

Troubled Inside:

Responding to the Mental Health Needs of Women in Prison

Dora Rickford



The work of the Prison Reform Trust is aimed at creating a just, humane and effective penal system. We do this by inquiring into the workings of the system; informing prisoners, staff and the wider public; and by influencing Parliament, Government and officials towards reform.

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Preface

The Prison Reform Trust has established a programme of work entitled 'Troubled Inside', which seeks to improve and accelerate the response from the authorities to offenders with mental health needs, so that they get the treatment they need, and fewer are imprisoned inappropriately.

This is the second stage of that programme of work and focuses on the mental health needs of women in the criminal justice system. As part of this work a conference was convened in 2002 to:

- reveal the complex mental health needs of women in prison;
- press for equivalence in health services for women in prison to those outside;
- campaign for alternatives to custody for women with severe mental health problems;
- prove a catalyst for action by the NHS and the Prison Service.

This report draws on conference papers and recent research findings, setting these in the context of current policy and practice, to provide a clear agenda for action. Published as the NHS begins the transition to assume full responsibility for prison healthcare, the report has been submitted to the Ministers for Health, for Prisons and Probation and Government officials.

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Foreword

I was a serving prisoner between June 1999 and December 2001. After my release I was invited to give a speech on the subject of 'Depression in Prison' at the PRT conference 'Troubled Inside: Responding to the Mental Health Needs of Women in Prison'.

I had experienced depression whilst in prison, and I witnessed the many mental health problems affecting women in prison, ranging from depression to severe mental illnesses.

Most women prisoners will at some point have mental health issues to deal with, caused by incarceration and separation from their families. Many women are the main carers for their children, and the separation and loss of control and care for them can have devastating effects on both the women and the children.

A number of women who enter prison are already seriously mentally ill; these women should not be sent to prison at all. They need care and help which the Prison Service does not provide adequately. They should not be incarcerated as it can lead to a decline in their health and an increasing dependency on medication.

The effect of imprisonment on women has a far more profound effect than on men, especially for those who are main family carers. Incarceration should be the last option for many female offenders and not the first. There needs to be a complete 're-think' about care and punishment of female offenders.

Remanding female offenders should only be considered if there is a real and serious threat to society and the community. Remanding a woman in custody may mean she will lose her home, have her children taken into care and/or lose her job. Often women are held on remand for several months and then acquitted. But the damage has already been done. Prison will have had a devastating effect emotionally and mentally on both her and her children.

This report highlights with great accuracy the important issues in this area. It argues that changes must take place if depression, suicide, self-harm, and the breakdown of relationships are to be prevented. Women are re-entering society with more problems than before they were sent to prison. They re-offend often and may experience further mental decline.

I entered prison as a person of sound mental health. During my incarceration, I experienced many mental health problems such as medical dependency, self-harm and suicidal thoughts and severe weight loss, due to the unbearable pain of separation from my daughter and being in prison. Now, 15 months after my release, the effect of imprisonment is still with me and I have found re-settling difficult and at times almost unbearable.

Wendy Cranmer

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I. Introduction and Background

“I believe women are in far more danger of becoming mentally ill during their incarceration: especially those that are family carers and have close family ties. The prison system is not prepared properly for this, for the complexity of women and their issues that do affect them deeply, mentally rather than physically. Physically I did not find prison too hard: I could cope by going into ‘auto pilot’ and physically do all the tasks I had to do, but mentally I was locked away.

For those women that come into prison with mental health problems, the prison is even less prepared. Yes, there are ‘medical wings’ and nurses, but the medical attention given and received is not ‘care’. It is still about incarceration, and for those with greater needs there is not the time, facilities or proper staffing levels to give that. Therefore, all too often the answer remains: More medication! More lock up! This is not the answer, and these women only deteriorate further in these conditions.” (Former prisoner)

A key message in *Women’s Mental Health: Into the Mainstream* (Department of Health, 2002a) is that, “Involving and listening to women should be fundamental to all service planning, delivery and evaluation”. The Prison Reform Trust (PRT) fully endorses this message and will argue in this report that despite much good work and good intentions the reality of care for women in prison is still bleak.

PRT believes that present policies, outlined below in Chapter five and elsewhere in this report, indicate a welcome change in direction but a deeper and more challenging change is required. Women in prison remain part of society. Many arrive in prison after enduring adverse social conditions and with significant mental health problems. The NHS now faces the challenge to ensure that mental health care in prisons is integrated and will provide care to an equal standard as in the community. In particular, women should be respected, listened to and actively involved in their care.

1.1 Women in prison: rising numbers

On 20th June 2003, there were 4,572 women in prison (HM Prison Service, 2003). Five years ago, the average female prison population was 2,675. Ten years ago, in 1993, it was 1,560 (Home Office, 2003a), an increase of 192 per cent in that time. The rate of increase is also accelerating. Almost 12,000 women were received into prison in 2001 (Home Office, 2003b). While the prison population has soared, the number of women in prison has risen more rapidly than the number of men. Why has there been such a dramatic increase?

“Few women are contract killers or muggers. I do not see them charging down high streets drunk after football matches looking for someone to stab. The tiny number imprisoned for assault mostly assaulted their spouses and friends and were themselves victims of violence. Few are any threat to society.”
Simon Jenkins, The Times

Concerned by the rapid rise in the women’s prison population, PRT commissioned a two-year independent inquiry into women’s imprisonment, chaired by Professor Dorothy Wedderburn. In its report, *Justice for Women: The Need for Reform*, the Committee of Inquiry concluded that:

“This rise is not just a reflection of the general increase in the prison population, but a symptom of a much more fundamental fault in the country’s arrangements for dealing with women offenders as a whole. The fact remains that the vast majority of women in prison are in prison for non-violent offences and have never been a danger to the public. They are women who the system has failed time and time again. These women are socially excluded. Imprisonment will only isolate them further.” (Prison Reform Trust, 2000b)

Several factors have driven up the number of women held in custody, including increases in:

- the number of women appearing before the courts
- the number of women remanded into custody rather than bailed
- the proportion of women receiving a custodial sentence
- the length of prison sentences imposed on women, and
- the number of women committing drug offences which attract heavy penalties

In addition to these:

- There are inequalities in sentencing options and limited alternatives to custody for women in some parts of the country.
- There is a lack of co-ordination in the criminal justice system in regard to women, and a failure, until recently, to prioritise reducing offending by women.

1.2 Social outcomes

Women suffer from imprisonment by being separated from their children and by often losing their homes and possessions. Because they are usually primary carers their families are the ones who suffer. Each year up to 17,000 children are separated from their mothers by imprisonment¹. HM Chief Inspector of Prison’s thematic review, *Women in Prison*, (1997) found that the imprisonment of women caused profound disruption to the lives of their children. Only five per cent of women prisoners’ children remained in their own home after their mother had been sentenced.

Nacro’s report, *Women who challenge: Women offenders and mental health issues* (2002) states that a significantly higher proportion of the children of women prisoners than those of males end up in care. They question whether the increase in the number of children looked after in local authority care (an average increase of 4.4 per cent from 1997-2000) is linked to the rapid increase in the female prison population.

“The separation of children from their mothers whilst they are serving a prison sentence has a detrimental knock on effect in terms of transmitted disadvantage and social exclusion. It is all the more important, therefore, when dealing with women offenders to ensure that custody is only used as a last resort for the most serious offences and where it is necessary for the protection of the public.” (Department of Health, 2002a)

The main reason that women are often held far from their families is that there are far fewer women than men in prison and therefore, there are fewer prisons for women. Although the sensible solution would be to provide smaller, more local facilities for women who offend, the Government appears to believe that building large new prisons or re-rolling male prisons to hold women is more economical. As a result, the geographic spread of prisons holding

¹ Based on a calculation that two-thirds of women in prison are parents (Hamlin and Lewis, 2000) and that they have, on average, 2.1 children (Caddle and Crisp, 1997). In 2001, 11,946 women were received into prisons in England and Wales (Home Office 2003a).

women continues to exercise a disruptive and destructive effect on women's families, as recognised in *Justice for Women*:

“Because of the relatively small number of women’s prisons, women are more likely than men to be held at a considerable distance from home and in locations which are both costly and difficult to access. This in itself creates great hardship for the significant proportion of women who are primary carers of children or other relatives. Keeping in touch with family and friends can be particularly hard, while the need to do so is often particularly strong.”
(Prison Reform Trust, 2000)

The pain of separation and the obstacles that prevent women from maintaining family ties after arriving in prison, have a damaging impact on their mental health.

1.3 Socially excluded women

Many prisoners come from a background of severe social exclusion. The Social Exclusion Unit's recently published report, *Reducing re-offending by ex-prisoners*, draws on a wide array of research findings (Social Exclusion Unit, 2002). This, with HM Chief Inspector of Prison's *Women in Prison* (1997) and the Office for National Statistics' survey of prisoners (Singleton *et al.*, 1997; O'Brien *et al.*, 2001) paint a picture of isolated, deprived and damaged women and their children.

The Social Exclusion Unit report records that almost two thirds of female prisoners are single, compared to 17 per cent of women in the general population. Forty-three per cent of the women interviewed by the ONS were living with their children immediately before coming into prison. A third of the women the HMCIP interviewed for their thematic review had one or more children under five years of age.

The Social Exclusion Unit revealed that over 40 per cent of women in prison had not worked for at least five years before their imprisonment. Only 39 per cent had any qualifications at all, compared with 82 per cent of the general population. In addition research has found that around a third of women prisoners lose their homes and often their possessions, whilst in prison.

The ONS measured intellectual functioning, using the 'Quick Test', adding that computerised data collection may have depressed the scores somewhat. The mean score for the general population is 42, equivalent to an IQ of 100. The ONS study found that 11 per cent of remanded women and 9 per cent of sentenced women had scores of 25 and below, equivalent to an IQ of 65. A child is deemed to have special educational needs if they have an IQ of 70 or below. In addition, one in five women presented Quick Test scores in the 26-30 range, some of whom also register an IQ below 70. Thus, the ONS figures suggest that a worrying proportion of women in prison (at least one in ten) may have significant problems in reading or in understanding instructions.

The ONS found that 40 per cent of women prisoners had received help or treatment for a mental health problem in the year before entering prison. Seventeen per cent stated that they had been admitted to a psychiatric hospital and seven per cent had been admitted to a locked or secure ward.

A quarter of the women surveyed by the ONS had been taken into local authority care as a child. The equivalent figure for the general population is just two per cent. HMCIP found that half the females they interviewed had suffered abuse. Of these, a third reported both physical and sexual abuse, a third reported sexual abuse and the remainder had been physically abused. Forty per cent of these women had been under 18 years old at the time and a further 22 per cent had been abused both as a child and as an adult.

More recently, the adolescent forensic mental health services at Salford NHS Trust, which accepts nation-wide referrals, carried out a study of 100 girls referred to their specialist service over a six year period. Seventy-one per cent had experienced at least one form of childhood abuse, and 56 per cent had been multiply abused. Seventy-nine per cent had behavioural disturbances in more than one major area of functioning with 25 per cent showing disturbed behaviour in all four areas of violence, substance abuse, non-violent offending and deliberate self-harm. Just under half were not attending school (Bailey, 2002).

The link between abuse and offending is complex and contentious. However it seems likely that children who grow up in deprived socio-economic conditions and/or high crime neighbourhoods, are at increased risk of both victimisation and offending (Hooper, 2003).

The prison population (male and female, adult and young offender) is disproportionately made up of people from minority ethnic groups. The proportion of women from minority ethnic groups is slightly higher than men, at 26 per cent and 21 per cent respectively. The major difference between male and female prisoners relates to their nationality. In 2001, one in ten male prisoners were foreign nationals, whereas the proportion of women foreign national prisoners was 19 per cent (Home Office, 2003a). Excluding foreign nationals, the proportion of black women serving sentences for drug offences (50 per cent) is considerably higher than that of white women (25 per cent).

1.4 Prevalence of mental disorder among prisoners

The ONS analysis of women prisoners in their survey of psychiatric morbidity (O'Brien et al., 2001) provides a comprehensive profile of mental disorder amongst women prisoners.

