Independent Advisory Panel on Deaths in Custody submission to the Justice Select Committee call for evidence on mental health in prisons – May 2021

1. The role of the Independent Advisory Panel on Deaths in Custody (IAPDC) is to advise Ministers and officials on how they can meet their human rights obligations, prevent deaths and keep those under the care of the state safe.[1] The IAPDC welcomes the opportunity to submit evidence to the Committee's call for evidence on mental health in prisons, which builds upon the important National Audit Office inquiry on the same subject in 2017[2], and follows the IAPDC's contribution to the Centre for Mental Health's review on the future of mental health care in prisons in September 2020.[3]

Q1. The scale of mental health need within prisons in England and Wales and whether enough is in place to determine the scale of the problem

2. Self-harm and self-inflicted deaths are the most extreme indicators of unmet mental health need in prison. Self-inflicted deaths remain at very high levels. In the 12 months to March 2021, 79 people took their own lives in prisons within England and Wales.[4] This represents a slight decrease compared to the preceding 12 months (and the second lowest figure since the 12 months to March 2017, when 116 people died through suicide). However, there are well-founded fears of another surge in self-inflicted deaths as people begin to emerge from severe restrictions and isolation of lockdown under COVID-19. In a message to National Prison Radio, one man told the IAPDC: '*'I'm sure there is a lot of prisoners suffering from severe anxiety, isolating in their cells not knowing when they're going to be unlocked.'*[5]

3. Self-harm incidents have increased over time, with a peak of 767 incidents per 1,000 prisoners in 2019. Inspectorate reports, investigation findings and prevention of future deaths reports issued by coroners (PFDs) regularly reference unmet mental health need as the most significant factor in prison suicides.

4. A substantial evidence base already exists detailing the importance of adequately funded and tailored mental healthcare provision for those in the criminal justice system, as well as the causes of mental health deterioration within prisons and wider places of custody. There have been a number of major independent reviews, including Lord Bradley's 2009 overarching review of people with mental health needs or learning disabilities in the criminal justice system.[6] Rather than re-examining the prevalence of mental health need in the estate, future research should prioritise improving assessment, linking assessment to interventions and developing understanding of the most effective treatment and practice.

---

[1] Advisory Panel on Deaths in Custody, *About the IAPDC*. Available at: https://www.iapondeathsincustody.org/about-us-1 [Accessed: 19/05//2021]

[2] National Audit Office: Mental Health in prisons (June 2017). Available at: Mental health in prisons - National Audit Office (NAO) Report [Accessed on: 19/05/2021]

[3] The IAPDC contribution to the Centre for Mental Health Review (September 2020). Available at: 200904+IAP+Centre+of+Mental+Health+evidence+-+September+2020+-+final.pdf (squarespace.com) [Accessed: 19/05/2021)

[4] HMPPS Safety in custody statistics. Available at: Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to March 2021, Assaults and Self-harm to December 2020 - GOV.UK (www.gov.uk) [Accessed on: 19/05/2021]

[5] Independent Advisory Panel on Deaths in Custody, '"Keep Talking, Stay Safe": A rapid review of prisoners' experience under Covid-19'. (June 2020). Available at: https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ee115af9592717e002903f8/1591809460419/200601+IAP+rapid+review+of+prisoner+experiences+under+Covid-19+-+FINAL+CLEAN.pdf.

[6] The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system (April 2009). Available at: https://www.lscft.nhs.uk/media/Publications/CJLT/The%20Bradley%20Report_%20Executive%20Summary.pdf. [Accessed on 19/05/2021]

5. In response to a rising tide of self-inflicted deaths and serious self-harm, in 2017 the IAPDC focussed on identifying practical steps to prevent suicide in prison custody through its Keeping Safe initiative.[7] Its conclusions on how mental health treatment and wellbeing could be improved for women[8] and men remain relevant. These include focussing on preventative work and diversion into treatment; improving assessment of suicide risk; ensuring a timely response by mental health teams, including counsellors and keyworkers; improving family contact and peer support; introducing mental health awareness and emergency response training for all staff; and tailoring drug treatment, including maintenance and detoxification, to needs of individuals in addition to different cohorts such as age and race.

