Howard League for Penal Reform

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Howard League for Penal Reform's response to proposed changes to 'The transfer and remission of adult prisoners under the Mental Health Act 1983 good practice guidance 2019'

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Summary

1. The Howard League for Penal Reform welcomes the opportunity to comment on the draft proposal for transfer to and from prison and hospital under the Mental Health Act 1983. The current guidance is outdated and a refresh is welcome in principle, especially in the current context where many people with mental health problems in prison are suffering without appropriate support and treatment. However, as presently drafted, a number of significant concerns arise.

2. The guidance has been drafted to address valid concerns about delays in the current system and to clarify various matters. It is impossible to see how either of these aims are achieved in its present form. Extending the period within which a transfer from prison to hospital must take place from 14 days to 28 days will not reduce delays and the guidance still lacks clarity as to how a transfer can commence and progress from the perspective of the patient.

3. The decision to impose a time limit of 14 days on remission back to prison raises significant concerns that people will be rushed back to prison without sufficient discharge planning.

4. The guidance is not applicable to children, leaving a disparity between the protections for adults and children. The guidance makes no express reference to the particular needs of young adults with mental health difficulties. This group requires special attention in respect of mental health.

5. The guidance includes a number of references to the operation of the Mental Health Act which do not correlate with the relevant statutory tests.

6. The proposed guidance presents a missed opportunity to address a number of concerns in the present system. It fails to give due weight to the rights of prisoners and patients and in particular fails to recognise the right of the patient or person in prison to request a transfer and ensure that time runs from that point.

1. About the Howard League for Penal Reform and summary of response

1.1 Founded in 1866, the Howard League is the oldest penal reform charity in the world. The Howard League has over 12,000 members, including prisoners and their families, lawyers, criminal justice professionals and academics. The Howard League has consultative status with both the United Nations and the Council of Europe. It is an independent charity and accepts no grant funding from the UK government.

1.2 The Howard League works for less crime, safer communities and fewer people in prison. We achieve these objectives through conducting and commissioning research and investigations aimed at revealing underlying problems and discovering new solutions to issues of public concern. The Howard League's objectives and principles underlie and inform the charity's parliamentary work, research, legal and participation work as well as its projects.

1.3 Our legal team works directly with children and young adults in prison.

1.4 We have drawn on our legal and policy work in responding to this consultation. While we welcome the opportunity to comment on the draft sentencing guideline for people with mental conditions or disorders, we are concerned that, as presently drafted, the guideline raises a number of concerns and presents a missed opportunity to ensure that people who have mental health conditions or disorders receive appropriate outcomes in the courts that meet their needs and do not exacerbate them.

1.5 The Howard League would welcome the opportunity to provide further information about any of the points below.

2. Context – mental health provision in prison

2.1 The current guidance is outdated and a refresh is welcome in principle, especially in the current context where many people with mental health problems in prison are suffering without appropriate support and treatment.

2.2 There is a wealth of evidence to show that custody can exacerbate poor mental health and increase the risk of self-harm and suicide. The Howard League and the Centre for Mental health conducted an inquiry on preventing prison suicides and found that prisons were unhealthy and unsafe places that were having a detrimental effect on prisoners' physical and mental wellbeing (Howard League, 2016). Prisoners experiencing mental distress often exhibit challenging behaviour and are subject to punishments that exacerbate their distress, such as being placed on basic regime or in solitary confinement. Prisons are not safe places for people with mental health conditions or disorders and in some cases, may precipitate them.

2.3 In 2018 the House of Commons Health and Social Care Committee published a report on prison health. It stated at paragraphs 83ff:

> "83. Numerous concerns have been raised with us about the demand for, and provision of, services catering for people with all severities of mental health need in prison. The environment, culture and conditions within prisons frequently compromise the mental wellbeing of prisoners and staff alike. For example, in

men's prisons, over the last two years, the vast majority of HMIP's inspection reports (90% in 2017/18 and 75% in 2016/17) have been critical of the establishments response to one or more of the key factors that contribute to self-harm and suicide. One fifth of reports in 2016/17 and a third in 2017/18 included a main recommendation relating to these issues. However, the inspectorate's latest annual report notes that "despite similar recommendations in the past, prisons had made insufficient effort to help prisoners in crisis."

84. HMIP recommended improvements in the provision of mental healthcare in just over half of all prisons inspected in 2017/18. To begin with, there is a gap in mental health services commissioned in prisons, particularly services catering for people with mild to moderate mental health needs (e.g. psychological services, counselling etc). This point was reiterated in CQC's evidence to us. There is also a difficulty with ensuring continuity of mental health care when prisoners are transferred to other prisons.