Symptoms of neurotic disorders were found in 66 per cent of the sample group. The comparable rate for the general household population is 16 per cent. Significant neurotic symptoms – particularly sleep problems, depression, impaired concentration and forgetfulness – were more prevalent in remand prisoners than sentenced prisoners, as were anxiety symptoms such as panic and phobias.

Fifty-four per cent of remand prisoners and 41 per cent of sentenced prisoners reported some degree of drug dependency in the year before they came to prison. The rate of heroin dependency was 40 per cent for remand prisoners and 23 per cent for sentenced prisoners. White women were twice as likely as black women to report dependence on opiates and /or stimulants. Excessive use of alcohol in the year before coming to prison was reported by 38 per cent of women.

Fifty per cent of the women who had a clinical interview had a personality disorder and 31 per cent were assessed as having an anti-social personality disorder.

The prevalence of mental health problems in the year prior to coming to prison were identified in the clinical interviews of a one in five sub-sample of women prisoners:

- any functional psychosis in the past year 14 per cent
- schizophrenia or delusional disorder 13 per cent
- severe affective disorders 2 per cent

Among white women, anti-social personality disorder was more common; among black women, there was a higher prevalence of other types of personality disorder. More white than black women were assessed as likely to have a psychosis.

The Government's Strategy for Women Offenders acknowledged the need for mentally disordered women offenders to be diverted to hospital by Magistrates' Courts.

“The Government encourages these schemes as part of promoting effective inter-agency arrangements for dealing with mentally disordered offenders. These schemes reduce substantially the use of remand for psychiatric assessment.” (Home Office, 2000)

The ONS analysis shows the extent to which, at the time of that study, attempts to divert women who had mental health problem from custody had failed. The Government says it ‘encourages’ court diversion, but the situation has not improved, as far too many people with mental health issues are inappropriately held in prison. From April 2002, central funding for diversion schemes was withdrawn, and schemes are now dependent on local funding.

The Governor of Styal Prison (where there is a dedicated unit to treat women prisoners with severe mental health problems) explained the consequences when vulnerable women are failed by services in the community and the courts fail to divert them from custody:

“We ... have a young offender who is due for release shortly: it has been accepted by the health authorities that she needs to be admitted to a psychiatric hospital. However it is unlikely she will be sectioned before her release date. Everyone working with this woman accepts that she should not be in prison. She is severely learning disabled as a result of a physical abnormality of the brain. ... We know that regardless of court diversion schemes, many like her slip through the net. They are the casualties of Care in the Community. Perhaps the courts think them to be insolent when they did not reply: In fact, when we had one of these women assessed we discovered that she had a mental age of between seven and eight.” (Moulden, 1999)

There is a wide range of services – crisis or home treatment mental health teams, in-patient units, social services, and court diversion schemes, among others – which exist in part to prevent the inappropriate use of custody for people with mental health problems. Stories such as this one from Styal and the statistics on the extent of mental health problems among women prisoners demonstrate that many women have been failed by services in the community.

This report will show that, having been failed in the community, these women are disadvantaged further by being placed in a prison system where mental health care is of a lower standard than in the NHS.

They are further penalised when prison staff fail to recognise and understand mental health and related problems – such as a learning disability – which may make it harder for the women prisoners to comply with prison rules.

1.5 The enduring problem

“A random sample of 708 women prisoners recently admitted to Holloway Prison was screened for evidence of psychiatric disorder. Of those 195 had a history of self-harm, (44 of whom had a history of cutting themselves), 125 had a history of psychiatric illness, 99 were dependent on opiates, and 89 regularly took psychotropic drugs regularly. These findings suggest ... that initiatives to alter policies of admission to psychiatric hospitals should be pursued.” (Turner and Tofler, 1986)

That survey was conducted in 1984/1985. The researchers cite similar findings from a 1971 study. The inappropriate use of Prison Service custody for women who are mentally ill is not a new problem and it applies, not only to HMP Holloway, but to the entire women’s estate.

Turner and Tofler's conclusion – that “mentally disturbed women are constantly being admitted to Holloway Prison, often because there is nowhere else for them to go” – is, shamefully, just as relevant today.

This report brings together evidence to explore the impact of imprisonment on women with mental health problems, challenging the assumption that Prison Service custody can meet their needs.

“Clearly a major question for public policy must be the extent to which prisons should be used to accommodate people with mental health problems.” (Prison Reform Trust 2000a)

1.6 Recommendations

- Resources should be invested in a range of community sentences. When the level of risk to public safety is manageable, a community option should always be the preferred option for women who offend, rather than imprisonment.
 - Government should develop its communications strategy to promote greater use of alternatives to prison by requesting that sentencers explain why they are sending a woman to prison rather than using other penalties in the community.
 - Drug Treatment and Testing Orders should be targeted to meet the specific needs of women offenders. The National Treatment Agency should expedite its plans to create a gender-specific (or specialist) drug treatment service for women in the community.
 - Early intensive, community-based services for girls and young women with mental health problems at risk of offending are needed.
 - Government should require all courts to have a diversion scheme which is properly resourced and integrated with local psychiatric services.
 - Concerns among sentencers about mentally disordered defendants who need medical remands and disposals but for whom there are no hospital beds should be addressed. The Draft Mental Health Bill should be amended to facilitate this (see Appendix 2).
 - Adequate information should be presented to the courts in each case documenting mitigating factors, giving evidence of mental health problems (if any), outlining options for punishment and rehabilitation in the community, and the specific social and economic impact imprisonment would have in each individual case.
 - The National Probation Service should prioritise the reduction of offending by women. In partnership with statutory health services and the voluntary sector, NPS should develop a range of appropriate accommodation and supervision and support centres with integrated mental health care.
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2. Women's experience of prison

In this section we consider the impact of the prison environment on women, including their arrival in prison reception, contact with families, issues of safety, and prison discipline.

2.1 Reception

Reception is a critical time for assessing the mental health of women and identifying those at risk. Prisoners often arrive at their destination prison late in the day. They may not have had adequate food and drink during long drives across the country, between different courts and prison establishments. Prisoners on regular medication may not have received this due to poor communication between agencies. It is not unusual for prisoners to arrive with no information about their health. The Chief Inspector of Prisons has expressed concern about the inadequate information provided to the receiving prison about the offender. This is often too little to assess a prisoner's level of risk.

“Reception staff in local prisons regularly tell us that they may receive prisoners simply on a warrant: it is rare for them to have full details of the offender and offence, previous convictions and pre-sentence reports. All too often, they are reduced to asking the prisoner him or herself whether they are a risk, or at risk. ... This gap [in information] needs to be closed if prisoners are not to be a risk to themselves, other prisoners or staff.” (HMCIP, 2002a)

Staff rotas and staffing levels are not necessarily sympathetic to the uncertain and late arrival time of new prisoners. At the critical point of reception there is a need for medically and psychiatrically trained staff to be working with the prisoners.

“On arrival, all new reception prisoners were seen by a nurse and then by a doctor the following day, in line with the Prison Service Standards. However, because there was no doctor in the prison in the evening, many women spent a very uncomfortable night withdrawing from drugs or because of mental health problems.” (HMCIP, HMP and YOI Brockhill, 2001)

The Prison Service has initiated trials carried out by the Department of Forensic Psychiatry at Newcastle University for a new screening tool to be used in reception to identify, amongst other things, those prisoners who are at risk to themselves. The intention is to identify, reasonably quickly, those who require further assessment or referral. Eastwood Park and New Hall, female remand prisons containing both adult women and women aged 16-21 years, were included in the 10 pilot prisons. Only 14 per cent of the adult women prisoners and four per cent of the under-21 women screened negative, requiring no further immediate assessment or referral. Of the sample of 194 women, 46 per cent had identified mental health needs and 67 per cent required treatment for substance use. Half of the 16-21 year old women had identified mental health needs and an equal proportion required treatment for substance misuse.

A report on the pilot by the Department of Psychiatry in Newcastle recommended:

- protocols for managing the health needs identified by the initial health screen should be developed locally but final protocols should be agreed by the Prison Health Task Force;
 - there should be a core team of staff responsible for reception screening; and
-

- formal staff training should be compulsory for staff carrying out reception screening. (Grubin, Carson and Parsons, 2002)

In response to the findings, Prison Health Care is working on a Reception Screening Prison Service Order likely to be issued in Autumn 2003. Pressures of prison overcrowding and the exceptional level of movement from one establishment to another make it difficult to carry out reception procedures. Local prisons on average replace half their population every month whilst some of them "turn over" the entire population every month (Safer Custody Group, 2002e). The disruptive movement of prisoners, alongside overcrowding, is likely to militate against realising the full benefits of improved identification and better management.

***"You just feel like a catalogue delivery, like you're nothing. 'Here's your delivery' that's it and you're just given a number ..."* (Young woman prisoner, Lyon et al., 2000)**

2.2 The first night in custody

Entering the prison system is distressing for any person but particularly so for women who have primary child care responsibilities. Most women, especially those on remand, are unprepared for the realities of prison life.

***"I unexpectedly found myself in Holloway prison. I arrived there in an emotional state having spent the weekend in a police station and consequently in the court on the Monday morning. Overnight my life had changed, and more importantly the life of my 14 year old daughter who I was very close to. I was undoubtedly distraught and really did not understand what was happening. ... my pain was caused mainly by the separation from my daughter, the pain, the worry, the 'uselessness'. To suddenly worry who would care for her, to not be there to check she was okay, the fear of her getting public transport, not being able to contact her on many an occasion. Phoning to find she is not in from school, imagining the worst, then being locked up so I can make no further phone call."* (Former prisoner)**

The First Night in Custody project run by the Prison Advice and Care Trust was established to respond to the very high levels of anxiety women experience at the time of reception into prison. Although many women display high levels of depression and anxiety when coming into custody, few admit to having mental health problems. The Revolving Doors Agency surveyed 1400 women who had drawn upon the services offered by the First Night in Custody project. Most presented mental health needs that required specialist services. The women's emotional distress was aggravated by the pain of separation from, and lack of information about, their children.

***"Fifty-five per cent of women in prison for the first time displayed symptoms of a mental health problem. The majority, 631 women, were suffering from depression. Seven per cent of the total had multiple mental health problems."* (Revolving Doors Agency, 2002)**

***"Mental health can be further damaged by women's anxiety over the safety of their children. Forty-two women in Holloway had no idea who was looking after their children. Nineteen children under 16 were looking after themselves."* (Revolving Doors Agency, 2002)**

Women offenders who have been misusing drugs also have a difficult time as they enter prison.

“The initial services offered to women who had recently arrived and were withdrawing from substance abuse were unco-ordinated and not meeting their needs. We were told that women were given little support on their first night, particularly late arrivals. We saw a woman who was withdrawing from drugs walking into the dining room. She was being supported by another woman who was concerned for her. Whilst we were talking to this woman, she had a minor attack of stomach cramps and then vomited. We were told that this happened frequently as there was no co-ordinated strategy for dealing with them.” (HMCIP, HMP Eastwood Park, October 2001)

‘Insiders’, a new support scheme for the first 24 hours in custody, has been developed by the Safer Custody Group. Selected prisoners are trained to provide reassurance and basic information to new receptions shortly after they arrive in prison. Three women’s prisons were included in the pilot sites: Brockhill, Durham, and New Hall. The results of the evaluation showed that the scheme had had a positive impact on prisoners’ early experience of custody (Safer Custody, 2003). Given these heartening results, the scheme should be extended.

2.3 A safe environment?

Interim results of the ‘Safer Locals Evaluation’ being carried out for the Safer Custody Group by Dr Alison Liebling, Institute of Criminology, Cambridge, show that levels of psychological distress vary according to prisoners’ perception of safety. Their fears can arise from negative experiences of the induction process, feeling alone during the first few days of custody and experiencing anxiety about the possibility of victimisation (Safer Custody Group, 2002e).

Recent Prisons Inspectorate reports on five women’s prisons confirm that, for many women, prison life is an intimidating experience. The following figures are based on the Chief Inspector’s prisoner surveys in Eastwood Park, Highpoint North, Holloway, Low Newton and Styal.

