national prisoners developed by the Prison Service.

2. **Policy**

- Development of a foreign national prisoner strategy for each establishment.

3. **Institutional Arrangements**

- Improved links with immigration services to avoid delays and confusion about release dates.

- Partnership arrangements so that interpreters are available as are health workers with experience of working with asylum seekers and different cultures. In addition specialist psychiatric support needs to be available.

4. **Operational**

- Zero tolerance of racism and abusive language.

- Provision of interpreters, translators and use of language link systems.
Elderly prisoners

I. Attitude and Awareness
   • Improved understanding of the increased vulnerability of older prisoners to stress, poor health and depression, developed by the Prison Service.

2. Policy
   • The Prisons Inspectorate’s recommendation that the National Offender Management Service and Department of Health introduce a nationwide strategy for assessing and providing for elderly inmates needs to be acted upon.

3. Institutional Arrangements
   • Partnership arrangements developed between community services and the prison service so that the health and social care needs of older prisoners in prison, and when discharged from prison, are properly assessed and met.

4. Operational
   • Prison staff encouraged to recognise the raised vulnerability of older prisoners to poorer physical and mental health and give additional support in daily routines.

Black and Minority Ethnic Prisoners

I. Attitude and awareness
   • Improved cultural awareness to recognise manifestations of mental health problems in BME prisoners developed by the Prison Service and Prison Healthcare

2. Policy
   • Review of the use of disciplinary measures such as segregation, and control and restraint techniques for BME prisoner.
   • Qualitative and quantitative research commissioned into how the mental health problems (and their manifestation) of BME offenders is interpreted by the Prison Service.
   • Involvement of service users and where possible their families.

3. Institutional arrangements
   • PCTs review how mental health services are delivered to BME prisoners so that there is good access to services, delivered with cultural sensitivity
   • Partnership arrangements so that counselling and support services are available.

4. Operational
   • Zero tolerance for racism and abusive language.
   • Training and awareness for prison officers and health care staff in order to manage mental health problems of BME prisoners fairly and professionally.
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Appendix

The Human Rights Implications of the Treatment of Mentally Ill Prisoners
Prepared for this report by the AIRE Centre, London

I. Introduction

The AIRE Centre (Advice on Individual Rights in Europe) is a United Kingdom charity providing advice and information to practitioners on the European Convention of Human Rights (ECHR) and European Union law. We have been asked to prepare a report identifying the jurisprudence of the European Court of Human Rights (ECtHR) relevant to the treatment of prisoners with mental illness. This paper therefore focuses on the ECHR and the case law of the ECtHR (and to some extent on the case law of the European Commission, which was abolished in 1998). However, as Article 53 of the Convention states, Nothing in this Convention shall be construed as limiting or derogating from any of the human rights and fundamental freedoms which may be ensured under the laws of any High Contracting Party or under any other agreement to which it is a Party. Other international standards such as the European Prison Rules and reports of the European Committee for the Prevention of Torture (CPT) will also inform the discussion of this subject.1

This paper will first look at the situations in which the ECHR permits individuals with mental health problems to be deprived of their liberty. It will then go on to examine the positive and negative obligations owed by the state to such persons and review the relevant ECtHR case law relevant to various aspects of mental health in prisons.

II. Deprivation of liberty under Article 5

Any deprivation of an individual’s liberty by the State must be carried out in conformity with Convention principles. Specifically, individuals may only be deprived of their liberty for one of the specified purposes as set out in Article 5/1.2 The Convention additionally requires that there is a causal link between the actual reason for the detention and the specific provision of Article 5/1 which is invoked to justify it.3 It is not acceptable for the detention to fall within one of the Article 5/1 categories if the specific justification has not been transparently and genuinely identified.

Detention must be genuinely linked to one of the specific reasons contained in Article 5(1) so that those deprived of their liberty can take advantage of the procedural safeguards contained in Article 5’s other sections (i.e. 2, 3 and 4)4 The new Draft European Prison Rules (Draft Prison Rules) reiterate that [w]here the decision is made to deprive persons of their liberty, lack of resources cannot justify prison conditions that infringe human rights . . .5

There are six identified situations in which detention may be lawful and justifiable. They are set out in the text of Article 5/1. In the context of mental health, it is necessary to distinguish between a person who is convicted of a crime and receives psychiatric

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1 The Council for Penological Co-operation (PC-CP) is in the process of updating the European Prison Rules, which were previously updated in 1987. Reference will be made throughout this paper to the draft of the updated Rules [Draft Prison Rules] as well as the draft commentary on the text of the Prison Rules [Draft Commentary], as they exist at the time of writing. The Draft Rules have been sent to Member States for comment, and are expected to be finalised and adopted by the end of 2005.

2 Broadly, these reasons include conviction; failure to comply with a Court order; pre-trial detention; detention of a minor for supervision purposes; prevention of the spread of disease; immigration detention. The State lacks the power, generally, to deprive people of their liberty either for their own good or for the good of the public at large. In contrast, such a general right does exist with regard to restrictions on freedom of movement under Article 2 of Protocol 4.


4 In Arts v. Belgium, for example, the ECtHR found a violation of Article 5/1 where it took seven months for local authorities to transfer the applicant from his original place of detention to the facility that had been chosen by the local mental health board as the appropriate placement given the applicant’s mental deficiencies. The reason for the delay offered by the Government was that there was no room for him at the mental health facility. In light of the multiple indications that the prison where he was detained was not only inappropriate, but harmful to Applicant, the Court found that the proper relationship between the aim of the detention and the conditions in which it took place was deficient and constituted a violation of Article 5/1.