6. The IAPDC welcomes the transparency and detail of the HMPPS's Safety in Custody bulletin, which provide statistics on self-harm and deaths on a quarterly basis. This reporting compares favourably to reporting from the other places of detention that the work of the Panel covers. We would welcome further breakdown of data by protected characteristics and further work on the identification of deaths related to substance misuse. Pilot work on the latter by ONS and HMPPS was positively received but the data set is now close to five years old.[9]

Q2. The appropriateness of prison for those with mental health needs

7. Prisons do not hold a representative selection of the wider population. Those in custody have significantly higher rates of mental health need, and rates of suicide among people in prison are elevated compared with people of similar age and sex who are living in the community.[10] Some 46% of women and 21% of men in prison have attempted suicide at some point in their lives compared to 6% of the general population. For many people in prison, mental health conditions have played a significant part in their offending history, yet the support they receive, both before, during and after prison, can be variable. Unmet mental health needs can cause feelings of isolation that can lead to self-harm and self-inflicted deaths.[11]

8. In the IAPDC's consultation with people in prison as part of the Keeping Safe initiative, the most frequently mentioned factor influencing poor mental health related to staffing in prisons, specifically the impact of staff cuts, exhaustion, low morale, loss of experienced staff, a lack of time to talk. Respondents discussed how positive relationships with experienced staff made a significant difference, but the high level of staff churn provided an environment not conducive to discussing concerns about emotional wellbeing. The important rollout of the keyworking scheme, which is well-thought of by prisoners, was impaired by the impact of COVID-19, will go some way to improving this.

[7] Independent Advisory Panel on Deaths in Custody, Keeping Safe project, https://www.iapondeathsincustody.org/keeping-safe.
[8] IAPDC report into Preventing the deaths of women in prison. (March 2017). Available at: IAP+rapid+evidence+collection+-+v0.3.pdf (squarespace.com). [Accessed on: 19/05/2021]
[9] HMPPS and Official for National Statistics on drug related deaths in prison custody. (July 2019). Available at: Drug-related deaths and suicide in prison custody in England and Wales - Office for National Statistics (ons.gov.uk). [Accessed on: 19/05/2021]
[10] Fazel, S., Wolf, A.,Larsson, H., Lichenstein, P., Mallett, S. and Fanshawe, T. R. (2017). Identification of low risk of violent crime in severe mental illness with a clinical prediction tool (Oxford Mental Illness and Violence tool [OxMIV]): a derivation and validation study. *Lancet Psychiatry,* 4, pp. 461-468.
[11] The Prison Reform Trust: Bromley Briefings Prison Factfile (2021). Available at: Winter 2021 Factfile final.pdf (prisonreformtrust.org.uk). [Accessed on: 19/05/2021]

9. Further areas raised which impacted negatively on wellbeing included the lack of peer support, prompt assessment or transfer into treatment, correct transfer of medical records and a lack of time for exercise and other constructive activities.

10. Prisons are, on occasion, still being used as places of safety when no alternative accommodation can be found for someone with complex needs. This is made possible by the Bail Act 1976[12] which states that an individual can be remanded in custody for their own protection, and the Mental Health Act, which allows it for someone for their own safety. The IAPDC is currently working with the Association of Directors of Adult Social Services and the Magistrates Association to explore possible accommodation options that might prevent a person being remanded into custody for their own safety or protection. The IAPDC welcomes the commitment in the recent Mental Health Act White Paper to end the use of prison as a 'place of safety'. This change should be pursued with urgency and vigour.[13]

11. A joint IAPDC survey with the Magistrates Association last year, meanwhile, showed that magistrates supported the use of robust community disposals as alternatives to short custodial sentences but have called for more local access to, and greater education about, such requirements.[14] Upcoming sentencing reform offers the opportunity to extend significantly the availability and use of Community Sentence Treatment Requirements. There is also a need for independent expert evaluation of the impact of Mental Health Treatment Requirements (MHTRs) for people with mental illness. MHTRs were introduced in legislation in 2005, their lack of widescale availability is unacceptable.

Q3. How mental health issues are identified on arrival at prison and/or while a prisoner is serving a custodial sentence

12. The IAPDC supports the greater use of court-based liaison and diversion services to identify mental health concerns. These services have recently been evaluated and should be funded to ensure adequate screening prior to any arrival in prison. Liaison and diversion assessments also inform pre-sentence reports (and therefore sentencing) at court. Assessment and the prompt transfer of this information would help to prevent self-inflicted deaths in the early days of custody.

13. Every individual arriving in prison should have a comprehensive mental health assessment in the days following their arrival to prison. In addition, adequate screening processes should be developed further to accommodate for a wider range of neurodiversity. An example of this could be dementia assessment for older prisoners.

14. Investigations frequently raise problems with information transfer as a cause of death. A more localised approach to commissioning (see below) offers one solution to this long-standing issue, as data too frequently remains within the same service instead of moving across multiple boundaries.