Percentage of women who said they felt unsafe in the prison ‘sometimes, often or most of the time’	
Eastwood Park Adult	40
Eastwood Park young women	19
Highpoint North	31
Holloway	46
Low Newton	16
Styal young women	22
Styal adult	20

These levels of fear were, to some extent, matched by the women’s experiences of victimisation in prison. For example, one-third of the women in Holloway said they had been insulted, while one in five women had the same experience in Eastwood Park, Highpoint North and Styal. Ten per cent in Holloway and Highpoint North said that they had been hit, kicked or otherwise assaulted; the rate in Eastwood Park and Styal was half that, and none at all were reported by the women in Low Newton. In four of the five prisons, over ten per cent said that other women had taken their personal property by force. More than one in ten of the women surveyed in Holloway and Styal said they had been subject to racial abuse from other prisoners. (HMCIP: HMP Eastwood Park, 2000, HMP Highpoint North, 2002, HMP Holloway, 2002, HMP and YOI Low Newton, 2001, HMP and YOI Styal, 2002.)

The ONS (O'Brien *et al.*, 2001) used a self-report measure of prisoners' experience of victimisation during the current prison term. Nearly half (46 per cent of sentenced women and 41 per cent of remand prisoners) reported experiencing some victimisation whilst in prison. The most common was property being stolen, followed by threats of violence and receiving unwanted sexual attention.

Official statistics, while an imperfect gauge of victimisation, also raise concerns about the safety of women in prison. Levels of reported offences in prison are recorded as the number of punishments per 100 prisoners. Punishments for violence include offences committed against staff and other inmates. In the past ten years, the rate of punishments for violence among adult women has ranged from a low of 23 to a high of 40 per 100 prisoners. The rate of recorded offences for violence by young women (under 21 years old) has been approximately twice as high as adult women, as the rate in 2001 was 79 per 100 population (Home Office 2003a).

Overcrowding undermines efforts to create a safe environment for women prisoners. Good relationships between staff and prisoners based on trust and understanding cannot be made and sustained with ever-increasing numbers of women entering the system and moving between prisons in order to accommodate new arrivals.

2.4 Maintaining family contact

Article 8.1 of the Human Rights Act (1998) states:

"Everyone has a right to respect for his private and family life, his home and his correspondence."

It is widely recognised by all agencies including the Prison Service that prison visits not only prevent further re-offending but are essential to maintain the prisoner's mental well-being. They are also vital for the families and children on the outside. HM Prison Service Standing Order Five states:

"It is one of the roles of the Prison Service to ensure that the socially harmful effects of an inmate's removal from normal life are, as far as possible, minimised and that his contacts with the outside world are maintained. Outside contacts are therefore encouraged between an inmate and his family and friends."

Yet many visitors' centres face critical funding shortfalls. Families can experience frustration in arranging visits and may feel humiliated and upset by the attitude of staff and conditions of the visit (Loucks, 2002). The Chief Inspector's Annual Report for 2001-2002 reveals that the number of visits has dropped although the number of prisoners continues to rise (HMCIP, 2002a).

Recent research in HMP Holloway, shows that only 35 per cent of a sample of prisoners on reception were from London. The majority were from Sussex and Hampshire with some from Devon, Dorset and Cornwall; five per cent were from the Midlands (Revolving Doors Agency, 2002). A third of the Holloway population surveyed by the Chief Inspector had not received a visit from family and friends throughout their sentence (HMCIP, HMP Holloway, December 2000).

For years, Holloway had facilitated family day visits to enable mothers to spend a decent length of time with their children. But early in 2002, these were suspended, due to staffing difficulties. They have yet to be re-instated.

A Qualitative Analysis of 30 Senior Investigation Officer Reports into the factors that combine in reports of deaths, identified the huge emotional significance attached to visits, planned visits that don't happen, painful visits and telephone calls (HM Prison Service, 2002d).

A reduction in family contact was one of the main effects documented by over 100 Boards of Visitors in a study of prison overcrowding produced by PRT and the National Association of Boards of Visitors (Levenson, 2002).

“For women prisoners the lack of contact with their children can be very distressing.” (Drake Hall Board of Visitors, Letter to PRT)

“Family visits are non-existent for some mothers because of the distance relatives have to travel.” (Askham Grange Board of Visitors, Letter to PRT)

“The question also arises of remands being sent to Suffolk from as far away as Shrewsbury and Bournemouth. Quite unnecessary, or certainly unjust, suffering is caused by women on remand being sent so far from their families.” (Highpoint Board of Visitors, Letter to PRT)

2.5 Prison discipline

Is there a relationship between the imposition of sanctions as a result of disciplinary offences and the mental health of women in prison?

Women prisoners are charged with offences against discipline at significantly higher rates than men. In 2001, there were 224 offences per 100 women prisoners compared to 160 per 100 for male prisoners (Home Office, 2002). In the community, offending is overwhelmingly committed by males. Although it is difficult to explain why women are more likely to be punished via prison discipline, high rates of mental health problems are likely to be a contributing factor. It is also possible that the regimes in women's prisons are more demanding than for men's prisons, with punishments being handed out for relatively trivial misdemeanours such as breaching prison dress code and eating too slowly (Devlin, 1998). Perhaps women, worried and preoccupied by problems at home, are less able to adjust to prison rules than male prisoners.

The ONS analysis (O'Brien *et al.*, 2001) provided evidence that women with mental health problems are particularly likely to be disciplined. For example, in total, one-third of sentenced women had some encounter with the disciplinary system; over a quarter had been punished with added days (a sanction which is no longer used), and just under one-quarter had been punished with cellular confinement in a segregation unit. Women held in cellular confinement were more likely than others to have shown evidence of psychotic illness in the past year. Women with evidence of anti-social or other personality disorders were three times more likely to be punished with cellular confinement (Ibid). Women with histories of drug and alcohol misuse were also more frequently charged with disciplinary offences.

Attempted suicide, while not in itself a psychiatric disorder, reflects some degree of mental distress. Suicide attempts in the past year were reported more frequently among women who had received either added days or cellular confinement. Those punished three or more times were also more likely to have attempted suicide in the last year than those punished once or twice.

“I got me head down. I were getting on with it and then I says to them, ‘I feel like cutting up’. They did nothing to help me. I went to me room. I got a glass jar. I cut up. The day after I got nicked for having the glass.”
(Young woman prisoner, cited in Lyon et al., 2000)

A Chief Inspector of Prisons Report on HMP Eastwood Park illustrated that women and girls with mental health problems are frequently subjected to discipline (formal and informal) as a means of controlling their behaviour:

“Because of the absence of proper mental health support, some very disturbed young women were segregated in cellular confinement: one 17 year old had spent almost all of her 60 day sentence under these conditions”.
(HMCIP Report, Eastwood Park, October 2001)

In her inspection of HMP Brockhill, the Chief Inspector found that, “those who were already suffering from mental illnesses and those who were at serious risk of self-harm were often held in the Segregation Unit” (HMCIP, HMP Brockhill, 2001). Further:

“The Segregation Unit was in fact used for women prisoners who would be held in Health Care accommodation in most other local prisons. Indeed, in some cases, prisoners were frequently held there who arguably, because of their mental illnesses, should not have been in prison at all but in psychiatric facilities where staff were better trained to deal with them”. (Ibid.)

There is therefore some evidence that prison disciplinary measures, including removal from normal location, are sometimes used inappropriately to control damaged women whose levels of distress and /or underlying mental condition make it hard for them to cope with prison routines. Many of these women should not be in prison, but assessed by diversion schemes to find the most suitable regime to address their mental health needs and take into account the low risk they pose to the community.

2.6 Recommendations

- A First Night in Custody project should be set up in all women's local prisons, managed by a voluntary organisation, working in collaboration with the Prison Service.
- Family caseworkers should be used to complement the work of the First Night in Custody project. This would help to reduce anxiety over loss of contact with children and family.
- The liaison between the First Night in Custody project and the Listener/Befriender schemes should be encouraged, because the latter is a valued source of advice and information and is independent of the Prison Service. The Insider scheme should be extended to all prisons.
- Professionally trained staff should conduct thorough screening for mental illness and the process for referring women to a secure health setting (preferably single sex) should be streamlined.
- All new arrivals should be assessed for their need for detoxification at the time of their arrival. They should be provided with detox services if they need it. This should be followed up by ongoing drug treatment and support.

- Distance from home must be reduced, preferably by establishing smaller, local women's units with multi-disciplinary support services.
 - The Prison Service should give urgent attention to the needs of visitors' centres for long term planning and secure funding of day-to-day running costs. Every prison should have a well-resourced and staffed visitors' centre with facilities for prisoners' children.
 - The Prison Service should review the use of disciplinary measures against women with mental health problems and incorporate awareness of mental health into its policies for discipline and control.
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3. Suicide and Self-injury

This section describes the extent and nature of self-harm and suicidal behaviour in prisons for women. Despite the best efforts of individual staff and despite the initiatives of the Safer Custody Group, overcrowding undermines the ability of the Prison Service to provide a decent, safe environment in which women are less at risk of harming themselves. And, as this report argues, prisons are often ill-equipped to respond to the particular needs of women with mental health problems.

3.1 Self-injury

Self-injury is a distressing and complex issue. Unfortunately, it is very difficult to measure the extent of this behaviour: Self-injury is often hidden from staff and other prisoners. A second difficulty is the problem of definition: what staff count as self-injury may vary from prison to prison.

Official figures on self-injury among prisoners probably under-estimate the scale of the problem, but we do not know by how much. Lacking a robust measure, it would be difficult to say whether self-injuring behaviour is increasing. What is more, a wide range of behaviour can be seen as self-injury, encompassing, for example, scratching one's forearms, a botched attempt to self-administer a prison tattoo, a refusal to eat, and attempting suicide through hanging. In gauging the extent of self-injury, it is crucial to take into consideration both the number of women who engage in the behaviour and the severity of the harm inflicted.

Form F2052SH is used by prison staff to identify prisoners at risk of self-harm. The Prison Service Safer Custody Group has identified problems with its usage. It:

- has been used in different ways by prison officers and the prison escort services;
- lacks the capacity to distinguish between persistent low-severity self-harm and serious attempts at suicide;
- leads to a reactive approach, opening F2052SH forms only after a prisoner has self-harmed;
- is under-used, giving a misleading impression of the prevalence of self injury.

(Safer Custody Group, 2003a)

Since November 2001, ten prisons have been involved in a pilot project, working with a new form, the F213SH. Data gathering on the use of the new form suggests that it will provide more accurate measures of self-injury in prison. The pilot was evaluated by staff from the Safer Custody Group. Two women's prisons were included.

A preliminary analysis of the pilot project has found much higher levels of self injury than previous research had revealed. However, the findings need to be interpreted with caution, as they are based on a limited sample of prisoners over a relatively short (ten-month) period.

- 33 per cent of the average daily population of female establishments in the sample injured themselves, which is equivalent to 21 per cent of the women passing through those establishments during that period.
 - Over half of these women injured themselves more than once and 14 per cent did so on at least ten separate occasions.
 - Women were shown to be almost eighteen times as likely as men to injure themselves.
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- Women were shown to be almost seven times more likely than young offenders to injure themselves.

(Snow, Greenaway and Paton, 2003)

The evaluation of the pilot project echoed other research in suggesting that much self-harm results in minor, not life-threatening, injuries. Snow *et al.* found that 40 per cent of the self injury incidents did not require any further medical treatment. When prison officers rigorously record every incident of self-harm, their efforts convey to prisoners that their behaviour is being taken seriously. Recording every incident may give the impression that self-harming behaviour is more widespread than previously believed. However, this is preferable to a more restricted criteria, which might record only those incidents that required the attention of a Medical Officer. The latter approach would imply to officers that they do not have to be vigilant about every case of self-harming behaviour. It would suggest to prisoners that, if they want to gain the attention of staff, they will have to inflict a serious injury.

In these ways, a period during which the recorded rates of self-harm are high may actually signify improvements in the way prisons respond to the problem of self-injury. Higher rates of reported incidents may also indicate that prisoners are becoming more confident that their self-harming behaviour will be received in a caring and supportive way.