5 Draft Prison Rules at para 4 (emphasis added).
treatment either in the course of, or as part of, a criminal sentence (Article 5/1(a)) on the one hand, and on the other a person who has been deprived of his or her liberty in order to receive compulsory psychiatric treatment or care, but whose detention is not linked to a criminal conviction (Article 5/1(e)). This paper focuses on those individuals who are detained by the State pursuant to sub-sections (a) and (c) of Article 5/1; that is, individuals who have either already been convicted of a criminal offence or those who are held in pre-trial detention and who, additionally, suffer from mental illness. A person who has been found incapable of standing trial for a criminal offence, or is acquitted of the offence, may be subject to compulsory detention for psychiatric treatment under Article 5/1(e) for mental health reasons, but would not be deprived of his or her liberty in the form of a prison sentence within the scope of Article 5/1(a).

**Article 5/1(a)**

Article 5/1(a) authorises detention following a conviction for a criminal offence. The detention must at all times be directly linked to the conviction. In *Eriksen v Norway*, the applicant had been detained on account of his underdeveloped and permanently impaired mental capacity and numerous violent outbursts for most his life since 1967 under the authority of various preventative detentions and extensions of previous sentences. The ECtHR considered that, while a detention may be lawfully prolonged under Article 5/1, there must always be a causal connection between the current reason for detention and the objectives of the initial decision.

**Article 5/1(b)**

Article 5/1(b) authorises detention for non-compliance with a lawful court order or to secure the fulfilment of an obligation prescribed by law. In *Perks and Others v. the United Kingdom*, the ECtHR rejected the argument that there had been a violation of Article 5/1(b) where a series of Magistrates Court proceedings had led to the detention of the applicant for failure to pay a poll tax. The mere fact that the lower court orders were overturned on appeal (domestically) did not in itself affect the lawfulness of detention. However, had the Magistrates Court lacked jurisdiction over the applicants, the period of detention following the orders would have been unlawful.

It is a particularly noteworthy aspect of *Perks* that evidence was submitted to the domestic court showing that Mr Perks was mentally and physically handicapped and, given his limited mental capacity, could not have deliberately avoided paying his [poll tax]. In a partially dissenting opinion, Judges Tulkens and Greve found that, in Mr. Perks case specifically, there had been a violation of Article 5/1 because the detention was arbitrary within the inherent meaning of the Convention based on the failure of the Magistrates Court to take into account Mr. Perks diminished mental capacity when making a determination as to the wilfulness of Mr. Perks neglect in paying the poll tax. Judges Tulkens and Greve would have held that, notwithstanding the jurisdictional argument relied on by the majority of the Court, the detention of a man in Mr. Perks situation for six days for not having paid a tax of some GBP 150 is, in itself . . . a flagrant violation of the right to liberty of a person protected by the Convention.

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6 See e.g. *Aerts v. Belgium*. In *Aerts*, the applicant was arrested after attacking his wife with a hammer, and was placed in the psychiatric ward of Lantin Prison, pending trial. He was never convicted of a crime, however. Instead, the court of First Instance determined that the applicant suffered from severe mental disturbance at the material time and imposed a detention order stating that Applicant would be held provisionally in the Lantin Prison psychiatric ward until the Mental Health Board determined which institution was appropriate for his detention. The Applicant, therefore, could only be lawful if it complied with Article 5/1(e); since he was never convicted of a crime, 5/1(a) was inapplicable (see para 43).

7 *Eriksen* at para. 6 et seq.

8 *Eriksen* at para. 76.


10 *Perks* at para. 62 (relying on *Bonham v. United Kingdom*, Judgment of 10 June 1996).

11 *Perks* at para. 10.


13 *Id* (emphasis added).
Article 5 / 1(c)

Article 5 / 1(c) authorises pre-trial detention linked to a pending criminal investigation or criminal charge. There is a strong presumption of bail that must be specifically and expressly rebutted to justify detention. It is therefore unlikely that pre-trial detention only for reasons relating to the mental condition of an individual would be in conformity with the requirements of Article 5(3) - there would have to be some autonomous justification. In Eriksen v. Norway, for example, the Government sought to justify the applicant's pre-trial detention by linking it to past criminal proceedings and noting that the detention could reasonably be considered necessary to prevent his committing an offence in the future. The Court ultimately agreed with the Government that the particular facts in Eriksen were substantial grounds for believing that the applicant would commit further similar violent offences and therefore his pre-trial detention under Article 5 / 1(c) was justified. The Court noted that it was reasonable to keep the applicant in detention for a short duration after the expiry of the maximum period prescribed by a court in part to obtain updated medical reports on the applicant's mental health. However, the relevance of the applicant's mental health and the justifiable detention was closely linked to the original criminal proceedings... and the resulting conviction and security measures.

Article 5 / 4

Article 5(4) of the Convention gives a procedural safeguard for those in detention, in that it provides that everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a Court and his release ordered if the detention is not lawful. The Court found a breach of this provision in Benjamin and Wilson v the UK (Judgment of December 26, 2002), in which the applicants were detained in a hospital following sentence by the Court to a term of discretionary life imprisonment. They alleged that they did not have available to them an adequate procedure by which they could challenge the lawfulness of their continued detention, as required by Article 5(4). They argued that the system by which they were detained, as technical lifers did not satisfy the requirements of Article 5(4) because the Mental Health Tribunal could only make recommendations for their release, with only Secretary of State (and not a Court or Tribunal) having the power to order release. The Government argued in response that the regulatory scheme satisfied the requirements of Article 5(4) because the applicants were legally entitled to release following recommendation from the Tribunal; the power to recommend release was adequate; and the Tribunal was independent of the executive branch of government. Moreover, a recommendation by the Tribunal would as a matter of policy be accepted by the Secretary of State. The Court, however, found in favour of the applicants, stating that the ability of an applicant to challenge a refusal by the Secretary of State to follow his previous policy in the courts would not remedy the lack of power of decision of the Tribunal. Article 5(4) presupposes the existence of a procedure in conformity with its provisions without the necessity to institute separate legal proceedings in order to bring it about. Although the Court accepted that, following the HRA, the Secretary of State would not be able lawfully to depart from the Tribunal's recommendation, this did not alter the fact that the final decision to release would