15. Those felt to be at risk of suicide or self-harm are managed through the Assessment, Care in Custody and Teamwork (ACCT) process. The IAPDC welcomes ongoing

[12] The Bail Act (1976). Available at: Bail Act 1976 (legislation.gov.uk). [Accessed on: 19/05/2021]
[13] Department of Health and Social Care: Reforming the Mental Health Act White Paper. Available at: Reforming the Mental Health Act - GOV.UK (www.gov.uk). [Accessed on: 19/05/2021].
[14] The IAPDC and Magistrates Association: Effective community sentences. Available at: MA+IAP+survey+final+270619.pdf (squarespace.com) [Accessed on: 19/05/2021]

Ministry of Justice work to move ACCT away from bureaucratic processes towards one which places a greater focus on individual safeguarding requirements and engagement of mental health professionals and family members.[15]

Q4. Support (clinical and non-clinical) available to those with mental health needs, whether it meets the needs of those in prison and if there are any gaps in provision

16. Responses to the Keeping Safe consultation referenced the importance of peer support, especially through the Samaritan Listener programme, which is understood to be variable in capacity across the country. We welcome news that HMPPS have piloted, and continue to develop, a postvention support service in collaboration with the Samaritans, which should be routinely available.

17. Family contact is closely linked to mental health. The COVID-19 period has demonstrated the positive possibilities posed by digital services, such as in-cell phones and video calling. This 'digital equivalence' should be continued to support prisoners accessing contact with family members, as well as medical professionals, though should not come at the expense of in-person visits.[16]

18. Local variation has a significant impact on mental health outcomes. Siloed working between substance misuse care, primary care and mental health care, for example, can have serious implications for the identification of risk related to mental health. The IAPDC is aware of cases of missed identification of mental health need where drug misuse was initially taken as the single focus for treatment.[17]

Q5. The effect of physical prison environment on mental health

19. People in prison told the Keeping Safe consultation that the physical prison environment had negative impacts on their mental health. Some suggested simple remedies to improve mood and morale, for example *"flowers, plantation and general greenery plus comfortable seating available to those with mental illness/depression."*[18]

20. In addition, ligature points in cells pose a clear route to self-harming behaviour and suicide, as does the availability of non-tearing bed sheets.[19] The IAPDC would recommend, similar to what can be found in in-patient psychiatric units, the use of cells free from ligature points, and the promotion of a culture which does not stigmatise these locations; the development of safer bedding which would break if used as a noose; and the use of larger ventilation units for 'safe cells' to help improve wellbeing.

Q6. The effect of COVID-19 on prisoner mental health, including on access to services

21. The challenges posed by COVID-19, especially the heightened isolation, up to 23 hour lock-up and the lack of keyworking opportunities,, has undoubtedly had significant

---

[15] *Ibid.* p.38.

[16] Edge, C., Hayward, A., Whitfield, A. & Hard, J. (2020). COVID-19: digital equivalence of health care in English prisons. *The Lancet Digital Health*, 2(9), pp. 450-452.

[17] The IAPDC and Royal College of Nursing: Natural Deaths in prison custody report. Available at: 200929+IAP-RCN+-+prevention+of+natural+deaths+in+custody+-+final+for+publication.pdf (squarespace.com). [Accessed on: 19/05/2021]

[18] *Ibid.* p.28.

[19] Gunnell, D., Bennewith, O., Hawton, K., Simkin, S. and Kapur, N. (2005). The epidemiology and prevention of suicide by hanging: a systematic review. *International Journal of Epidemiology*, 34(2), pp. 433-442.

impact on mental health.[20] A measure of distress is that calls from prisoners constituted 15% of all calls to the Samaritans national helpline in December 2020. There was a sharp initial rise in self-harm incidents within the women's estate following the start of the pandemic[21] and more recently early signs of an increase in self-inflicted deaths in male prisons.[22] Of the 17,000 prisoners who have contracted the coronavirus during the pandemic, it is not known how many are suffering from 'long Covid' and associated harm to their mental and physical health. While necessary to save lives during the pandemic's first 'wave', it is unjustifiable that this protracted lock-up has not been shortened and brought carefully to a close– either by streamlining and making full use of the early release scheme or by adopting a whole institution approach to vaccinations, as recommended by, amongst others, Public Health England, the Scientific Advisory Group on Emergencies (Sage)[23] and the IAPDC.[24]

22. Mental health provision and deterioration emerged as key themes of both the IAPDC's consultations with people in prison on the impact of COVID-19 on their lives. [25] Support provided by mental health teams appears to have varied across establishments during the COVID-19 period. There remains an inconsistent level of psychological therapy and mental healthcare across the prison estate. The IAPDC is concerned at the impact that the long-term lack of mental health support during the pandemic will have had on prisoners once restrictions are lifted. We recommend additional support as has been offered to schools.