3.2 Understanding and responding to self-injury and distress

There is frequently a lack of understanding of self-harm behaviour by staff who are rarely trained or supported to deal with this extremely challenging problem. The culture of the wider staff group can militate against sympathy for these women who are sometimes regarded as a nuisance and attention seeking. The Prison Service response has traditionally been to prevent self-harm by removing items likely to be used by women. However, the reality is that many of these women have self-harmed prior to coming to prison and continue to do so as a way of coping with their distress and pain.

The Howard League for Penal Reform recently published a report, 'Suicide and Self-Harm Prevention'. The Howard League states that all of the women prisoners they interviewed had used self-harm as a way of coping prior to imprisonment (Howard League, 2003).

The ONS report found that 89 per cent of the women who said they had self-harmed without suicidal intent had done so to relieve unpleasant feelings of anger, tension, anxiety and depression. Over half said they had done so to draw attention to their situation and to change it (O'Brien *et al.*, 2001). Ironically, when self-harm is employed as a coping strategy, denying that person any opportunity to self-harm (in the absence of intensive support) might add to their desperation. There is evidence that the methods of self-harm used by prisoners are more lethal than those they would use in the community (Towl *et al.*, 2000).

The ONS report again highlights links between mental health problems, post-traumatic stress and self-harm (O'Brien *et al.*, 2001). Women prisoners were asked about their experience of stressful life events which might adversely affect their mental health such as a child or partner's death, sexual abuse, serious life-threatening illness or injury. Over 97 per cent had experienced at least one of these stressful events and about half the sample had experienced five or more. The events most commonly reported by women were violence at home and sexual abuse. Post-traumatic stress was linked to a significantly higher risk of self-harm than for those without such experiences. Rates of self-harm ranged between 17 and 25 per cent for those who had exhibited symptoms of post-traumatic stress.

The ONS analysis also found links between self-harming behaviour and mental health

problems. Over a third of women assessed as having a probable psychotic disorder reported self-harming without suicidal intent. Only one in ten women without such a disorder had reported self-harming. There was a significant relationship between many of the neurotic disorders and the prevalence of self-harming. Prisoners with a generalised anxiety disorder, depressive episode, or phobias showed a higher prevalence of deliberate self-harm than those with no disorder present (O'Brien *et al.*, 2001).

ONS data (O'Brien *et al.*, 2001) and previous studies (Liebling, 1992; Maden, 1996) have linked deliberate self-harming without suicidal intent to alcohol problems. Thus there is an urgent need for services for women who misuse alcohol, which has yet to be identified in the Prison Service strategy (HMCIP 2002a).

Since 1992, The Bethlem and Maudsley Hospital in London has worked with people who repetitively self-harm, using therapeutic strategies. The approach is compassionate and non-punitive, viewing self-harm as symptomatic of some greater distress. Abstinence is not imposed by coercion; rather, residents are encouraged to understand themselves and take responsibility for the choices they make. "Our therapeutic aim is to enable individuals to develop alternative, more healthy ways of coping and of gaining a better understanding of themselves" (Crowe and Bunclark, 2000).

A consistent theme voiced by women interviewed by the Howard League was that the prison system never asked them about what they wanted or what would make a difference in terms of the seriousness or frequency of their self-harm.

“One woman in her 30s told us that she had been in and out of prison since she was 15 years old and no-one had ever asked what she wanted in terms of self-harm, but she added, ‘they’ve told me enough times.’” (Howard League, 2001)

3.3 Self-inflicted deaths in custody

In the wider community, a far greater proportion of males take their own lives than females, one study estimating that men were 2.5 to four times more likely than women to commit suicide (Sattar, 2001). Yet, in prison, the gender imbalance is reversed:

“The self-inflicted death rates for prisoners in 2000 were 199 per 100,000 for males and 239 per 100,000 for females, and in 1999 were 140 per 100,000 for males and 154 per 100,000 for females.” (Ibid)

Sentencers should be fully aware that women prisoners are between 16 and 40 times more likely to die by suicide than women in the general population when adjustments are made for confounding factors such as age and gender. Inquest has published on-line its data on the number of self-inflicted deaths among women prisoners (1992–2002):

Statistical Information

		Deaths in Prison (England and Wales)						Deaths of Women in Prison				
Year		1992	93	94	95	96	97	98	99	2000	01	02
Frequency		1	1	1	2	2	3	4	5	8	6	9

(Inquest, 2003)

These data show a steady increase over the past decade of a problem that seems to have overwhelmed the Prison Service. The nine self-inflicted deaths of women prisoners in England and Wales in 2002 were the highest ever recorded. But by the end of June 2003, ten women in prisons in England had taken their own lives. Four were under 21 years old, suggesting a level of risk for this age group which is disproportionate to their numbers in the female prison population.

A study by Nicola Mackenzie, Chris Oram, and Jo Borrill reported that:

“Between 1996 and 2001 there was an increase of 67% in the female prison population but an increase in self-inflicted deaths of 200%, although it is important to be cautious in interpreting small numbers.”
(Mackenzie *et al.*, 2003)

Research has identified links between mental distress, the prison setting, and suicide. For example, the ONS analysis cites a 1999 study by Meltzer *et al.* that found high proportions of women in prison having had suicidal thoughts. The ONS study states ... “59% of remand prisoners had thought of suicide in their lifetime, 50% in the past year, and 23% in the week prior to the interview. Women, both sentenced and remand, reported higher rates of suicidal thoughts and suicide attempts than their male counterparts.” (O’Brien *et al.*, 2001)

It is shocking that one-quarter of the women on remand said they had considered suicide in the week prior to their participation in the research. The high proportion of women prisoners who consider suicide while they are in custody strongly suggests that prisons are ill-equipped to respond to the mental health needs of prisoners.

Risk factors associated with committing suicide in prison include: having a personality disorder; psychoses or severe neurotic symptoms (for example, depression, anxiety, phobias or obsessions); receiving psychiatric treatment before prison and inside prison; dependency on stimulants or stimulants plus opiates; having a history of severe alcohol misuse; having a limited social network; having been placed in local authority care as a child; having experienced numerous adverse life events; or being located in a healthcare unit, segregation unit or vulnerable prisoner unit (Meltzer *et al.*, 1999). We have noted that these risk factors are present in significant numbers of women offenders.

Research has also explored in depth the lives of a sample of women prisoners whose deaths in custody were self-inflicted. Mackenzie *et al.* (2003) collated information about 33 women who had taken their own lives in custody between 1992 and 2001. They found a combination of factors had led these women to suicide, including the type of prison, the influence of problems such as drug dependency and depression, loss of contact with loved ones, and constant relocation within the prison.

Mackenzie *et al.* studied the background of 13 of these 33 women in depth (the case study group). The case studies document the multiplicity of problems women prisoners must manage; and the efforts that prison staff need to make to support these women.

Reading about the circumstances in which these self-inflicted deaths took place, it is difficult to believe that the imprisonment of these women with mental health and social problems was either necessary for public safety or appropriate to meet their needs for support, care and treatment. For example, one of the 13 women:

“... had a record of 60 previous convictions from when she was 13 years old such as offences against the person, property, theft, public disorder, and drugs. Her current charge was for stealing goods worth £9.95 from a shop. She had served previous custodial sentences. (She was 22 when she died.)” (Mackenzie et al., 2003)

Although she had committed violent offences in the past, the immediate reason for her being sent to prison was for a theft of less than £10. Previous research suggests that offenders sentenced for violent offences have a higher than average risk of suicide, yet many of the 33 women whose circumstances were studied by Mackenzie et al. were imprisoned for non-violent offences and one in three had been charged with (or convicted of) theft and handling stolen goods.

One of the women in the case studies had been remanded into custody because she had breached a condition of bail – i.e. she had missed an appointment which had been booked with a consultant psychiatrist to assess her mental health. Mackenzie et al. comment, ‘No further steps [to conduct the assessment] had been taken whilst she was in custody.’ (Mackenzie et al., 2003)

These stories suggest that prison was not the answer to the offending patterns of these women. But even more striking is the evidence that prison is not an adequate or appropriate setting for managing the mental health problems exhibited by these women and others like them.

Consider the circumstances of another woman’s last four days. Staff recognised the risk of serious self-harm (as indicated by their use of the F2052SH form). However, despite their use of physical restraint, close surveillance, and their removal of possible weapons, prison staff were unable to prevent her suicide. Mackenzie et al. record that this woman:

“... had three F2052SH documents opened during her time in custody, resulting in her spending 153 days out of 166 on F2052SH. She had 37 reported injuries, mostly self-harm, during this period. The first F2052SH was opened because she had cut herself within five days of being sentenced. She said that she was fed up and not coping, that no one listened to her, and that it helped when she cut herself. ... During her last four days, [she] reopened old scars, set fire to her bedding, allegedly cut her leg with a piece of metal, and was found with a ligature around her neck. She assaulted an officer who was trying to remove the ligature, and was moved using control and restraint techniques to another cell, where she cut herself with a piece of glass she had hidden on her body. She hid behind the privacy screen and would not answer staff so she was moved to the segregation unit, into a ‘safer’ cell which contained cardboard furniture in order to give her, staff and prisoners on her wing a rest. It was in this cell that she died.” (Mackenzie et al., 2003)

A Safer Custody Group report, drawing on statistics from 2001, detailed the greater levels of risk faced by male and female remand prisoners and those in the early stages of their sentence (Safer Custody Group, 2002a). Entry into the prison system is stressful, particularly when it involves forced changes in relationships with families. Further, local prisons must manage a high throughput of people, and may be less able than more stable prisons to respond to personal problems. Like men, women’s deaths are most likely to occur in the prisons in which they are initially allocated. A study published in 2000 found that eight per cent of self-inflicted deaths took place in the first day of custody; 26 per cent in the first week; and 42 per cent in the first 28 days of custody (Marshall et al., 2000).

Overcrowding is a contributing factor. A small but statistically meaningful correlation was found between increased through-put and an increased rate of self-inflicted death. Levels of overcrowding in a group of local prisons were associated with a higher rate of self-inflicted death despite the fact that overcrowding meant more prisoners shared cells (a protective factor).

On any one day, prison staff are called on to support some 1,200 prisoners identified as being at risk of suicide (HM Prison Service, 2002d). However, only about a quarter of the prisoners who died had been identified as being at increased risk of suicide at the time of their death. The Safer Custody Group Annual Report presents the proportion of prisoner suicides who were registered as 'at risk' on the Prison Service form F2052SH at the time of their deaths. In the years 2000-2001, 26 per cent of prisoner suicides had been on an open F2052SH; in 2001-2002, it was 29 per cent; and in 2002-2003, the proportion was 26 per cent (Safer Custody Group, 2003b).

The difficulty of predicting which prisoner is at risk can be met in part by improving staff practice in documenting risk (for example by extending the use of the new form) so that people at risk are targeted more effectively. However, in some ways a more 'joined up' and pro-active approach is needed. Methods of predicting self injury and suicidal behaviour will always be inexact.

The Listener schemes, where specially selected prisoners can be put in touch with prisoners who are showing signs of distress have undoubtedly contributed to suicide prevention in prisons and are to be applauded. Unfortunately it is particularly difficult to retain Listeners at local prisons, where prisoners are at greatest risk, because of the management need to relocate prisoners to cope with overcrowding.

Stephen Shaw, Prisons and Probation Ombudsman, in his address to the seventh annual Joint Prison Service/Samaritan's conference in June 2002, focused on the "things that cost nothing, matter a lot and which seem so hard to deliver". The examples he gave were showing respect for prisoners and their property, avoiding casual use of swear words, calling prisoners Mr or Ms and saying sorry when something went wrong. The provision of phonecards, tobacco and a radio or television to every prisoner on their first night in custody, raising the private cash limits, ensuring meal times were at proper times and making prisons welcoming places for families to visit were of vital importance both to the decency agenda and for suicide prevention (Safer Custody Group, 2002b).