14 See e.g. Caballero v. United Kingdom, Judgment of 8 February 2000.
15 Eriksen at para. 66 (referring to language of Article 5 / 1(c) of the ECHR).
16 Eriksen at para. 86.
17 Eriksen at para. 86.
18 Eriksen at para. 86.
19 See paragraph 36.
be taken by a member of the executive and not by the Tribunal. The Court’s conclusion left
the UK government with the need to make changes to the system of review of lawfulness of
detention as it applied to mentally ill prisoners.

III. Positive and Negative Obligations

Even if a particular instance of detention is a justified interference with an individual’s right to
liberty under article 5, the other Convention rights of the detainee must be observed in the usual
way except insofar as interference with those rights are an unavoidable aspect of detention, or
are necessary to maintain order and discipline in the prison.20 The ECtHR noted in Hirst v.
United Kingdom that even though the enjoyment of [other fundamental rights in the
Convention] must inevitably be tempered by the requirements of [a prisoner’s] situation, the
State must still justify the restriction of such rights by a legitimate aim and proportional
means.21 Although Hirst involved the restriction of prisoners voting rights generally, in the
course of its opinion the Court makes reference to a number of previous ECtHR cases where
the mere fact of imprisonment was insufficient to justify blanket restrictions on a variety of
other rights.22 Hirst demonstrates that a State would not be able to justify an interference with
a prisoner’s rights by making vague references to the continuing danger he poses to society.23

This principle is reiterated by the Draft Prison Rules which state that [p]ersons deprived of
their liberty retain all rights that are not lawfully taken away by the decision sentencing them or
remanding them in custody. 24

Negative Obligations

It follows from the principles above that, even if a detainee has been lawfully deprived of his or
her liberty, the State remains under an obligation not to interfere with the other Convention
rights of the detainee. Any interference by the State, as with the rights of non-offenders, may
only be justified where the interference is in accordance with law as well as being necessary and
proportionate given the particular circumstances of the case.25 The Draft Prison Rules state that:
Restrictions placed on persons deprived of their liberty shall be the minimum necessary and
proportionate to the objective for which they are imposed. 26

Positive Obligations

The settled jurisprudence of the ECtHR indicates that the rights contained in the ECHR impose
both positive and negative obligations on member States. That is, the Convention not only
protects individuals from State interferences with the exercise of their rights, but it additionally
imposes positive obligations on States. States’ positive obligations require them, firstly, to
protect individuals from interference with their rights by non-state actors and, secondly, to
facilitate enjoyment of Convention rights.27 In the context of detention, it was emphasised in
Rivas v France that when a person is taken into police custody the State is under a positive
obligation to ensure his general well-being.28 Furthermore, where there has been a lawful
deprivation of liberty under Article 5, the state remains under an obligation to take positive steps
to secure the detainee’s other, continuing, Convention rights. The ECtHR judgment in Osman v
United Kingdom established the standard by which a court should measure a State’s compliance
with its continuing positive obligations towards detainees, a determination that is made on a
case-by-case basis:

20 Hirst v. United Kingdom (no. 2), Judgment of 30 November 2004, at para. 44.
21 Hirst at para. 41 et seq.
22 See e.g. Silver and Others v. the United Kingdom, Judgment of 25 March 1983 (right of a prisoner to correspond); Campbell and Fell v. the United Kingdom, Judgment of 28 June 1984 and Golder v. the United Kingdom, Judgment of 21 February 1975 (right of a prisoner to have effective access to a lawyer or to court); T v. the United Kingdom, Commission decision of 8 October 1982 (right of a prisoner to have access to his family); Polovodin v. Ukraine, Judgment of 29 April 2003, at paras. 167-171 (right of a prisoner to practice his religion); T v. the United Kingdom, Commission report of 12 October 1993, at paras. 44-48 (right of a prisoner to exercise freedom of expression).
23 Hirst at para. 49. While disenfranchisement may have been a logical method of punishment for a convicted offender, the Court failed to see how the denial of the right to vote was proportionally linked to the detention of a prisoner on grounds of his continuing danger to society after having served the portion of his detention linked to punishment.
25 See Rivas v France, Judgment of 1 April 2004 (holding that the burden rests on the State to show that an injury inflicted on a detainee while in custody was a proportionate response to the perceived situation).
26 Draft Prison Rules at Rule 3.
The Court notes that the first sentence of Article 2/1 enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction . . . In the opinion of the Court where there is an allegation that the authorities have violated their positive obligation to protect the right to life in the context of their above-mentioned duty to prevent and suppress offences against the person . . ., it must be established to its satisfaction that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk. The Court does not accept the Government’s view that the failure to perceive the risk to life in the circumstances known at the time or to take preventive measures to avoid that risk must be tantamount to gross negligence or wilful disregard of the duty to protect life . . . Such a rigid standard must be considered to be incompatible with the requirements of Article 1 of the Convention and the obligations of Contracting States under that Article to secure the practical and effective protection of the rights and freedoms laid down therein, including Article 2 . . . For the Court, and having regard to the nature of the right protected by Article 2, a right fundamental in the scheme of the Convention, it is sufficient for an applicant to show that the authorities did not do all that could be reasonably expected of them to avoid a real and immediate risk to life of which they have or ought to have knowledge. This is a question which can only be answered in the light of all the circumstances of any particular case.29

While the facts of Osman gave rise to an application specifically under Article 2, the Osman principle may be extrapolated to other Convention Articles under which positive obligations towards detainees may arise. Note that a heightened positive obligation may apply in the case of a minor with no prior convictions, or in the case of mentally ill detainees, given their particularly vulnerable condition.

