



Submission to Health and Social Care Committee inquiry into Prison Healthcare May 2018

Background - the UK National Preventive Mechanism

1. The UK National Preventive Mechanism (NPM) was established in March 2009 following the UK's ratification of the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in December 2003. It is made up of 21 statutory bodies that monitor and inspect places of detention.¹
2. States which ratify OPCAT are obliged to designate a 'national preventive mechanism', a body or group of bodies whose role is to:
 - i) regularly examine the treatment of people deprived of their liberty with a view to strengthening their protection against torture and other forms of ill-treatment;
 - ii) make recommendations to the relevant authorities with the aim of improving the treatment and conditions of detainees;
 - iii) submit proposals and observations on existing or draft legislation.
3. Effective monitoring of prison healthcare is essential to preventing the ill-treatment of people in detention and to safe-guarding their rights and well-being. The NPM role, as set out in OPCAT, is focussed on preventing ill treatment in detention. Monitoring places of detention with a preventive approach requires a focus on *"analysing the place of detention as a system [...], to identify problems which could lead to torture or ill-treatment."*²
4. In 2015, NPM members agreed to focus joint efforts on examining pathways between different detention settings. Given that NPM members usually examine treatment and conditions in detention by looking at an individual establishment, we were keen to look at whether there were issues about the treatment of detainees relating to movements from one establishment to another that this approach did not capture. This joint work would allow NPM members to identify and examine the pathways across detention settings³ that extend beyond the scope of individual bodies, or fall outside members' usual monitoring methodology. We welcome the Committee's inquiry and the opportunity to submit evidence drawn from our joint work.

Pathways from prisons to mental health settings⁴

5. The pathways examined by the NPM through our thematic work related in some way to mental health needs, whether these were the reason for initial detention, or became a factor requiring that the detainee be

¹ A full list of the designated members of the NPM and further information about the UK NPM can be found on its website at:

<http://www.nationalpreventivemechanism.org.uk/>

² Association for the Prevention of Torture, *What is preventive monitoring?* <http://www.ap.t.ch/en/preventive-visits/> [accessed 06/10/17]

³ With a focus on pathways that have a start and end place in detention.

⁴ A literature search was undertaken to inform the development of this project. Input was provided by CJINI, HIW, HMIPS, IMBs (E+W), IMBNI, MWCS, RQIA

moved from one place of detention to another. Specifically, we looked at pathways between different mental health settings; pathways from police custody arising from mental health issues; and, of direct relevance to the Committee's inquiry, from prison to mental health settings.

6. The inappropriate detention of persons with mental health problems in prisons and the prevalence of mental health problems among prisoners have been a matter of public concern over many years.⁵ The provision of healthcare in prisons more generally is a growing concern for NPM members. In addition to the need to provide appropriate physical and mental healthcare to all prisoners in prison, Individual NPM members have identified concerns about the situation of prisoners with serious mental health issues requiring in-patient treatment, which requires a pathway for them to be moved from prisons to secure mental health care.⁶ The absence or inaccessibility of such a pathway can pose significant risks to the ability to treat them appropriately and in a timely fashion, and prevent further deterioration of their conditions.
7. A turning point in the understanding of mental health issues in the criminal justice system came in 2009 with the publication of the Bradley Report. As a result of this, there has been greater focus on developing liaison and diversion schemes to ensure that people in need of treatment for mental disorders in hospital are identified by police and courts and are not sent to prison. However, despite the intention to introduce and implement such schemes, research shows that there has been a decline of more than 25% in the use of hospital orders (which allow defendants to be sent for medical care instead of receiving a prison sentence) since 2011.⁷

Legal and policy framework

8. Involuntary psychiatric treatment of persons detained in prisons is not permitted in the UK, to safeguard detainees from potential abuse. Instead, legislative frameworks across the UK provide for the transfer of detainees who require assessment and treatment for mental disorder to hospital, and their subsequent return to prison when the health episode is completed.
9. Codes of Practice guide appropriate care and treatment under relevant legislation in England, Wales and Scotland and one is being drafted in Northern Ireland.⁸

Table 1: Legislative instruments

	Transfer from prison of a person who is suffering from a mental disorder for which medical treatment is available in the hospital	Transfer from hospital to prison following completion of hospital medical treatment
England and Wales	Mental Health Act 1983 Section 47, Section 48 and Section 49 (restrictions)	Mental Health Act 1983 Section 50
Northern Ireland	Mental Health (NI) Order 1986 Article 53 and 54 (removal to hospital)	Mental Health (NI) Order 1986 Articles 56 and 57
Scotland	Mental Health (Care and Treatment) (Scotland) Act 2003 Section 136	Mental Health (Care and Treatment) (Scotland) Act 2003 Section 216(2) <i>[Revocation by Scottish Ministers]</i>

⁵ See Bradley Report.