3.4 Investigating deaths in custody

A qualitative analysis of 30 Senior Investigation Officer Reports (HM Prison Service 2002c) found that problems in mental health provision played a part in about eight of the 30 prisoner deaths (a conservative estimate). The identified difficulties related primarily to health care accommodation, staffing levels, skill levels and access to specialists. Health Care staff often faced serious shortfalls in the resources they had available to treat very challenging and complex problems.

With the implementation of the Human Rights Act 2000, the Prison Service, alongside other agencies such as the police, has faced an increasing number of calls for independent investigations into deaths in custody in accordance with Article 2 of the European Convention of Human Rights. Article 2 not only protects the right to life but also requires an 'independent investigation' into the death of any person in the care of the state. A recent Appeal Court judgement confirms that the current systems in place for investigating a death in custody are sufficient, if properly followed, to satisfy the requirements of Article 2 (Safer Custody Group, 2002c).

However, there are two key areas where the Prison Service may be deficient in respect of the requirements of Article 2: firstly, the quality of the reports, which should be detailed, thorough, and if necessary critical of the establishment and secondly, the need for greater involvement of the next of kin in the investigation. Legitimate family concerns need to be addressed.

PRT welcomes current efforts to establish a mechanism for the independent investigation of deaths in custody.

3.5 Safer Custody strategy

The Safer Custody Group was established in April 2001 to deliver a new Safer Custody Strategy. The Group has a broader agenda than the Suicide Awareness Support Group which it replaced. One of its main tasks is to develop a revised suicide and self-harm prevention policy and to communicate and work with other agencies. A Research and Training Group, amongst other things, analyses deaths to ensure that lessons are learnt. A Safer Prisons Group develops safer environment design standards, a local prisons programme and use of technology to help suicide prevention. The Violence Reduction Unit is also developing a new strategy to reduce violence.

The Safer Custody Strategy is in the process of being refined. However, its general direction is:

- to move from awareness to prevention;
- to invest more resources where the risks are highest;
- to provide a better physical environment for prisoners (particularly when first received into custody);
- to provide more training in mental health and suicide prevention for front line staff in particular;
- to develop better interventions for the management of repetitive self injury;
- to increase numbers of prisoner Listeners in high risk prisons; and
- to develop better links with other agencies in the criminal justice system.

The Safer Custody Group is advocating a pro-active approach, focusing on specific areas of prison practice (rather than on targeting individual prisoners) to improve the services provided. For example, in the context of the known risks associated with drug dependence and mental health, one of the proposals for Safer Local Prisons is clinical management of substance misuse in a dedicated unit.

A new Prison Service Order, 2700, on Suicide and Self-harm Prevention, was published in November 2002 (HM Prison Service 2002a). PSO 2700 replaces previous guidance with mandatory requirements. The new PSO is to be welcomed and should provide for safer, healthier and more decent prisons provided increased prison numbers do not undermine the best efforts of prison staff.

3.6 Recommendations

- The most recent figures on suicide of women prisoners and self injury by women prisoners give great cause for concern. Gender specific suicide and self-harm figures should be reported to Parliament and monitored by the Women's Estate Policy Unit as well as the Department of Health.
- The courts should be alerted to the high levels of suicide risk and advised of options for diverting women from custody.

- Given the positive feedback concerning the new self-harm form F213SH, implementation of that form should take place in all prisons.
 - Communication between staff groups needs to be improved, in particular between health care and the residential staff when an individual is discharged from health care to ordinary location, and between health care staff and discipline staff regarding risk factors.
 - All staff should have training in the multi-disciplinary approach to suicide prevention. Staff need more training to recognise objective risk factors, in addition to listening to what the prisoner says about her feelings and intentions, and to understand that observation should be used as an opportunity to interact with a distressed prisoner.
 - Even if the Prisons and Probation Ombudsman is asked to investigate whether a death is self-inflicted or not, the internal procedures should be strengthened. Investigations need to be more uniform with terms of reference which include compliance with relevant mental health standards, such as the National Service Framework, as well as compliance with suicide prevention policies and procedures. (Department of Health, 1999a; see Appendix 1).
 - Liaison and communication with family members who are concerned about the mental health of a prisoner or where there has been a self-inflicted death, need to be improved.
 - The Prison Service should listen to what women prisoners who self-harm say they need to cope more effectively, and it should implement changes where possible. The Home Office should consider commissioning further research to explore the background circumstances that lead to self-injury and self-inflicted deaths in prisons. Part of the remit of such research should be to examine the possibility that other institutions are more appropriate to manage the needs of prisoners who harm themselves.
 - The Prison Service should develop a strategy for women who misuse alcohol.
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4. Mental health care

The number of women entering prison with serious health care needs is increasing. This presents a huge challenge for the Prison Service, which cannot, like services outside, refuse to admit a woman on the grounds that there are no available beds, insufficient trained staff, inadequate facilities, or because her diagnosis does not warrant admission.

A series of reports from the Home Office (1964), House of Commons (1986) and the Royal College of Physicians (1992) have documented the chronic deficiencies in recruitment and training of prison doctors. In addition, Reed and Lyne (2000) reveal that in the 13 prisons they inspected, no doctor providing healthcare of inpatients had completed specialist psychiatric training, only 24 per cent of nursing staff had mental health training, and almost one-third of staff were in fact non-nursing trained health care officers. Most prisoners were unlocked for about 3.5 hours a day and none for more than nine hours a day. Reed and Lyne concluded that the services for mentally ill prisoners fell far below the standards of the NHS.

The unacceptable gap between the complex needs of women prisoners and resources provided by the Prison Service is detailed below, in the use of medications, the provision of treatment, special needs of substance misusers, consent to treatment, acutely ill women in prison, and quality of care.

4.1 Medication

A higher proportion of women prisoners than men enter prison with mental health problems. Given the stresses of concerns about their families, their housing and finances, and the risk of victimisation inside, it is not surprising that the mental health of many women deteriorates while in prison.

The ONS survey reveals that at the time of interview, half of the women were being prescribed one or more forms of medication acting on the central nervous system (CNS). Twenty-two per cent were using anti-depressants, one in six were taking hypnotics or anxiolytics and one in ten were being prescribed anti-psychotic medication. Women on remand were more than twice as likely as sentenced women to be prescribed hypnotic and anxiolytic medication. They were also more likely to be prescribed anti-psychotic medication (14 per cent) than were sentenced women (eight per cent) (O'Brien *et al.*, 2001).

Women's use of medication increases further during a period of custody. In the ONS sample, only 17 per cent of women had been taking CNS medicines before coming into prison, whereas half had been prescribed them while in prison (O'Brien *et al.*, 2001). A Chief Inspector of Prisons report on HMP Holloway found that 90-95 per cent of the prisoners were on psychotropic medication; mainly benzodiazepines (HMCIIP, HMP Holloway, 2001). The Revolving Door Agency estimated that of the two-thirds of women in Holloway who were not taking medication for stress, anxiety or depression when they entered prison, at least 90 per cent would have taken tranquillisers by the time they left (Revolving Doors Agency, 2002).

There is anecdotal evidence that this increase in medication is not a result of careful exploration of the mental health needs of women in prison but rather a response by under-trained staff who resort to medication to contain a 'problem'. Some of these medications are addictive and have unpleasant side effects, and would normally be prescribed outside prison only after careful professional judgement, and with proper supervision. Yet, in prison, they are given to women who are not in the best position to challenge their use.

“I was undoubtedly distraught, and really did not understand what was happening. Arriving at Holloway made things no clearer and immediately I was put on medication, later finding this to be Melleril, Zimovane, and Librium. ... The pain inside became so very intense, that on many occasions the only way I could stop this would be cause myself physical pain. I would bang my head on a radiator until my forehead, eye and cheeks were a mass of bruises ... I would be given more medication. Valium, Prothiaden, Largactil, Prozac, to name but a few.” (Former prisoner)

Custodial factors were found to influence the extent to which CNS medication was used (O'Brien et al., 2001). For instance, CNS medications were most frequently prescribed to women in local prisons. There was a marked association between the time women had spent in their cells the day before the ONS interview and the prescription of CNS medications. Women serving short sentences (under 18 months) were more likely than those serving medium to long sentences to be prescribed CNS medications (O'Brien et al., 2001).

Although psychiatric medication undoubtedly has its place in treating and alleviating symptoms of mental distress, it should not be a substitute for giving women a chance to talk and be listened to. Whenever possible women prisoners need to be involved in all aspects of their care and their full consent to treatment should be sought.

“Today they’ve got me on so much medication yeah and I know it fucking me up because when I talk I get lockjaw and I sit there sometimes, you know, proper ‘duh’ and all that ... and like they say to me, ‘You’re on medication because you need it,’ and I say, ‘No, I don’t need medication, all I need is someone to sit down and talk to me, ask me why I’m coming in.’” (Young woman prisoner, cited in Lyon et al., 2000)

4.2 Availability of treatment

This report has acknowledged the use of medication in treating women with mental health problems. With the advent of NHS mental health in-reach teams, therapies available through community mental health teams should, in theory, become available to the prison population, but full implementation will be some time in the future. Counselling and ‘talking therapies’ are very slowly being made available to some of the prison population and this is to be welcomed, but staff need to be trained to recognise the signs of mental distress and to offer services to prisoners. Often, prisoners are reliant on self-help, concerned and caring fellow prisoners, or the voluntary sector, for help with their mental health needs:

“I am not someone with mental health issues, but in prison I became someone with mental health issues. I was lucky in that another inmate, noticing my deep distress, my isolation, my ‘turning inwards’ recommended I see a counsellor from the Bourne Trust. [She] became my counsellor in a very long and difficult road, for both of us! It was not the prison that helped me, it was not the medical staff or doctors, their answer is to ‘knock us out’, keep us quiet and calm. Without [her] intervention, I believe there is a strong danger that I may not even be here today in body, but an even stronger danger I may not have been here in mind! I was on the brink of breaking down utterly and completely, this was not noticed by staff who are not trained to deal with this in any way, and doctors just want to give medication, no more.” (Former prisoner)

Dialectical Behaviour Therapy (DBT) is a programme for women with borderline personality disorder who also engage in self-harm and suicidal behaviour. It has been evaluated using randomised controlled trials, and found to be significantly better than other treatments for this specific population. DBT began in three women's establishments in December 2001. Independent academic research has been commissioned by HM Prison Service to evaluate the initial pilot stage of delivery (Hughes, 2002).

A therapeutic community prison is in the process of being set up at Winchester West Hill in 2003. It will be the first women's therapeutic community prison in England and Wales and will follow the example of Grendon, a male therapeutic community prison established 40 years ago. The basis of a therapeutic community was described by Robert Rapoport as four core aspects: democratisation of the decision-making in the community; communalism, meaning that day-to-day tasks and responsibilities are shared; reality confrontation, methods to give each member of the community direct feedback about the impact of their behaviour on others; and permissiveness, toleration of mistakes as learning opportunities (Rapoport, 1960). This is a welcome development, and it will be important to explore the differences that emerge between the established therapeutic communities for male offenders and the new one for women.

4.3 Substance misuse

We have seen from the ONS survey that over half (54 per cent) of remand prisoners and 41 per cent of sentenced women reported some degree of drug dependency in the year before coming to prison. Substance misuse commonly occurs alongside mental illness and personality disorder (McMurrin, 2002). The substantial number of women prisoners with dual diagnosis suggests that many of them have been failed by the services in the community. In particular, those with dual diagnosis may not get the help they need from mental health services. Sometimes because they do not fit the criteria for their local service, their mental health problems are not recognised, or the services are insensitive to their needs.

The Chief Inspector of Prisons voiced concern in her recent annual report that women's prisons do not have proper detoxification, voluntary testing facilities and appropriate therapy (HMCIP, 2002a).

Mentally ill substance misusers require integrated treatment. It could be damaging to treat women with dual diagnosis by the confrontational tactics employed by some addiction services (Mueser *et al.*, 1992). Effective intervention with mentally ill substance misusers includes assertive outreach, motivating people to change, intensive supervision, and attention to broader issues, such as relationships, work, leisure and accommodation. In addition, relapses must be anticipated and the multiple interventions must be integrated in a long-term approach (McMurrin, 2002). Staff training will need to take these requirements into account.