Convention rights engaging the State’s positive obligations in the prison context may include the right to life (Article 2); the right to be free from inhuman and degrading treatment or punishment (Article 3); the right to a fair trial, in which is subsumed the right to adequate legal advice (Article 6); and the right to freedom of religion (Article 9). These obligations are reflected in the Draft Prison Rules which require that prison authorities provide detainees with reasonable facilities for gaining access to [legal] advice 30, and that prison life is organised so far as is practicable to allow prisoners to manifest their religion and beliefs, to attend services or meetings and have in their possession books or literature relating to their religion or beliefs 31.

The case law of the ECtHR relating to these rights is discussed in more detail below.

IV. Review of relevant ECHR case law

Relatively few cases have been taken to Strasbourg by prisoners suffering from mental health problems. Much of the analysis that follows is extrapolated from other case law, but the principles contained in these cases will also be applicable in the mental health context.

The General Duty of Care towards Vulnerable Individuals

Throughout its jurisprudence, the ECtHR has evinced in the Convention particular protection to vulnerable individuals subject to the care and control of the State. The offenders who were the

29 Osman at paras. 115-116 (emphasis added).
30 Draft Prison Rules at Rule 20(1).
31 Draft Prison Rules at Rule 20(2).
subject of *T and V v United Kingdom*[^32], for example, were particularly vulnerable because of their youth at the time they committed, and were convicted of, a very serious crime. The fact that they were convicted aged eleven (for a crime committed when they were ten) was not an automatic violation of their rights under Article 3 ECHR, but the Court went on to consider whether the conditions under which their conviction came about amounted to a violation. In so doing it referred to the international tendency in favour of the protection of the privacy of juvenile defendants under various international instruments. The Court considered the specific positive measures taken by the state to minimise the boys’ trauma relevant to its eventual finding that there had been no violation of Article 3. Similarly, in *SC v United Kingdom*, the Court considered it relevant that the authorities had taken steps to modify the trial process in the case of a young defendant (for example, the legal professionals did not wear wigs in Court and the applicant was allowed to sit next to his social worker). These measures helped accommodate the young defendant’s particular susceptibility to intimidation by the Court process. However the State had not taken sufficient notice of the fact that the child had below average intelligence for his age and, consequently, was unable to comprehend the importance of making a good impression on the jury or the fact that he risked a custodial sentence. The medical evidence disclosed that he was able to understand that what he had done was wrong, and was therefore fit to plead, but his vulnerability arising from his youth and intellectual capacity meant he was unable to effectively participate in the trial process to which he was subject. The State’s failure to account fully for this led to a violation of Article 6.

The Court’s reasoning in these cases reflects the State’s obligation to treat individuals with respect for their particular vulnerabilities, a general principle which is relevant to treatment of individuals within the criminal justice system who are vulnerable because they experience mental health problems.

*Z v United Kingdom*[^33] concerned the obligation to protect children brought to the attention of social services form abuse and neglect. The Court considered that the measures required of States to protect individuals from inhuman and degrading treatment, within the meaning of Article 3, should provide effective protection, in particular, of children and other vulnerable persons and include reasonable steps to prevent ill treatment of which the authorities had or ought to have had knowledge.[^34]

Many individuals in prison who suffer from mental health problems can be considered to be in an analogous situation to the individuals in *Z v United Kingdom* and in the line of cases to which *Z v United Kingdom* gave rise. If the State, which has almost total control over detainees lives, does not take appropriate care of them, there is no-one else to ensure that care will be given. As a consequence, the ECHR imposes a heightened duty of care on the part of the State, and requires exacting scrutiny of the State’s conduct by the Court. Indeed, in *Rohde v Denmark*[^35] the Court pointed out that in the case of [detained] mentally ill persons, both the Court and the State should be mindful of their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment.

In sum, the State’s duty to accommodate individuals’ particular vulnerabilities, as well as to ameliorate the potential negative consequences of those vulnerabilities, is an obligation present throughout Convention jurisprudence. This principle’s general application and the importance attributed to it by the Court means that it can be considered a fundamental principle of the Convention scheme.

[^34]: *Z and Others v United Kingdom*, at para 73. See mutatis mutandis *Osman v United Kingdom* (note 27 above) at para 116.
**Deterioration in health while in detention**

Article 3 of the ECHR prohibits, inter alia, inhuman or degrading treatment or punishment. This concept has been described by the Court as treatment such that tends to arouse feelings of fear, anguish and inferiority capable of humiliating [an individual]. In order to fall within the ambit of Article 3, ill treatment suffered whilst in detention must rise to a minimum level of severity. This determination is to be done on a case-by-case basis: the assessment of this minimum is, in the nature of things relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim.

A prisoner who suffers from mental illness may well be more susceptible to feelings such as fear, anguish and inferiority than a mentally fit prisoner and may consequently suffer from inhuman or debasing treatment more readily than his fellow inmates. This should be borne in mind when considering the case law involving applicants with physical, rather than mental, health problems. However the degree of suffering incurred by the complainant must exceed the unavoidable level of suffering inherent in detention in order to constitute a breach of Article 3.