85. For those with severe mental health problems, guidelines introduced in England and Wales following the Bradley Report stipulate that prisoners should be transferred to a mental health unit within 14 days of the first medical recommendation for transfer. A second medical opinion and all administrative tasks, including finding a bed, should also be completed in those 14 days. However, this is rarely the case. Instead, in England and Wales in 2016–17, only 366 (33.7%) of the 1083 transfers from prison to hospital were completed within 14 days. 717 (66.3%) took longer than 14 days and 76 prisoners (7.1%) waited 140 days or longer. HMIP found excessive delays in 27 male prisons in 2017/18."

2.4 The latest annual report published by the Chief Inspector of Prisons (Her Majesty's Inspectorate of Prisons, 2019) found,

> "In over half the adult male prisons inspected, we found a lack of assessment and treatment for prisoners with mental health, learning disabilities or emotional needs. Many prisoners were held in conditions that were in no way therapeutic, and which often clearly exacerbated their condition. We remained concerned about the continuing plight of prisoners experiencing severe delays in transfer to secure mental health beds. In the vast majority of prisons, the 14-day target for transfer was not met; one prisoner at Swinfen Hall had waited seven months before he was finally admitted".

2.5 In light of these concerns, it is imperative that people who require hospital treatment are identified, assessed and treated. Potential patients should be able to identify themselves as suitable for section under the Mental Health Act 1983, just as they would in the community and requests for assessment ought to be responded to urgently and monitored. In the Howard League's experience of working with young adults, it is often the case that those who would like to be considered for hospital are routinely not assessed.

3. Delays and clarification

3.1 The guidance has been drafted to address valid concerns about delays in the current system and to clarify various matters. It is impossible to see how either of these aims are achieved in its present form.

3.2 The guidance proposes to extend the period within which a transfer from prison to hospital must take place from 14 days to 28 days. This will not reduce delays – in fact a longer time period will most likely increase delays. It may reduce the number of cases which are recorded as delayed but that would not translate into more positive outcomes for patients in reality. The real problem is one of resources: delays occur because of a shortage of places to transfer people to. That is not addressed in the guidance.

3.3 The guidance still lacks clarity as to how a transfer can commence and progress from the perspective of the patient.

Paragraph 4.1 states:

> "The referral should be initiated as soon as it is identified that a person's mental health needs cannot be appropriately treated within a prison and they fit the criteria for detention under the MHA and they require a transfer to a mental health hospital."

Paragraph 4.1.1 entitled, 'Timescales for referral, assessment and transfer' states that "monitoring of time to transfer begins on the day that the initial referral is made to the appropriate clinical team by the relevant prison mental health team."

In many instances it will be the patient or prisoner who identifies the need. However, the Howard League has found that when concerns are raised by the individual affected they are often not acted upon and time does not appear to run from then. The guidance should be clear that identification can take place by a medical professional or the person concerned (or a person acting on their behalf with appropriate authority) as would be the case in the community in order to ensure compliance with Article 8 of the European Convention on Human Rights and the duty to ensure equality of care in the community and custody (R (Brooks) v Secretary of State for Justice [2008] EWHC 3041).

3.5 The proposed guidance also purports to assist in providing clarity as to the responsible health authority at paragraph 3.1 entitled, 'establishing the responsible commissioner' with reference to the "Who pays" guidance. However, the "Who pays" guidance says someone is usually resident where they say they live/what address they give, which is not always a straightforward. The critical issue is that there should not be delays on account of who should pay. While the guidance does make this clear by stating that "the NHS is expected to act in the best interests of patients at all times and work together in the spirit of partnership", in the absence of a fall back procedure in cases where it is not clear, it is unlikely that delays will be avoided.

4. Children and young adults

4.1 The guidance is not applicable to children, leaving a disparity between the protections for adults and children. The guidance applicable to children in also out of date. In our legal work, the Howard League has come across a number of extremely concerning examples of children who have been extremely unwell and considered suitable for transfer but have not been transferred for an excessive period of time due to the lack of a suitable bed.

4.2 The guidance makes no express reference to the particular needs of young adults with mental health difficulties, even though it will apply to young adults. This group requires special attention in respect of mental health.