Prison Service Order 3550, which is to be implemented in prisons that have developed mental health in-reach services, should bring significant improvements in the ability of prisons to provide this kind of multi-disciplinary, integrated drug treatment for women suffering under dual diagnosis. However, all of this is put at considerable risk by the impact of overcrowding, which inevitably distorts the priorities of prison managers as they struggle to cope with increased numbers and the 'churn' as women are moved from one prison to another.

4.4 Consent to treatment

Many women prisoners take medication. The prison is not a hospital for the purposes of the Mental Health Act 1983. Hence, new guidance (Department of Health, 2002c) makes clear

that prisoners who demonstrate a need for treatment and care; who exhibit severe mental distress; 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 new guidance (Ibid.) 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 standard which will be difficult to achieve in women's prisons, given the level of staffing, the number of women on medication, and a culture which sees containment as more important than communication.

To give informed consent the prisoner has to understand and retain information relevant to making that decision. In particular she 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 health care centre and women may have arrived with no useful information about their mental health history.

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.”
(Department of Health, 1999a)

The professional standards to assess capacity to consent, which apply to mentally ill women in the community under the Mental Health Act, need to be applied consistently to women prisoners. These standards need to be rigorously and independently monitored.

To protect the interests of prisoners the following need to be established as consistent daily practice:

- professional standards to assess capacity to consent should be applied consistently;
- all staff – health care and discipline – to follow protocols and procedures when restraint is required, because a prisoner exhibits behaviour that is violent or threatening;

- interventions that are the responsibility of non-health care staff to maintain good order and discipline (i.e., control and restraint, segregation, mechanical restraint and special accommodation) and those that are the responsibility of health care staff (usually for the purposes of medical treatment) should clearly operate as distinct and separate (HM Prison Service, 2002c).

In addition, there needs to be rigorous and independent monitoring of consent, capacity and compulsion in psychiatric treatment given within the Prison Service.

4.5 Acutely ill women

Seriously mentally ill women need to be transferred to appropriate NHS facilities and should not be treated in the health care centre of a prison. However, delays in finding suitable beds in the NHS mean that very ill women are sometimes contained in settings without adequate qualified care and treatment. This lack of adequate mental health care has been referred to in the introduction to this section. Holding women in urgent need of mental health care in health care centres or in seclusion (for their own protection) while awaiting an available bed creates unacceptable distress for the woman, for staff and for other prisoners. In addition, the need for crisis management of these women makes it more difficult for staff to attend to less ill patients.

“We were told that four women who were suffering acute mental illness were being held in the Health Care Centre and it would take six to seven months before they could be assessed, and sectioned appropriately to psychiatric hospital.” (HMCIIP, HMP Eastwood Park, October 2001)

Figures from an unpublished survey of in-patient units in prisons in West Midland and Trent NHS regions, reveal that there are likely to be up to 500 patients in prison health care centres sufficiently ill to require NHS admissions at any one time (Reed, 2003).

There is evidence that the Government is trying to tackle the problem by issuing a new administrative protocol for prisoners who have been waiting more than three months (following assessment and acceptance) for transfer to a NHS unit. But it often takes considerable time for the assessment to take place and then a hospital has to agree to the transfer. The three months maximum waiting time is very quickly exceeded. In the community, a woman with severe psychiatric illness needing urgent local admission would normally be admitted for care and treatment in a matter of hours. For mentally ill female prisoners, a place in a suitable, single-sex secure hospital has to be found.

The Chief Inspector’s Annual Report 2001-2002 suggests that the number of prisoners subject to such delays is growing.

“In 1997 we estimated that a third of prison in-patients ought to be in secure NHS accommodation. This year, in three local prisons, we found that the proportion was 41 per cent.” (HMCIIP, 2002a)

A response to a recent parliamentary question confirmed that there are still problems in diverting prisoners with mental health problems to more appropriate NHS facilities, and that about one in eight of those requiring a transfer between 1 October and 31 December 2002 had waited more than three months:

“... 651 prisoners were identified by health care staff in prisons as requiring mental health assessment for possible transfer to secure hospital. In that same period 258 prisoners were transferred. The position on 31 December 2002 was that, of those accepted and waiting for a transfer to hospital, 33 had waited longer than three months.” (Hansard, 2003)

The belief that patients with serious mental illnesses are safe from suicide once they go into the health care centre is misguided. Over 14 per cent of all suicides in prison take place in a health care centre (Reed, 2003).

4.6 Health Care Standards and quality of care

The Prison Service reissued its Health Care Standards in July 2002. Their main tenet was:

“To provide prisoners with access to the same range and quality of services as the general public receives from the National Health Service (NHS).” (HM Prison Service, 2002b)

This standard is not being met in local prisons.

“Yesterday, two CPNs and psychologist colleagues, coming back from a prison in-reach session, recounted how they had found that morning that prisoners had courses of anti-depressant medication stopped without being assessed or spoken to. A prisoner with schizophrenia had just arrived from another prison with no notes or clinical information. There were no psychiatrically trained nurses available. A prisoner’s transfer to hospital had not progressed because the hospital letter had been addressed to a locum doctor who had since left the prison. That was a typical day”. (Psychiatrist working in a prison, March 2002)

A recent Chief Inspector’s report found that the mental health unit relied on nursing staff to cover for psychiatrists:

“Referrals and reviews took place weekly and decisions about admission were made mainly by the nursing staff. While we are content with the idea of a nurse-led in-patient unit, input from psychiatrists seemed poorly organised and, to an extent, marginalised. This was in contrast to the well-organised nursing aspect of care. ... There was no day-to-day psychiatric input. In short, the psychiatric cover to the ... unit was not equivalent to that from the National Health Service.” (HMCIP, HMP Styal, February, 2002)

Monitoring of prison mental health services can only be done convincingly by external bodies. With transfer of responsibility for prison health care to the NHS, the quality of prison health care should be defined and monitored by using the same methods and standards that apply in the health service. The bodies responsible for external assessment of mental health care standards and clinical governance in the NHS such as the Mental Health Act Commission and the Commission for Healthcare Audit and Inspection (CHAI, from 2004) should have their roles extended to provide oversight of prison health care. In addition, the NHS complaints procedures should extend to prison health services.

4.7 Recommendations

- Training and recruitment of health care staff need to be developed so that medical and nursing staff caring for mentally disordered prisoners hold appropriate psychiatric qualifications and all prison staff have a basic awareness of mental health issues. Specialist skills are required to deliver treatment and to work therapeutically with women who have mental health problems.
 - NHS training structures for doctors need to include the prison context. Medical student placements such as those from Durham Queens Campus to HMP Holme House should be extended across the prison estate. Specialist training schemes in general practice, public health medicine and psychiatry should include prison placements. The Government should take a lead in persuading the Royal Colleges, NHS teaching centres, Post-graduate Deans and prison health care centres to achieve this. Medical manpower needs of the Prison Service should be included in assessments of NHS medical manpower needs.
 - The quality of mental health care standards in prison should be assessed and monitored by the same methods as in the NHS. Use of medication should be audited to comply with best practice guidance in the NHS.
 - Care planning should be based on the Care Programme Approach with continuity of care being proactively arranged for those entering and leaving custody. Women should be actively involved in reviews of their care and treatment.
 - Integrated health care should be developed for women with substance misuse and mental health problems.
 - There is an urgent need to ensure that a sufficient number of high, medium and low secure hospital places are provided to meet the needs of severely mentally disordered women currently held in the prison system. Checks should be established by the Department of Health and the Home Office to ensure that the added capacity achieves a measurable reduction in the number of women with mental illnesses held in custody.
 - Following the transfer of responsibility from the Prison Service to the National Health Service, external monitoring and oversight of health care and clinical governance standards in prison should be carried out by the bodies responsible for those functions in the NHS.
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5. Opportunities for change

5.1 The principle of equivalence

Services for women with mental health problems in prison are improving. The unacceptable nature of provision has been reported by a range of distinguished agencies and Government strategy and policy has reflected this widespread concern. However, this report argues that the planned improvements are not ambitious enough.

The joint report of the Prison Service and NHS Executive, *The Future Organisation of Prison Health Care*, (1999) noted that the principle of equivalence was fundamental. It means that any mental health care policy and guidance set by Government for the general population must apply equally to those in prison. Targets, priorities and policies set by Government for mental health services in the community must also apply to the care of the mentally disordered in custody. There must be equivalence in service access, standards and quality.

5.2 The legal framework

The Mental Health Act, 1983

Substantial numbers of offenders enter the prison system because the mental health services in the community have failed to provide the necessary support for them. In particular people with dual diagnoses (substance misuse and mental illness) have sometimes inappropriately been excluded from services in the community.

The consultation document for the Draft Mental Health Bill notes that the proposed powers would provide a framework for prisoners to receive compulsory psychiatric treatment in prison, if they would otherwise be eligible for a treatment order in the community as opposed to a hospital treatment order. PRT considers that this could be a useful step, because many prisoners need care and treatment which they cannot receive unless they consent, and without treatment some people will undoubtedly deteriorate. However there is a substantial risk that such powers would provide an excuse and disincentive to transfer mentally ill prisoners to the NHS. Although the consultation document states that compulsory treatment orders for prisoners would not be appropriate and should not be available, when the prisoner would otherwise have been eligible for a treatment order in hospital, stronger safeguards will be needed. PRT believes that to safeguard against compulsory treatment orders being used as an alternative to transfer to NHS hospitals, the courts will require stronger powers to enable those who need hospital care to receive it.

The consultation document noted that the new Bill would provide a framework for patients to receive compulsory treatment in prison, if they would otherwise be eligible for a treatment order in the community as opposed to a hospital treatment order. PRT considers that this would be a useful step, not only because so much mental health treatment occurs in prison without protection for prisoners or external monitoring, but because many prisoners need care and treatment which they cannot receive unless they consent. Without treatment the condition of some prisoners will undoubtedly deteriorate. However, before any changes are made to the law, it is absolutely essential that prisoners be protected by firm and specific safeguards (see Appendix 2).

Human Rights Act 1998

The Human Rights Act came into force in October 2000. As a public authority, the Prison Service must comply with the Act and respect the rights and freedoms it guarantees. Under Article 2, "Everyone's right to life shall be protected," the Prison Service has a positive obligation to protect the people in its care. In relation to mental health, the Prison Service could be challenged if it has not done enough to prevent suicides. For example where staff have not received training in suicide prevention or where night staff do not carry ligature scissors. The latter is specifically mentioned in the Findings of the Qualitative Analysis of 30 Senior Investigation Reports (HM Prison Service 2002d and various reports by the Chief Inspector of Prisons). This report has noted at 3.4 the position regarding investigations into suspicious deaths. The Human Rights Act should stimulate higher quality, more independent and rigorous reports with much greater involvement of the next of kin.

Paul and Audrey Edwards submitted an application to the European Court of Human Rights, arguing that the agencies involved had failed in their responsibility to protect the life of their son, Christopher Edwards, when they put him in the same cell as a violent schizophrenic prisoner, Richard Linford. The medical profession, police, prosecution and court had failed to pass on information about Richard Linford to the Prison Service and the inadequate nature of the screening service on Richard Linford's arrival in prison was a breach of the state's obligation to protect the life of Christopher Edwards (ECHR, 2002).

This case has important implications for the procedures and information systems of the prison system. The Home Office should consider the implications of the ECHR decision and report on it. Recommendations of the inquiry report into the treatment of Christopher Edwards and Richard Linford in 1999, such as the effectiveness and potential abuse by staff of the cell call alarm system which was to be improved as funding permitted, need to be revisited and fully implemented.