The Court held in *Novoselov v Russia* that the State is obliged to ensure that given the practical demands of imprisonment, the detainee’s health and well-being are adequately secured. A comparatively minor deterioration in health while in prison attributable to the restrictions placed on detainees by prison authorities, will not alone meet the level of severity amounting to treatment in breach of Article 3 of the ECHR. However the Court went on to find in *Novoselov* that deterioration in the applicant’s health, combined with the effect of poor sanitary conditions and severe overcrowding amounted to a breach of the applicant’s Article 3 rights. The Court made a similar finding in *II v Bulgaria* and *Labzov v Russia*.

In *Price v United Kingdom*, the applicant was four-limb deficient. She was detained under standard prison conditions but, because the authorities failed to make any special provisions for the applicant in light of her condition, she became dangerously cold, risked developing sores because her bed [was] too hard or unreachable, and [was] unable to go to the toilet or keep clean without the greatest of difficulty. Her conditions of detention therefore amounted to treatment beyond the minimum level of severity, constituting degrading treatment contrary to Article 3 of the Convention. The case points to the existence of a general obligation on the State to modify the standard conditions of detention to ameliorate the effects of pre-existing health conditions (including mental health conditions) so as to place the detainee in the same position as a detainee with no such problems. An analogy can be drawn with the cases of *T and V v United Kingdom* and *SC v United Kingdom* (above, page 11) in which the State was obliged to take positive steps to make the trial process less traumatic for young and vulnerable defendants, who would otherwise be more frightened and intimidated by the experience than an average, adult defendant.

**Entitlement to medical treatment for existing conditions**

While no Convention case law suggests that prisoners may freely access hospitals of their choice, any interference with their access to medical treatment comparable to that which would be available to non-offenders may only be justified if it is necessary for the maintenance and good order of the prison, and proportionate to that need.

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38 Judgment of 2 June 2005.
39 Ibid.
40 Judgment of 9 June 2005, in which the Court held that the cumulative effects of the unduly stringent regime, the material conditions in which he was kept and the specific impact which these conditions and regime had on the applicant’s health constituted a violation of article 3.
42 See Draft Prison Rules. Paragraph 36.3 states: Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.
The general principle set out in Hirst (see above) requires that there should be a proportionate justification for any refusal by the State to provide prisoners with adequate mental health care. Indeed, failure to provide prisoners in ill health with adequate access to health care has been found, in some cases, to be a violation of Article 3. In Hurtado v. Switzerland, for example, the Applicant asked to see a doctor two days after his arrest for suspected drug-trafficking. It was not until six days later that the applicant was finally examined, upon which time it was discovered that the applicant had a fractured rib. The case was later struck out after a settlement was reached between the applicant and the State in which the State admitted no Convention violation. However, the Commission originally reached a unanimous decision that the failure of authorities to provide the applicant with prompt medical attention amounted to a violation of Article 3. The Commission noted: . . . [u]nder Article 3 of the Convention the State has a specific positive obligation to protect the physical well-being of persons deprived of their liberty. The lack of adequate medical treatment in such a situation must be classified as inhuman treatment.

Compelling reasons will therefore be required to demonstrate that interference with the access to healthcare of a physically or mentally ill detainee is a necessary and proportionate incident of maintaining order in prisons. In McGlinchey and Others v United Kingdom, the ECtHR considered that Article 3 obliges the state to:

. . . ensure that a person is detained in conditions which are compatible with respect for her human dignity, that the manner and method of the execution of the measure do not subject her to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, her health and well-being are adequately secured by, among other things, providing her with the requisite medical assistance.

In Mouisel v France, the Court found a violation of Article 3 of the Convention where the State s treatment of a prisoner who suffered from Leukaemia rose to a level that was considered inhuman or degrading within the meaning of that article. More specifically, the Court determined that the use of handcuffs during the applicant s transport to hospital for chemotherapy treatment where there was no indication that the applicant was a flight risk, the degrading treatment by prison authorities during his hospital visits, as well as his continued detention despite his severe illness were disproportionate to the aims sought.

The Court in Mouisel took notice of recommendations by the European Committee for the Prevention of Torture (CPT) that raised concerns about the way in which sick prisoners were being transported to hospitals for medical treatments or examinations. The CPT noted that certain practices such as forceful handcuffing, medical examinations in the presence of law-enforcement officials, and physical restraints in hospital beds were in breach of medical ethics. In reaching the conclusion that there was a violation of Article 3, the Court noted the similarities between the CPT report and the practices of which the applicant complained.

In any Article 3 case, the treatment must rise to a minimum level of severity, whether or not the applicant is mentally ill. However, the fact of mental illness invokes a heightened duty of care on the part of the state as well as exacting scrutiny on the part of a court. The Court in Mouisel considered the case of Chartier v Italy in which the Commission found no violation of Article 3 because the prisoner, who suffered from hereditary obesity, had been treated appropriately, but
noted that detention per se inevitably affect[s] prisoners suffering from serious disorders and in particularly serious cases situations may arise where the proper administration of criminal justice requires remedies to be taken in the form of humanitarian measures . . . 54 In another case, the Court considered that the long-term detention of an elderly sick person could fall within the ambit of Article 3. 55 Finally, in De Varga-Hirsch v. France, the Commission held that on the material facts there was no violation because the Government showed that the applicant had been referred to medical experts a sufficient amount of times, and that the applicant had contributed to his bad state of health by refusing . . . his transfer to a prison hospital . . . The Commission had first noted, however, that it cannot be excluded that detention of a person who is ill may raise issues under Article 3 of the Convention. 56