Q7. The quality and availability of mental health support in prison compared to that in the community

23. To achieve its legal principle and aspiration of equivalence[26], prison healthcare should be more closely integrated with healthcare in the community and adequately funded to recognise and respond proportionately to the well-documented greater needs of prison populations. Social networks with family and friends in prison do not exist in the same way they do in the community. This places greater importance on the retention of staff who will hold institutional knowledge instead of relying on temporary workers.

Q8. The mental health care pathway in prison to the community

24. Services must include transitional interventions that link to other resettlement provision to provide joined-up care for people with mental illness. A steadier approach to tendering and commissioning services over more extended periods would reduce the risk of disruption and discontinuity of care (see below).

---

[20] HMIP COVID-19 thematic review (February 2021). Available at: What happens to prisoners in a pandemic (justiceinspectorates.gov.uk). [Accessed on 19/05/2021]
[21] Self-harm rates went up by approximately 18% between June and September 2020
[22] This was most evident in the first quarter of 2021 when recorded self-inflicted deaths increased by 38%
[23] SAGE report on transmissions in prison settings. (March 2021). Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/979807/S1166_EMG_transmission_in_prisons.pdf. [Accessed on 19/05/2021]
[24] See the IAPDC COVID-19 Hub for relevant correspondence. Available at: COVID-19 Hub — Independent Advisory Panel on Deaths in Custody (iapondeathsincustody.org).
[25] Independent Advisory Panel on Deaths in Custody, '"Keep Talking, Stay Safe": A rapid review of prisoners' experience under Covid-19'. (June 2020). Available at: https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ee115af9592717e002903f8/1591809460419/200601+IAP+rapid+review+of+prisoner+experiences+under+Covid-19+-+FINAL+CLEAN.pdf; Independent Advisory Panel on Deaths in Custody, "Just One Thing: COVID-19 and prison safety" (September 2020). Available at: 200925+IAP+COVID-19+safety+briefing+-+final.pdf (squarespace.com)
[26] NHS: National Prison Health Board Principle of Equivalence of Care. Available at: PowerPoint Presentation (publishing.service.gov.uk). [Accessed on: 19/05/2021]

Q9. Whether current commissioning of mental health services in prison is working

25. The current multi-layered and complicated sub-contracting and commissioning processes for mental healthcare are wasteful and time-consuming, with damaging impact on continuity of care, staff retention and patient outcomes. A move from a three- to five-year tendering process is a recognition of the disruption this has caused staff and prisoners, but this must go further. Local mental health trusts – with understanding of links with secure hospitals, general psychiatric hospitals and follow-up services – should be the providers of choice, even if they are not always the cheapest option. This would provide stability, consistency and improve the ease and speed of transfers where required. These improvements would all help to reduce the risk of self-inflicted deaths. They will also ultimately reduce costs in the medium and longer term. Commissioning processes must also be flexible to account for population churn.

26. The IAPDC is grateful for this opportunity to submit written evidence to the inquiry and would welcome the opportunity to provide further information or oral evidence if required by the Committee.

About the Independent Advisory Panel on Deaths in Custody

The Ministerial Council on Deaths in Custody formally commenced operation on 1 April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and Social Care and the Home Office. The Council consists of three tiers:

- Ministerial Board on Deaths in Custody (MBDC)
- Independent Advisory Panel (IAPDC)
- Practitioner and Stakeholder Group

The remit of the IAPDC (and overall of the Council) covers deaths, both natural and self-inflicted, which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAPDC, a non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials and the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAPDC's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Juliet Lyon CBE chairs the IAPDC.

Members of the IAPDC appointed in July 2018 are:

- Deborah Coles, Director, INQUEST
- Professor Seena Fazel, professor of Forensic Psychiatry, University of Oxford
- Professor Jenny Shaw, professor of Forensic Psychiatry, University of Manchester
- Jenny Talbot OBE, Prison Reform Trust
- John Wadham, Chair, National Preventive Mechanism

Further information on the IAPDC can be found on its website:
www.iapondeathsincustody.org

Contact: juliet.lyon@justice.gov.uk
piers.barber1@justice.gov.uk Head of Secretariat