5.3. Government policy

The Government's Strategy for Women Offenders, 2000 and 2001

Jack Straw, then Home Secretary, described a vision of collaborative work in the foreword to the above report:

"... where Prison and Probation Services work together effectively to stop them re-offending, and a network of support in the community, both to prevent them offending in the first place and to support resettlement of ex-offenders." (Home Office, 2000)

One of the key elements of the Government's strategy is that more research is needed on what reduces offending and re-offending. This, it is argued, will lead to more effectively targeted offending behaviour programmes. Research suggests that a history of abuse is only one factor among many that may be linked to a higher rate of offending, but the specific ways in which this, with other factors, lead to subsequent offending, have not been established (Hooper, 2003). However, developing good community support for women is very likely to prevent a pattern of offending developing. As the Nacro Mental Health Advisory Committee argued:

"The Committee believes there is already sufficient evidence available of what is needed to support women in the community to begin to put a programme of provision in place without awaiting the outcome of new research." (Nacro, 2002)

The Committee expressed concern that the emphasis on offending behaviour programmes did not recognise that women with responsibilities as primary carers and with health and social needs need more general support and practical help.

The practice of mentoring provides support that is structured yet informal and personal. Mentoring has worked well with young offenders, as exemplified by the Trailblazers programme at HMYOI Feltham. A scheme of volunteer mentors, carefully selected, trained and supervised, could provide women who have mental health issues with guidance and support to enable them to manage their everyday lives. Because it is not a professional service, mentoring would not replace treatment for women with serious mental illnesses. Crucially, to divert women from custody, mentoring would need to be provided early, before the person's behaviour leads to a court appearance.

A second element of the Government's strategy is the importance of joined-up policy – that work across Government needs to be linked effectively. The Women's Unit in the Cabinet Office is seen as having an important role in ensuring women's needs and interests are represented in Government policy. One of the main recommendations in the Nacro Mental Health Advisory Committee is that the Women and Equality Unit should assume a more proactive role in co-ordinating policy relating to women offenders (Nacro, 2002).

The Government strategy identifies as part of 'joined-up policy', the need to tackle poverty and social exclusion, giving survivors of domestic violence the support and help they need, and working with drug abusers. The strategy recognises that women are less likely to use drug services than men. Fears that their children will be taken into care and concerns that services will not be geared to women, are suggested as being the most likely reasons. The strategy refers to two initiatives which may prove beneficial to women offenders who are drug dependent. The first is the arrest referral scheme and the second is the Drug Treatment and Testing Orders (DTTO). However, women will only be able to benefit from either scheme if they are developed to take account of their specific needs.

The Nacro Report highlights the danger of not having a clear list of initiatives and milestones which allow progress to be assessed and co-ordination scrutinised:

“For current initiatives to be made to work more effectively, there needs to be joined-up thinking and working at two levels; at the national level in terms of Government thinking and policy making, with cross-departmental initiatives and co-ordination, and at a local level in terms of inter-agency working and agreements ... what is needed is a fully comprehensive list of all activities and initiatives relevant to women offenders, complete with target and implementation dates, which is regularly updated ... and readily accessible to practitioners and policy makers.” (Nacro, 2002)

One of the five key messages from the report on consultation on the Government's strategy for women offenders (Home Office 2001) is that the research into 'what works' to reducing offending by women should be broadened and should include listening to the views of women offenders. We strongly support this approach and look for its early implementation.

'Changing the Outlook' A strategy for Developing and Modernising Mental Health Services in Prisons in December 2001

This report identifies ways that the Standards in the National Service Framework for Mental Health (see Annex 1) could be delivered in a prison setting. In order to achieve this ...:

“All prisons and their local NHS partners will be expected to have completed a detailed review of mental health needs, based on their existing health needs assessment work, to identify gaps in provision between what is currently available and that set out in Section 3 (Vision for Service), and to have developed action plans to implement the changes needed to fill those gaps. This work should include a training needs analysis for prison staff and NHS in-reach teams. Prisons and their local NHS partners should work together to achieve this.” (Department of Health and HM Prison Service, 2001)

One of the key elements of the strategy is the use of in-reach services. In 2001-2002, 22 prisons joined the first wave, including four women's prisons. A further 25 will come on stream during 2002/2003, including three more women's prisons. The intention is that by March 2004, around 70 prisons will be working with their local NHS partners to develop in-reach teams. By 2004 at least 300 additional staff will be employed to provide services to prisoners.

Women's Mental Health: Into the Mainstream: Strategic Development of Mental Health Care for Women 2002

In the foreword, Jacqui Smith, Minister for Mental Health, emphasises the importance of listening to women:

“We must take heed of what women are saying. They want to be listened to, their experiences validated, and most of all to be kept safe while they recover from mental ill health. They want importance placed on the underlying causes and context of their distress in additions to their symptoms, support in their mothering role and their potential for recovery recognised”.
(Department of Health, 2002b)

How will this strategy be implemented?

The Prison Reform Trust fully endorses this approach but the test of the rhetoric is in the detail and management of implementation. Why, in this important report, is there nothing new to say about women in prison? The extent of the problem is recognised but the only way forward suggested is a reiteration of the need for joined-up work:

“Women with a range of problems and needs can feel assured that the departments and agencies responsible for providing help and support respond to their needs as a whole rather than in isolation.”
(Department of Health, 2002b)

There is a disturbing disconnection between this aspect of Government planning and the daily struggle faced by women prisoners with mental health problems to meet some of their basic needs. The crucial questions are:

- Why, after a series of reports, has it taken so long to get to this stage?
- How much longer will it take for the initiatives to be implemented?

5.4 The NHS Plan (2000)

The National Health Service Plan (July 2000) specifically identifies prisoner services:

“By 2004, 5000 prisoners at any time should be receiving more comprehensive mental health services in prison. All people with severe mental illness will be in receipt of treatment, and no prisoner with serious mental illness will leave prison without a care plan and a care co-ordinator”. (NHS, 2000)

5.5 The new landscape

At senior Government level the Prison Service and NHS have recognised that the health care of prisoners has to be provided in partnership with the NHS. Prisons are now encouraged and required to work with other agencies to deliver mental health services to prisoners. Local NHS partners have worked with prisons to review mental health needs in prison and to develop action plans. Money for the new in-reach services is to be channelled through Primary Care Trusts and initially ring-fenced. From April 2003, funding responsibility for prison health care in England has been transferred from the Home Office to the Department of Health. At the same time, changes will be introduced to the way PCTs are funded for providing secondary care for prisoners. This is separate from, and complementary to, the shift in funding for the totality of prison health care to the Department of Health.

The test of these new plans and partnerships will be in the actual delivery of services in prison. To implement the new strategy, the Prison Service will need to adapt to new ways of working. Equally, the incoming health providers will need to adapt in order to cope with the closed institutional environment of the prison system with its ethos of rules, discipline, punishment, and segregation.

5.6 Equivalence with the NHS – rhetoric and reality

We have reported some of the commitments made by Government on the policy of equivalence. But does the rhetoric stand up to close examination? Do health targets, priorities and policies that the Government sets for the general population apply to the prison population?

Patient partnership. The NHS is expected to shape its services around the needs and preferences of individual patients, their carers and families, and the NHS and health organisations should systematically build in patient involvement in the way they operate, with particular attention being paid to under-represented groups. (Department of Health 1999b; 2001a). The National Survey of NHS patients will regularly obtain patients' views about the services they receive. Will this extend to prisoners?

Complaints procedures. Recent recommendations have been made for an improved, uniform national complaints procedure which would apply to primary care and hospitals (Department of Health 2001b). Do these apply to prison health care?

Access to information. The information strategy for NHS mental health services envisages that there will be national application of the mental health minimum data-set, and mental health integrated records shared by NHS specialist mental health services by 2005 (NHS Executive 2001; Department of Health 2001c). Will prison health records be part of this?

Follow-up of those at risk. A specific target set by the Department of Health is that all patients with a history of severe mental illness or deliberate self injury must be

followed up by personal contact with a mental health professional within seven days of discharge from hospital (Department of Health 2001d). Does this apply to women with histories of self-harm leaving custody?

Involvement and employment of service users. All mental health services will be expected to recruit and train service users as part of the workforce (Department of Health 2001d). What plans has the Prison Service for developing the skills of prisoners to form self-help groups and work with professionals?

Implementation and standards of mental health care. The Mental Health Policy Implementation Guide (Department of Health 2001e) is designed to help local mental health services achieve practical change and new service models. It gives detailed guidance on the components and specific standards that need to be in place for crisis resolution and assertive outreach teams, early intervention in severe mental illness and primary mental health care. Will the Implementation Guide be applied in prisons where there are so many mentally ill people?

Substantial work has been done by the Prison Health Policy Unit and Task Force including the prison health needs assessments; the work on primary care; workforce issues; clinical governance; the prison in-reach target in the NHS Plan; and the important mental health strategy document, 'Changing the Outlook' (Department of Health, HM Prison Service 2001). All this is to be welcomed.

However, the tone of these initiatives is about improvement, a 'direction of travel' across a gulf that separates prisons and the health service, rather than about real equivalence and integration. As NHS targets for mental health rapidly develop and become more ambitious, the gulf that has to be bridged is becoming wider.

Given the scale of problems associated with holding women with mental health problems in prison custody, a 'direction of travel' is insufficient. The situation is becoming worse as prisons become more overcrowded and more women are incarcerated.

The gap between standards set for the NHS and the actual practice of prison health care becomes especially important because women prisoners have much higher rates of mental disorder, drug misuse, and histories of abuse and self-harm than their counterparts in the community. The NHS needs to develop an integrated service to ensure that a woman in prison with a given mental health problem receives the same range and standards of care as would apply to someone with the same problem outside.

There are some simple practical questions that can be asked on behalf of a prisoner who, because of psychotic illness, is confined in a prison health centre:

- Is the doctor treating her psychiatrically qualified?
 - Are RMN trained nursing staff on duty at night?
 - Does she have the full range of treatment and care she needs?
 - Does she have a proper care programme?
 - If and when released, is a follow up contact with a clinician within seven days arranged?
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For less seriously ill women who remain on the wings:

- Have they had mental health needs assessed by a practitioner who has psychiatric qualifications?
- Have they been offered effective treatments including referral to a specialist service?
- Are they able to make contact round the clock with someone who can meet their needs and give them adequate care?
- Are their needs for mental health attention unmet because the professionally qualified staff must devote their time to seriously ill women who should not be in prison?
- Are they able to use NHS Direct for initial advice or referral on to specialist services?
- Do they have access to a day centre?
- Have they been able to talk to a counsellor?

Resource requirements are a complex issue but some key points can be made. Section 5.5 above has referred to the Health Care assessments undertaken by the prisons and the Health Authorities and the Health Action Plans needed. This gap in service has been quantified by the Department of Health at a regional level and now needs to become part of development plans.

The budget for all prison health care was about £90 million in 2000; it is estimated that roughly half of that total was spent on mental health. The document, *Changing the Outlook*, which sets the strategy for developing and modernising mental health services in prison, states, "The improvement or reform of prison health care services is predicated on a good understanding of health care costs." That strategy had begun to be implemented by September 2002, when all prisons were asked to complete returns stating how their health care spend was distributed. The list included areas of work that had never been captured statistically before, such as health care uniforms and training. The Department of Health and Home Office ministers then decided what fell under the scope of health care. They will attempt to smooth out variations in funding to prisons, and discrepancies in allocations will, in theory, be identified and rectified (personal communication with Department of Health, 2003).

To make the improvements that are urgently required, the available funding must be used as efficiently as possible. This means looking at issues such as skills mix and how work is organised. There is evidence of efforts to improve efficiency, and these are welcome. However, action will need to be taken on, for example, staff sickness levels (averaging 17.2 days per officer in 2002), absenteeism, huge agency costs and escort services to prisoners taken out to hospital. Will such hard decisions be supported by management?

***"One Health Care Officer, who was a qualified mental health nurse, had been off sick for over a year. The Personnel Department should resolve this matter without further delay. Long term sickness absences should be kept to a minimum."* (HMCIP, HMP Durham, February 2001)**

This report has noted that there is significant new money for prison health care: £35 million of capital to improve health care centres, and about £17 million for the mental health in-reach programmes over three years. But this figure pales into insignificance compared with the £126 million that is being invested in the Dangerous and Severe Personality Disorder (DSPD) programme for an estimated 200-300 individuals in special prison units.