With specific regard to mental health, the Court has held that certain types of treatment may infringe Article 3 on account of the fact that the person being subjected to them is suffering from mental disorders. 57 The concept of inhuman treatment contained in Article 3 has been interpreted by the Court to include mental suffering that is not accompanied by physical suffering. 58 Indeed, in Mouisel, the applicant suffered physical pain from the gratuitous use of handcuffs but also experienced mental suffering and humiliation when the prison guards who accompanied him to chemotherapy sessions regularly ask[ed] the nurses to make sure that [he was] . . . injected as quickly as possible so that they [did] not have to spend all day waiting around for [him]. 59 From this line of cases, it is clear that Article 3 does not give rise a blanket prohibition on the detention of physically or mentally ill people. They remain liable to detention for any of the reasons contained in Article 5(1) (see above). However, the fact of a prisoner’s disability might oblige the detaining authorities to afford the prisoner an enhanced standard of treatment. The required standard will be determined by the particular circumstances of the prisoner’s condition. If this enhanced standard is not met, the way in which a prisoner in poor mental or physical health is treated by the detaining authorities might constitute treatment of the minimum level of severity, even though the minimum level of severity would not be reached had a prisoner of good mental and physical health been subject to the same conditions of detention or treatment by the detaining authorities. 60 In sum, there is no objective minimum level of severity necessary to constitute a breach of Article 3 and, furthermore, the requisite level is likely to be lower in relation to a prisoner in poor health.

The importance of the State’s obligation towards detainees in ill health is reinforced by the positive obligations required of prison authorities by the Draft Prison Rules. 61 In particular, Part III of the amended rules is devoted solely to the health of detainees, adhering to the general principle that prison authorities shall safeguard the health of all prisoners in their care. 62 The Rules require that every prisoner shall be examined by a medical practitioner as soon as possible after admission, thereafter as necessary and at release. 63 The duty to provide adequate medical care is therefore a continuing obligation on the part of the state. The Draft Commentary on the Text of the European Prison Rules (Draft Commentary) notes that Rule 38 [having to do with the duties of the medical practitioner] makes it clear that the task of the medical practitioner (i.e. a fully qualified medical doctor) begins as soon as any person is admitted to a prison and that following the initial examination the doctor should see all prisoners as often as their health requires it.

This continuing obligation applies with equal, and in some cases greater force with regard to mental, as opposed to physical health. 64 The Rule 38 Draft Commentary notes that the medical

56 Mouisel at para. 39, referring to Keenan v. the United Kingdom (emphasis added).
58 Mouisel at para. 16.
59 See Mouisel at para. 40.
60 See generally, Draft Prison Rules, supra note 1.
61 Draft Prison Rules at Rule 35.
62 Draft Prison Rules at Rule 30(1).
63 Draft Prison Rules at Rule 30(1).
64 Draft Commentary on Rule 38.
practitioner's duty to see prisoners on a continuing basis is particularly important in respect of prisoners who may be suffering from mental illness or are mentally disordered, who are experiencing drug or alcohol withdrawal symptoms or who are under particular stress because of the fact of their imprisonment. 65 The Draft Commentary refers to the McGlinchey judgment in which the ECtHR ruled that the prison authorities' failure to provide adequate or timely medical treatment to a female prisoner, whose severe symptoms of heroin withdrawal eventually contributed to her death, amounted to inhuman or degrading treatment as prohibited by Article 3. 66 The ECtHR, having regard to the responsibility owed by prison authorities to provide the requisite medical care for detained persons found that the failure of the prison authorities to provide accurate means of establishing [the applicant's] weight loss . . . [the] gap in the monitoring of her condition by a doctor over the weekend when there was a further significant drop in weight and [the] failure of the prison to take more effective steps to treat [the applicant's] condition amounted to an Article 3 violation. 67

The Draft Prison Rules envision the particular issues that affect mentally ill prisoners in Rule 43. The Draft Commentary notes:

[the] conditions of imprisonment may have a serious impact on the mental well-being of prisoners. Prison administrations should seek to reduce the extent of that impact and should also establish procedures to monitor its effects on individual prisoners. Steps should be taken to identify those prisoners who might be at risk of self-harm or suicide. Staff should be properly trained in recognising the indicators of potential self-harm. Where prisoners are diagnosed as mentally ill they should not be held in prison but should be transferred to a suitably equipped psychiatric facility. 68

Deaths in Custody and Article 3

In Keenan v UK the ECtHR found the prison authorities' treatment of a mentally ill detainee in the period preceding the detainee's suicide a violation of the State's positive obligations under Article 3. The Court reiterated the that there is a heightened duty of care on prison authorities when dealing with prisoners with known mental health problems. The Court states that:

It is relevant in the context of the present application to recall also that the authorities are under an obligation to protect the health of persons deprived of liberty . . . In particular, the assessment of whether the treatment or punishment concerned is incompatible with the standards of Article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment . . . 69

Furthermore, the Court in Keenan considered that there are situations in which the applicant need not prove the actual effects of ill-treatment to demonstrate a violation of Article 3. 70 That is, some treatment is so antithetical to the respect for human dignity that the mere fact of its occurrence could give rise to an Article 3 violation. 71 Mentally ill prisoners may lack the ability to articulate the ill effects of certain treatment; nevertheless, the state has a positive obligation to ensure that persons with such diminished capacity are treated in a way that respects the standards imposed by Article 3 in the protection of fundamental human dignity. 72 In Keenan, the Court was struck by the lack of medical notes concerning [the applicant], who was an identifiable suicide risk and undergoing the additional stresses that could be foreseen from

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65 Id (emphasis added).
66 McGlinchey at paras. 52 et seq.
67 McGlinchey at paras. 57-58.
68 Draft Commentary on Rule 43.
69 Keenan at para. 110 (emphasis added).
70 Keenan at para. 112
71 Keenan at para. 112.
72 Keenan at para. 112.
segregation and, later, disciplinary punishment. The lack of proper care provided for a prisoner with a deteriorating mental health condition was seen as incompatible with the standard of treatment required in respect of a mentally ill person thereby reiterating the notion that mental incapacity gives rise to a heightened duty of care.