⁶ CJINI, Hydebank Wood Secure College report, Ash House Women's Prison report, Maghaberry Prison report; HMIP Annual Report 2016-17 p36; HMIPS, Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons (2008).

⁷ Yeung, P. 'Rise in prisoners moved to mental health hospitals'. The Guardian 14.09.16.

⁸ England and Wales: *Mental Health Act 1983: Code of Practice* (2015) chapter 22. Scotland: *Mental Health (Care and Treatment) (Scotland) Act Code of Practice*, Volume 3: Compulsory Powers in Relation to Mentally Disordered Offenders.

10. To effect the transfer of a person from a prison to a hospital and vice versa, a transfer direction is required to provide legal authority. In England and Wales the transfer direction is provided by the Secretary of State of Justice, in Northern Ireland the Minister of Justice and in Scotland by the Scottish Ministers. There is no right to appeal for prisoners who do not want to be transferred from prison to hospital, although some patients (including all patients transferred from prison in Scotland) can apply to a tribunal to revoke the transfer once it has taken effect.
11. After the recommendation in the Bradley report that prisoners requiring hospital assessment and treatment should be transferred from prison to hospital within 14 days, guidelines⁹ were introduced in England and Wales with the intention that a prisoner should be transferred to a mental health unit within 14 days of the first medical recommendation for transfer. During this 14 days, a second medical opinion was to be sought and all administrative tasks, including finding a bed, should also be completed. In Scotland, once the Direction has been signed by Scottish Ministers, the transfer must take place within 7 days, although the Act does not specify a time period before the application for a Direction must be determined.

In practice

12. The NPM requested data on the number of transfers from prisons to hospitals and was informed that in 2016-17 there were 1083 transfers in England (983 men and 100 women), 15 in Northern Ireland (12 adult men, one young male and two women) and 57 in Scotland (50 men and 7 women).¹⁰ Information obtained by a freedom of information request cited in a newspaper article suggests that the number of male prisoners being transferred to hospital grew by more than 20% between 2011 and 2014 in England and Wales.¹¹ The most recent data we accessed showing the number of patients returned from hospital to prison was 305 during 2015.¹² In 2016 1175 prisoners were transferred to a secure hospital under the Mental Health Act 1983, of whom 104 were women and 1071 were men.¹³
13. Not all prisons are involved in transferring detainees to secure hospitals for treatment, and in England in 2016-17, 31 out of 112 did not initiate any transfers and 80 prisons had 12 or fewer transfers. Most transfers are from category A and B prisons that have 'inpatient' units and where the most seriously mentally disordered prisoners usually accumulated.¹⁴

Table 2: The ten busiest prisons in England from which prison to hospital transfers are made

Prison	Detainee gender	Security category	Number of MHA transfers from prison to hospital initiated and/or completed in 2016-17
Pentonville	Male	B	106
Wandsworth	Male	B	66
Leicester	Male	B	50
Woodhill	Male	B	37
Belmarsh	Male	A	33
Long Lartin	Male	A	33
Thameside	Male	B	33

⁹ Department of Health, 'The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act' (2011)

¹⁰ Data from different jurisdictions may not be collected in standardised ways and definitions may vary so this data is not comparable and may not be entirely accurate.

¹¹ Yeung, P.

¹² NHS England, Written evidence to the Justice Committee inquiry on governor empowerment, 6 February 2017.

<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/justice-committee/prison-reform/written/46720.html>

¹³ Hansard, Prisoners: Mental Illness, Written Answer to David Hanson MP, 12 September 2017

¹⁴ NHS England Central Database Working Document 090617 PT MH Assessments and Secure Transfers (email correspondence between HMIP and NHSE).