5.7 Recommendations

- Mainstream NHS Policies should be implemented for the prison population. It is time to build on good policy and planning to effect much needed change in practice with women who offend.
 - Given the aim of the NHS agenda to involve patients in their care, clear and accessible information must be produced and disseminated to inform women, prisoners and prison medical staff about the change in direction as highlighted by the Department of Health document, Seeking Consent: Working with People in Prison (Department of Health 2002c).
 - Developments underpinning Government strategy need to be effectively joined up with target and implementation dates for all initiatives for women offenders.
 - With the devolving of responsibility for prison health care to the Department of Health, and ultimately the Primary Care Trusts, money for prison health care, such as mental health in-reach, needs to continue to be ringfenced beyond the original period envisaged.
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6. Agenda for action

This report has argued that too many women are imprisoned. Many of these women have mental health problems which are exacerbated by prison conditions. Self-harm figures are at epidemic levels. In the first six months of this year, the number of prison suicides by women has already exceeded the highest annual levels previously recorded. Standards of care in custody need to be, if anything, more demanding than in the community.

Justice for Women, the report of the Committee of Inquiry into Women's Imprisonment, provided a starting point for a radical overhaul of the ways society responds to women offenders (Prison Reform Trust 2000). The Government's strategy for women offenders embraced its key recommendations, stating that:

“The best way to reduce women’s offending is to improve women’s access to work; to improve women’s mental health services; to tackle drug abuse by women; to improve family ties and to improve the life chances of young women at school and in the community.” (Home Office, 2001)

But the question remains how to turn that rhetoric into reality.

“Instead of implementing the strategy and moving from policy to practice, in a series of panic measures designed to prevent overcrowding the Home Office has concentrated on its plans to expand the women’s prison estate. This makes neither social nor economic sense. Imprisonment only isolates still further many women who are already on the margins of society. Failure to produce and promote effective community sanctions and support flies in the face of evidence collected over two years by the Committee on Women’s Imprisonment which presented an overwhelming case for reducing the use of custody and for proportionality and fairness in sentencing.” (Prison Reform Trust, 2003)

The following ten recommendations present a challenge to the Government, Department of Health and Home Office. If implemented, these proposals would begin to address the tragedy of wasted lives.

1. Develop pro-active and early intensive community based services for young girls and women with mental health problems who are at risk of offending. Ensure such services build on what is known about girls with high risk behaviour who come to the attention of mental health services.
 2. Recognise that women would benefit from advocacy and /or mentoring services at their earliest involvement with law enforcement agencies so that they can begin to access, with support and guidance, the maze of agencies and professionals who are there to help them.
 3. Prioritise effective comprehensive court diversion schemes as an integral part of core local psychiatric provision, so that offenders who are acutely ill or at risk of suicide can be given hospital places, possibly under the Mental Health Act 1983. For those who are not at risk of custodial sentence and whose mental state does not justify hospital admission, there needs to be effective linking to appropriate services and agencies in the community.
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4. Confront magistrates' and judges' failure to use alternatives to prison for vulnerable women. Government, NHS and Home Office need to invest in accessible and appropriate mental health provision, drug treatment and community penalties which command the confidence of the courts and where women who offend can pay their debt to society and rehabilitate themselves within the community without causing unnecessary damage to their children and themselves.
 5. Provide both the resources and the ministerial focus to ensure that the ambitions for improvements in mental health services are realised in the practice of the NHS and the Prison Service, recognising that women prisoners have much higher rates of mental disorder, drug abuse and histories of abuse and self-harm than their counterparts in the community.
 6. Meet NHS standards and protocols, particularly regarding the use of medication, training for doctors and health care staff and procedures on, and recording of, use of compulsory treatment. With transfer of responsibility for prison health care to the NHS, quality should be defined and monitored by using the same methods and standards that apply in the health service. The bodies responsible for external assessment of mental health care standards and clinical governance in the NHS such as the Mental Health Act Commission and the Commission for Health Improvement and its successor body the Commission for Healthcare Audit and Inspection (from April 2004) should have their roles extended to provide oversight of prison health care.
 7. Recognise and nurture links with families by establishing the First Night in Custody project in all local women's prisons with family caseworkers to complement the work and help reduce the anxiety over loss of contact with children and family. Prioritise long term planning and secure funding of day-to-day running costs for Visitors' Centres with a brief to improve visiting numbers to ensure support for vulnerable women and their families. Provide effective and accessible lines of communication for family members when they are concerned about the mental state of a woman prisoner.
 8. Train staff in a multi-disciplinary and therapeutic approach to suicide prevention. Provide more focused training to enable prison staff to recognise objective risk factors, and to talk with and listen to distressed women rather than isolate and observe them.
 9. Learn promptly from analysis of self-inflicted deaths and disseminate necessary changes effectively throughout the Prison Service. Liaise and communicate more effectively and compassionately with family members when there has been a self-inflicted death.
 10. Respect and listen to women prisoners with mental health problems. For those who self-injure, listen to their ideas for coping more effectively, and implement changes where possible. Develop, encourage and support self-help groups and good practice in patient-focused care, using the experience and resources of women themselves.
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Appendix I

National Service Framework for Mental Health: The Seven Standards

Standard One

Health and Social Services should:

- promote mental health for all, working with individuals and communities
- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

Standard Two

Any Service user who contacts their primary health care team with a common mental health problem should:

- have their mental health needs identified and assessed
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

Standard Three

Any individual with a common mental health problem should:

- be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care
- be able to use NHS Direct, as it develops, for first level advice and referral on to specialist helplines, or to local services.

Standard Four

All mental health service users on the Care Programme Approach (CPA) should:

- receive care which optimises engagement, prevents or anticipates crisis, and reduces risk
- have a copy of a written care plan which:
 - includes the action to be taken in a crisis by service users, their carers, and their care co-ordinators
 - advises the GP how they should respond if the service user needs additional help
 - is regularly reviewed by the care co-ordinator
- be able to access services 24 hours a day, 365 days a year.

Standard Five

Each service user who is assessed as requiring a period of care away from their home should have:

- timely access to an appropriate hospital bed or alternative bed or place which is:
 - in the least restrictive environment consistent with the need to protect them and the public
-

- as close to home as possible
- a copy of a written after-care plan agreed on discharge, which sets the care and rehabilitation to be provided, identifies the care co-ordinator and specifies the action to be taken in a crisis.

Standard Six

All individuals who provide regular and substantial care for a person on the CPA should have:

- an assessment of their caring physical and, mental health need repeated on at least an annual basis
- their own written care plan, which is given to them and implemented in discussion with them.

Standard Seven

Local health and care communities should prevent suicides and:

- promote mental health for all, working with individuals and communities (Standard one)
- deliver high quality primary mental health care (Standard two)
- ensure that anyone with a mental health problem can contact local services via the primary care team, a helpline or an A & E department (Standard three)
- ensure that individuals with a severe and enduring mental illness have a care plan which meets their specific needs, including access to services around the clock (Standard four)
- provide safe hospital accommodation for those who need it. (Standard five)
- enable individuals caring for someone with severe mental illness to receive the support which they need to continue to care (Standard six)

And, in addition:

- support local prison staff in preventing suicide amongst prisoners
 - ensure that staff are competent to assess the risk among individuals at greatest risk
 - develop local systems for a suicide audit to learn lessons and take any necessary action.
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Appendix 2

Extract from PRT submission to DoH Consultation Document on the Draft Mental Health Bill.

The Consultation Document states that compulsory treatment orders for prisoners would not be appropriate, and should not be available, in cases where the prisoner would otherwise have been eligible for a treatment order in the community. We agree with this and with the statement (para 3.38) that:

It will be important to safeguard against compulsory treatment orders being used as an alternative to transfer to NHS hospitals where that is what the prisoner patient really needs.

However, we believe that in order to ensure this it will be necessary to amend the clauses in the Draft Bill dealing with patients in criminal proceedings. The courts will need stronger powers to enable those who need hospital care to receive it. Specific suggestions about how to achieve this are outlined in the following paragraphs.

Powers of criminal courts

There is wide concern amongst sentencers about cases in which mentally disordered defendants need medical remands and disposals but no order can be made because a hospital bed is not available. Such individuals may be sent to prison as a consequence. They would be the cases most at risk of compulsory treatment orders being used as an alternative to transfer to NHS hospitals where that is what the prisoner patient really needs. There is already very substantial concern about the high numbers of mentally disordered people in prison and the difficulties and unacceptable delays in transferring them to appropriate psychiatric care. The introduction of new mental health legislation provides an important opportunity to reduce this problem by altering the statutory framework so as to make inappropriate imprisonment of the mentally disordered less likely.

In cases where medical disposals are judged by the courts to be the correct outcome it is not right that the courts should be so powerless to effect them. The clauses concerning the powers of the criminal court to make remand and treatment orders should therefore be amended. Two ways in which this might be done are outlined below. Under the first option, courts could require hospital beds to be made available in cases where the other conditions for making an order are met. Under the second option, the onus on the relevant hospital/NHS body would change, so that it would have to decline a request by a court to admit a patient judged suitable for hospital care. We prefer the first option, but recognise that it could be strenuously opposed by mental health services concerned about resource implications and the independence of clinicians in relation to admission decisions. The second option would be a significant step forward, although probably less strong in effect.

Option 1: Under the Draft Bill an order for hospital assessment or treatment requires the court to be satisfied that arrangements have been made for the admission of the person to a particular hospital within a set period (seven days in the case of a remand and 28 days in the case of a mental health order). The court could not make an order in the absence of information confirming the availability of a bed. This would perpetuate the current unsatisfactory position under the Mental Health Act 1983. The necessary amendment would be that where the court is satisfied that the other qualifying conditions (other than bed

availability) are met the court may require the appropriate Minister² to arrange for the person's admission to an appropriate hospital within the relevant time period.

For example, clause 78 (power of court to make mental health order) could be amended to the effect that if the court is satisfied on the appropriate evidence that three conditions are met, and that such an order is the most suitable disposal, it may make a mental health order. The three conditions are:

- (i) That the person is suffering from mental disorder;
- (ii) That the mental disorder is of such a nature or degree as to warrant the provision of medical treatment to the person;
- (iii) That appropriate medical treatment is available in the person's case.

(The third condition should be understood in the sense of being potentially available, ie such treatment services exist and are clinically appropriate in the person's case).

If the three conditions are fulfilled the court may require the appropriate Minister to make arrangements for the person's admission to an appropriate hospital, agreed by the court, within 28 days beginning with the date of the order.

Option 2: The second alternative option would involve introducing an amended provision in the relevant sections of the Bill to apply in circumstances where the court is satisfied that the criteria for treatment (or remand) order (other than bed availability) are met. The courts should then have specific power to request 'the appropriate Minister' (in practice a relevant NHS body) to make a bed available in an appropriate hospital within 28 days. This would not require or bind the services to admit if they did not wish to, but it would put the onus on the NHS to advise the courts that the request could not be met.

Amendments to the Draft Bill such as those suggested in options 1 & 2 would help address the concerns of sentencers, facilitate appropriate psychiatric care for people in criminal proceedings, and provide a safeguard against treatment orders being imposed on prisoners who should be in hospital.

² The Draft bill uses the term "appropriate Minister" where there are duties on the "state", and this provides a means of allowing delegation under the NHS legislation to the relevant NHS bodies. For example, in clause 57 (3) (concerning powers of a court to remand for a psychiatric report) the Bill specifies that the court may "require the appropriate Minister to arrange for an approved clinician to prepare a report..." A similar formulation could be made with respect to hospital admissions.

Troubled Inside:

Responding to the mental health needs of women in prison

“During the two and half years of my incarceration I was to discover the depths of despair one can fall into, believing I was losing my mind, believing I was dead, believing I was buried alive, believing I would never be free. I learnt about self-harm, physically and emotionally, I learnt how to survive, yet at the same time how it feels to want to die every day... Prison is not a place for the mentally ill, and too many women are there already that should not be.”

(Former prisoner)

This report reveals the extent of the mental health needs of women in prison. It exposes the gap between improved policy and still bleak practice. It offers a set of detailed recommendations and a ten point action plan which, if implemented, would ensure that the needs of women troubled inside the prison system are met.



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