On the other hand, Sir Stephen Sedley noted in his concurring opinion in Keenan that the applicant’s death (arguably the effect of the maltreatment) informed his conclusion that the facts of the case gave rise to a violation of Article 3. While Sedley emphasised that his conclusion was not dependent on a consequential death, he also considered that if the applicant had not killed himself it is not easy to see what his case would have been under Article 3.

Deaths in Custody and Article 2

In Keenan v UK, the ECtHR had found a violation of Article 3 in respect of a lack of effective monitoring of and a lack of informed psychiatric input into the condition of a mentally ill person known to be a suicide risk. The ECtHR later considered the State’s positive obligation to secure the individual applicant’s right to life (contained in Article 2 ECHR) in Tanribilir v Turkey. In that case, the applicant’s son, Mr Tanribilir, was detained in a police station and questioned about his activities as a member of the PKK. He was later found hanged in his cell. The Court found insufficient evidence to suggest that the police were directly responsible for his death, but went on to consider the State’s positive obligation under Article 2 to prevent his suicide whilst in its custody. The Court considered whether in the circumstances of this case, the State took all of the required measures to prevent the life of the applicant’s son from being needlessly placed in danger. The Court found that a positive obligation under Article 2 could give rise to a duty on the part of the authorities to watch over detainees and prevent suicides. That duty arose when the authorities ought to have known at the moment that there was a risk the detainee might commit such an act and that the authorities did not take the measures within their powers which, from a reasonable point of view, would probably have lowered that risk. Whether or not this standard was met would depend on the totality of the circumstances of the case in question. The same test was applied in Kılın v Turkey, in which it was found that the authorities were well aware of the mental health history of the individual and his status as a suicide risk. The individual was undertaking compulsory military service and was therefore sufficiently within the control of the State to give rise to an obligation on the part of the State to do everything in its power to prevent the risk of suicide materialising. The Court found that they had failed to discharge this duty towards the individual. In particular, the fact that the mental health facility to which he was to be admitted was closed for Ramadan was no excuse; on the contrary, this was a factor within the control of the State and integral to their failure to do everything within its power to prevent the individual’s suicide.

In Younger v UK, the ECtHR emphasised that although it is incumbent on the State to account for any injuries suffered in custody, which obligation is particularly stringent where that individual dies, the Court would nevertheless bear in mind the difficulties in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources when assessing whether the State’s positive obligation under Article 2 had been fulfilled in any particular instance. In that case, it was held that there was no breach of Article 2, principally because the detainee in question had shown no signs of being a suicide risk or of being distressed until moments before his suicide occurred.

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73 Keenan at para 113.
74 Keenan at para. 115.
75 Concurring opinion of Sir Stephen Sedley in Keenan v. United Kingdom at para. 4.
76 Concurring opinion of Sir Stephen Sedley in Keenan v. United Kingdom at para. 4.
78 Kılın v Turkey, Judgment of 7 June 2005.
79 Admissibility decision of 7 January 2003.
Whilst the Court accepted that an enhanced risk of suicide is a well-known feature of the custodial situation, it said that it could not be extrapolated from this principle that Article 2 required that every prisoner should be treated as a real and immediate suicide risk merely by virtue of being a prisoner. The presence of actual or imputed knowledge of a prisoner's suicide risk was crucial to a finding that there had been a breach of Article 2. Similarly, in Trubnikov v Russia, the authorities' failure to prevent the suicide of a detainee was found not to constitute a breach of Article 2. Although the detainee had had a history of self-harm and had made a suicide attempt three years earlier, the Court accepted the submissions that the earlier suicide attempt had been merely demonstrative in character; the detainee did not demonstrate mental health problems amounting to any psychiatric disorder during his regular psychiatric assessments in the three years since his last suicide attempt; and that the authorities had taken appropriate general precautions by depriving him of his belt and shoelaces. The authorities were not entirely faultless because they should have been alerted to a risk of suicide by a combination of factors, namely, the detainee's past history; the fact that he was being placed in solitary confinement; and his inebriation at the time of confinement. Nevertheless such failures were not severe enough to amount to a breach of the state's positive obligation towards the detainee arising under Article 2.

The ECtHR has identified a separate, procedural obligation contained within Article 2 to carry out an effective investigation to the death of an individual within its custody. In Trubnikov v Russia, although the state was not in breach of a positive obligation under article 2 (by virtue of the fact that the authorities had no actual or imputed knowledge of the detainee's risk of suicide), the ECtHR found a breach of their separate obligation under Article 2 to conduct an effective investigation into the detainee's death. The rationale behind the obligation was described as follows: in cases of homicide, the interpretation of Article 2 as entailing an obligation to conduct an official investigation is justified not only because any allegations of such an offence normally give rise to criminal liability, but also because often, in practice, the true circumstances of the death are, or may be, largely confined within the knowledge of State officials or authorities. Thus although there was no automatic obligation to initiate a criminal investigation, the minimum requirements of any investigation included promptness, independence and effectiveness. Accountability to the public was an important factor, which dictated that the family of the deceased was entitled to be involved with the investigation and promptly informed of its progress.