Wormwood Scrubs	Male	B	31
Bronzefield	Female	B	30
Preston	Male	B	27

14. It appears that there is no central record of how many prisoners are currently awaiting a transfer to a secure hospital.¹⁵

Issues identified by NPM members

Appropriate location

15. International human rights standards set out the requirement that *“Prisoners who require specialized treatment [...] shall be transferred to specialized institutions or to civil hospitals”*.¹⁶ NPM members have frequently raised concerns in their inspection reports about the appropriateness of the prison environment for detainees with serious mental health problems.
16. It is of particular concern that prisoners awaiting transfer to hospital are often found in segregation units.¹⁷ During its 2016 visit, the European Committee for the Prevention of Torture (CPT) noted that the in-patient healthcare unit at HMP Pentonville was primarily being used to hold psychiatric patients, and concluded that such units should *“not become a substitute for the transfer of a patient to a dedicated facility”*.¹⁸ Similar concerns were identified by HMIP, who reported that prisoners awaiting transfer were being managed either in the in-patient unit, the segregation unit or on open landings on the wings, and that in all three environments their mental disorders were not being assessed or treated as would occur in a hospital facility. In segregation and on the wings their vulnerabilities would have been exposed, leading to a potential deterioration in their mental states.¹⁹
17. The Prisons and Probation Ombudsman (PPO) reported that prisons had tried to arrange transfers to hospital for one in ten of the 139 prisoners who died from suicide between 2012 and 2014 and had identified mental health problems at the time.²⁰ The PPO found further cases where prisoners had not received appropriate support for their mental health problems, while waiting for a transfer or waiting to be assessed for a transfer to a secure hospital.

¹⁵ See NAO report (NOMS and NHS England told this to NAO).

¹⁶ Standard Minimum Rules for the Treatment of Prisoners, Rule 27

¹⁷ See, for example, CJINI report Ash House [http://www.cjini.org/getattachment/efa315e4-3288-47e1-85f6-2de9186916fc/Hydebank-Wood-Young-Offenders-\(1\).aspx](http://www.cjini.org/getattachment/efa315e4-3288-47e1-85f6-2de9186916fc/Hydebank-Wood-Young-Offenders-(1).aspx) page 43, para 2.78, HMIP *HMP Pentonville*

¹⁸ CPT, *Report to the Government of the UK on the visit to the UK carried out by the European CPT*, CPT/Inf (2017) 9, paragraph 66.

¹⁹ HMIP, *HMP Pentonville*

²⁰ PPO, *Learning from PPO Investigations: Prisoner mental health* (2016). It is not known whether the deaths would have occurred had the prisoners been in hospital rather than prison.

Case study – Dean Saunders

On 4 January 2016, a 25-year old prisoner held at HMP Chelmsford, Dean Saunders, committed suicide. The independent investigation into his death, conducted by the PPO, noted that on 21 December 2015 a prison psychiatrist had assessed Mr Saunders as suitable for transfer to a secure hospital, but did not complete the first recommendation required for a transfer under the Mental Health Act because the local secure hospital did not have a bed available. The first recommendation was completed several days later on 31 December. Though the local hospital had a place for Mr Saunders, prison healthcare staff believed they needed a second recommendation from the prison psychiatrist, who was on leave until 5 January, when in fact a signature from any other doctor would have sufficed. This meant that though all those involved in his care agreed that prison was not an appropriate place for him, the opportunity to transfer Dean Saunders to a more suitable placement in a hospital was missed. In their evidence to the Joint Committee on Human Rights, Dean Saunders' parents said they had been told not to worry, that "He's secure until we can get him transferred". The Prisons and Probation Ombudsman concluded that the criminal justice system did "too little to protect this very vulnerable young man" and an inquest jury found that Dean Saunders and his family were "let down by serious failings in both mental health care and the prison system" and that the cause of death was "contributed to by neglect".

NPM members are concerned that the lapses in understanding the transfer pathway correctly evidenced in this case are not untypical.

Timeliness of transfers

18. International human rights standards emphasise that arrangements for prisoners who are diagnosed with severe mental disabilities and/or health conditions, for whom staying in prison would mean an exacerbation of their condition "*shall be made to transfer them to mental health facilities as soon as possible*".²¹
19. The NPM was able to access NHS England data showing the timeliness of transfers from prisons to hospital in England and Wales in 2016-17.²² This showed that of a total of 1083 transfers from prison to hospital, 366 (33.7%) were completed within the agreed 14 day time period and 717 (66.3%) were not. 76 prisoners (7.1%) waited for 140 days or longer.²³ This same data indicated that men were less likely to be transferred within the guideline target of 14 days than women. Transfers of 67.7% of men were not completed in 14 days compared to 54% of women. 7.6% of men and 2% of women waited for 140 days or longer. Data on delays in transfers obtained for a debate on prison safety in Parliament by Committee Member Luciana Berger MP showed, in her words, "*such ubiquitous failure [that] would never be tolerated in the outside world*".²⁴
20. More specifically, the NPM understands that delays often arise for administrative reasons between the first and second assessments, which prolongs the waiting time from first assessment to transfer. These delays are hard to quantify as data is not captured centrally.
21. A study published in 2016 examined the transfer of 64 male prisoners in England and Wales and found that the mean time from referral to hospital admission was 76 days. They noted that a sizeable number of prisoners were left in prisons for excessive periods of time, with suspected mental disorders for which

²¹ Nelson Mandela Rules, Rule 109.1

²² NHS England Central Database Working Document 090617 PT MH Assessments and Secure Transfers (email correspondence between HMIP and NHSE).

²³ NB this data refers to the time interval from first referral to the hospital admission

²⁴ Hansard, Suicide and Self Harm in Prison (England). 1 March 2017, Volume 622

treatment is readily available in hospital but cannot be administered without consent in prisons.²⁵ At its most recent inspection of HMP Pentonville, HMIP and its partners noted that the range of transfer times from referral to arrival at a hospital was 0-187 days, with only 15% of prisoners transferred within the 14-day guideline.

22. We were unable to obtain data for Northern Ireland, but NPM members report delays beyond 14 days, sometimes lasting weeks, due to bed availability and the need for a consultant from the receiving hospital (usually the Shannon Clinic in Belfast) to come to the prison to assess the person and determine if it is a suitable case. We understand the experience in Scotland to be that, in most cases, a hospital place can be found reasonably quickly for a prisoner who requires to be admitted, although there are pressures in the medium secure hospital estate, and delays can occur, particularly for prisoners with complex needs'
23. Evidence from various sources available to the NPM, including complaints from prisoners to NPM members, indicate that there are often delays in the process of assessment for transfer, essentially before the 14-day guideline starts to be counted. This was also commented on by the PPO who indicate that the recording of the length of wait for transfer to secure hospital does not generally begin until an assessment has taken place, which opens up the possibility of assessments being pushed back until there is the possibility of a place being available.²⁶
24. Some of the difficulties in achieving timely transfers of prisoners to mental health hospitals reported to NHS England Health and Justice Quality Surveillance Groups were shared with HMIP. These included: disagreements about transport arrangements, ineffective communication between mental health teams and prison officers, contradictory policy and good practice guidelines (e.g. between DH guidance, Health and Justice Performance Indicators, and contract specifications). A forensic psychiatrist interviewed by HMIP reported many frustrations and "*incessant time on the phone*" attempting to expedite transfers to secure hospitals. More specifically, she cited problems arising from clinicians taking different views on cases, ineffective communications between medium secure unit staff acting as 'gatekeepers' to accessing other secure hospitals, and the fact that some psychiatric intensive care units will not take transferees from prisons.²⁷

Case study – HMP Bristol: a mixed picture

During its 2017 inspection of HMP Bristol (Category B men's prison), HMIP identified very good links between the prison's mental health service provider and the local NHS medium secure unit (MSU). The prison psychiatrist also practiced at the MSU and a forensic psychiatrist from the MSU attended the weekly prison health multi-disciplinary meeting, which kept the prison on the MSU's agenda. As a result, transfer times to the unit were reasonably good. This was not the case for transfers to high secure units or MSUs that were further away. The transfer time was being counted from when a bed became available, which is not compatible with the 14-day guideline. HMIP noted that most prisoners were admitted to a hospital within 2-4 weeks, but between April 2016 and February 2017, 6 out of 14 transfers had taken longer than 5 weeks to complete.

Capacity in secure mental health services

25. Across the UK, capacity constraints in secure mental health services hinder the pathway from prisons and lead to prisoners being transferred across jurisdictions.

²⁵ Sharpe, R., Vollm, B., Akhtar, A., Puri, R., and Bickle, B. (2016) Transfers from prison to hospital under Sections 47 and 48 of the Mental Health Act between 2011 and 2014. *The Journal of Forensic Psychiatry and Psychology*, Volume 27, 2016 – Issue 4 pp459-475.