Injuries suffered at the hands of the detaining authorities

The ECtHR found in both Tomasi v France and Ribitsch v Austria that, where it could be shown that the applicant sustained physical injury whilst in the custody of detaining authorities, it was for the State to show that such injuries were not inflicted by the authorities, or that the treatment leading to the injuries was made strictly necessary by the applicant's behaviour (e.g., the injuries were caused in the course of restraining a violent detainee). In these cases, the States involved failed to rebut the presumption that they had unlawfully caused the applicant injury. Consequently the Court found in both instances that there had been a breach of Article 3 ECHR. In the mental health context, it may well be difficult for an applicant to demonstrate that the treatment which triggered or exacerbated his mental health condition arose during the period of detention and was not sustained before detention took place. In theory, however, the same principles would apply.

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81 See 73 above.
V. Protection from the Acts of Co-Detainees

The case law dealing with attacks on prisoners by co-detainees further illustrates how the State’s inaction may violate Convention principles where vulnerable persons, such as the mentally ill, are involved. Prison authorities have a positive obligation to protect prisoners from attacks by other prisoners. In the decision of Pantea v Romania, the ECtHR found a violation of Article 3 when the prison authorities put the applicant, who was being held on remand, into a cell with convicted and dangerous prisoners, failed to come to his aid when he was attacked by them, and possibly even acquiesced to the attack. The prison authorities then failed to provide the applicant with adequate medical care after he had been assaulted. The Draft Prison Rules place a positive obligation on the medical practitioner to report to the director whenever it is considered that a prisoner’s physical or mental health has been or will be adversely affected by continued imprisonment or by any condition of imprisonment. Conditions of imprisonment would of course include the characteristics of a detainee’s cellmates.

Pantea demonstrates the need to educate prison authorities in respect of their obligation to treat prisoners with respect for their human dignity. Respecting human dignity involves taking into account that person’s individual circumstances and particular vulnerabilities. In the case of a mentally ill person, respect for his human dignity involves monitoring his likelihood of harming himself or others or being harmed by his surroundings. Indeed, the Draft Prison Rules includes a section on the training of prison staff and particularly addresses the needs of the mentally ill in this context. Rule 79(3) reads: Staff who are to work with specific groups of prisoners, such as women, juveniles or mentally ill prisoners, shall be given specific training for their specialised work.

The son of the applicants in Paul and Audrey Edwards v the United Kingdom was killed by a mentally ill prisoner with whom the son was sharing a cell. The Court found a violation of the right to life under Article 2 due to the failure of the medical profession, the police, the prosecuting authorities and the domestic court to pass on information about the mentally ill prisoner to the prison authorities. Thus as well as owing a heightened duty of care to mentally ill prisoners with regard to their own treatment, the State has a duty to all members of the prison population in situations where the actions of mentally ill prisoners might pose a risk to their safety.

Forced Medical Treatment and Article 3

The ECHR gives only limited protection for prisoners who wish to refuse medical treatment. The protection is largely procedural rather than substantive. In X v Germany the Commission pointed out that the force feeding of prisoners brought the State’s obligations under Article 3 into conflict with its positive obligations under Article 2 (to preserve the life of the prisoner), a conflict which the Convention itself did not explicitly resolve. In Herczegfalvy v Austria the Court found that [it] was only [the applicant’s] resistance to all treatment, his extreme aggressiveness and the threats and acts of violence on his part against the hospital staff which explained why the staff had used coercive measures including the intramuscular injection of sedatives and the use of handcuffs and the security bed. It was relevant that the treatment was not inflicted in malice or as a form of punishment. In relation to the force feeding of the applicant, the Court went on to state that as a general rule, a measure which is a therapeutic
necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist. It was found that the latter requirement had been fulfilled and that, consequently, force feeding the applicant had not constituted a violation of Article 3.

Herczegfalvy dictates that treatment in the best medical interests of a detainee will not per se constitute a violation of Article 3. However, two factors must be present in order to avoid a finding of a breach of Article 3. Firstly, the State is obliged to provide proof of the necessity; secondly, it is obliged to put in place procedural safeguards to ensure that the manner in which forced treatment is administered does not in itself breach the individual’s rights under Article 3. More recently, the Court has carefully scrutinized the observance of these qualifying factors. In Nevmerzhitsky v Ukraine, the Court referred to Chapter III of the CPT Standards of Health care services in prisons [CPT/Inf/E (2002) 1, Rev. 2004], which includes the principle that Every patient capable of discernment is free to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances which are applicable to the population as a whole. The Court went on to find that the State had failed to demonstrate that force feeding the applicant, who was a prisoner staging a hunger strike, was medically necessary to prevent his death. Consequently the treatment was found to constitute torture within the meaning of Article 3, and a violation of the State’s obligations under that Article. Note that the applicant in Herczegfalvy was found by the Court to be without the capacity to validly give or withhold his consent, whereas the applicant in Nevmerzhitsky was apparently competent. The Court draws no explicit distinction on these lines. However, it seems that, the lack of competence of the applicant in Herczegfalvy gave rise to the very broad general principle that a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. Similarly, the unnecessary force feeding of a competent individual in Nevmerzhitsky may well have led the Court to find that the treatment he sustained amounted to torture, a more severe standard of treatment than inhuman and degrading treatment within the meaning of Article 3.

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93 Herczegfalvy v Austria, Judgment of 24 September 1992, at para 82.
94 Nor a violation of Article 8 (which includes the right to respect for private life). See Herczegfalvy v Austria at para 86.
95 Nevmerzhitsky v Ukraine, Judgement of 4 May 2005.