²⁶ PPO, *Learning from PPO investigations: Prisoner mental health*, 2016

²⁷ Further analysis of the problems and difficulties associated with the transfer process is detailed in RCPsych, *Prison transfers: A survey from the Royal College of Psychiatrists. Occasional Paper OP81*, (2011)

26. In Northern Ireland, the lack of a local high secure hospital means that some prisoners are sent to Carstairs (in Scotland) or Ashworth, Broadmoor or Rampton (in England) but it is often the case that some very dangerous mentally disordered offenders can remain in Maghaberry prison for the whole of their sentences.²⁸ Similarly in Wales there are no high secure hospital beds.
27. Successive inspections by HMIPS have identified delays in transfers from prisons for women and men due to the insufficient provision of medium-secure hospital beds in Scotland. The absence of high secure mental health beds for female prisoners has been identified as an area of concern in Scotland by the MWCS. The matter is under consideration by the Scottish Government, although the way forward has not been agreed.
28. In England there are insufficient secure mental health beds to meet demand.²⁹ Lack of access to secure hospital beds is the most frequently cited reason for delayed transfers from prison to secure mental health services. The NPM is aware that there are aspirations to increase capacity but this will not be achieved for several years.

Transfers at the end of prison sentences

29. The failure to effect transfers before a prisoner has completed his/her sentence means that opportunities to prevent mental deterioration through appropriate treatment may have been missed and/or the public placed at risk. One NPM member identified three cases where prisoners had been released before the prison had completed the process for transfer to a secure hospital. This was of concern because the prisoners in question had suspected mental disorders which may have responded to treatment and/or a mental disorder which may have been a factor in the offence/alleged offence.

Account from a forensic psychiatrist

A forensic psychiatrist interviewed by HMIP related the story of a patient that had been under her care in prison. The man had been seen by the liaison and diversion worker at court who recommended admission to a mental health hospital, but the judge remanded the man to prison. After three days at the receiving prison the man was relocated to the 'inpatient' unit. The forensic psychiatrist made a referral for a possible low secure hospital placement and established that the PICU was unwilling to take him. Low secure staff assessed the patient six days after referral and accepted him for transfer 20 days after referral but indicated that a bed was unlikely to be available for another month. Whilst in the inpatient unit the patient was regularly on 3-man unlocks. 40 days after first referral the man appeared in court once again, but this was a different court with no liaison and diversion service. The man was given unconditional bail and allowed to leave the court. The attempt to transfer the man for mental health assessment and treatment had failed. Because of the safety precautions indicated for this detainee whilst in prison the prison mental health team were concerned for his safety and the safety of others in the community because of his untreated behaviours.

Conclusions

30. It is of particular concern to the NPM that the failure to effect transfers efficiently can cause deterioration in prisoners' wellbeing. The evidence gathered by NPM members makes clear that the problems with transfers between prisons and secure hospitals identified over the last decade, not least in the Bradley Report, have not gone away. In fact, analysis by HMIP of its inspection recommendations shows a year on year increase in the proportion of inspections in which recommendations are made about Mental Health Act

²⁸ CJINI, *Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland* (2010), <http://www.cjini.org/getattachment/24d6cd45-20bb-4f81-9e34-81ea59594650/Mental-Health-and-the-criminal-justice-in-Northern.aspx>

²⁹ Department of Health, *The NHS Plan*, London: DoH 2000 page 118

transfers. Though this data should be treated with caution because HMIP inspects different prisons every year, it is notable that in 2016-17, HMIP made a recommendation to improve the timeliness of transfers in more than half (56%) of its published inspection reports.

31. The lack of public and comparable data, particularly from Scotland, Northern Ireland and Wales, makes it difficult to analyse the extent of the problem across the UK.
32. The NPM welcomes recent scrutiny of these issues by the National Audit Office, the Joint Committee on Human Rights and the CPT. All agree that the current recommended 14-day target is not being met and that this requires review, and made the following specific suggestions:
 - introduce a legal maximum time between the diagnosis and transfer of detainees requiring care in a secure hospital (JCHR);
 - Ministry of Justice and NHS England to routinely report how many prisoners are waiting to be transferred (NAO);
 - all patients transferred from prison should automatically trigger a review by the Mental Health Tribunal of the transfer measure.³⁰
33. These recommendations were made with the English system in mind, but their implementation across the four nations of the UK could be considered.
34. The NPM agrees with the need to review the current 14-day guideline, but believes this should be done with a view to removing the obstacles to its implementation and reducing it further in future (as recommended by the CPT), rather than extending the time period in response to current delays. In addition, stronger mechanisms are needed to ensure transfer assessments cannot be delayed as a means of postponing the start of the 14 day guideline.

³⁰ CPT, paragraph 176