4.3 It is well established that this group is still maturing and inherently vulnerable. There is a firmly established evidence base that young adults between 18 and 25 years old continue to mature and in particular the frontal lobes of the brain, which help regulate decision-making and impulse control, develop until around 25 years old (Blakemore et al 2006; T2A and University of Birmingham, 2011). In R v Clarke [2018] EWCA Crim 185 the Lord Chief Justice observed:

> "Reaching the age of 18 has many legal consequences, but it does not present a cliff edge for the purposes of sentencing. So much has long been clear… Full maturity and all the attributes of adulthood are not magically conferred on young people on their 18th birthdays. Experience of life reflected in scientific research (e.g The Age of Adolescence: thelancet.com/child-adolescent; 17 January 2018) is that young people continue to mature, albeit at different rates, for some time beyond their 18th birthdays. The youth and maturity of an offender will be factors that inform any sentencing decision, even if an offender has passed his or her 18th birthday."

4.4 Mental health difficulties are more prevalent in this age group. There is a significant body of evidence that demonstrates that mental health problems are disproportionately prevalent among young adults in the criminal justice system (Royal College of Psychiatrists, 2015). Mental health conditions may still also be present but undiagnosed either due to lack of system contact or the practice of not diagnosing some disorders until people are in their mid-twenties.

4.5 Prison can have a particularly detrimental effect on the well-being of this group and may exacerbate or even precipitate mental health conditions. The latest annual report by Her Majesty's Inspector of Prisons for 2018-19 states:

> "As of 31 December 2018, 13,474 young adult men aged 18 to 24 were held in adult male prisons (17% of all male prisoners). In our survey, they generally reported a less positive experience of prison life than their older peers. They were often overrepresented on the lowest level of the incentives scheme and in disciplinary proceedings, and prisons were not investigating the underlying reasons for this sufficiently."

4.6 At the Howard League, we have worked with a significant number of young adults who have mental disorders who have asked to be considered for transfer to hospital. All too often these requests are ignored or they are labelled as not being suitable due to having "personality disorder", even though such a diagnosis does not preclude a transfer under the Act.

5. Wrong in law

5.1 The guidance includes a number of references to the operation of the Mental Health Act 1983 which do not correlate with the relevant statutory tests.

5.2 For example, the executive summary states some individuals "will require inpatient care as their clinical needs cannot be met within a prison setting and they have been assessed by a Section (s) 12 doctor as meeting the criteria for detention under the Mental Health Act 1983 (MHA)." This gives a misleading impression as to the correct legal test for transfer to hospital under the Mental Health Act 1983. The Act does not require an analysis of whether or not an individual's needs can be met in prison. The test is whether the nature or degree of the individual's mental disorder "makes it appropriate for him to be detained in a hospital for medical treatment". It is conceivable that a person's needs might be met in prison but it may still be appropriate for them to be transferred to hospital. It is disappointing that the incorrect test is set out in the executive summary. The interpretation of the test set out in the executive summary is also indicative of an undertone throughout the guidance that transfers to hospital should be kept to a minimum: see for example the sentence preceding this in the executive summary which states that "most individuals will be treated successfully by prison mental health services". It is unclear what the purpose of that sentence is or the evidence base for it given the concerns outlined at paragraph 2 above.

5.3 The error noted above is replicated in the first paragraph under section two of the guidance headed, "introduction". It states "prisoners with mental illness who require inpatient treatment in secure mental health services can only be transferred to hospital under the MHA with the agreement of the Secretary of State for Justice." The test is not one of "requirement" but "appropriateness". In addition, the language of the guidance should replicate the Act and refer to "mental disorder" rather than "mental illness".

6. Missed opportunities: patient involvement and patient rights to initiate transfers

6.1 The proposed guidance presents a missed opportunity to address a number of concerns in the present system.

6.2 It fails to give due weight to the rights of prisoners and patients. The first mention of involving the individual affected is at page 11. This is contrary to human rights which require individuals to have a greater level of involvement in matters affecting their physical and psychological health and integrity (Article 8, European Convention on Human Rights) and NHS policy, which is underpinned by statutory duties to involve patients in their care and treatment (National Health Service Act 2006; Involving people in their own health and care: Statutory guidance for clinical commissioning groups and NHS England).

6.3 In accordance with the rights of individuals to be involved in their own health and care, it is essential that the guidance should recognise this and cater for what should happen when a person raises concerns that they may be appropriate for transfer. Time should run from that point. There should be clarity as to exactly how prisoners or people supporting them can bring such requests to the attention of the relevant authority and there should be a list of contact details publicly available on a central website and in each prison. At present, it is difficult even for lawyers to identify which NHS body is responsible for in-reach mental health in each prison, let alone find the contact details for the relevant psychiatrist who would be responsible for carrying out the first assessment. People in prison are not provided with essential information about this either. In fact, many people in prison do not know the full name of the mental health professionals they see, despite the "Hello my name is"-campaign and as this has been recognised by the NHS and the Department of Health as central to

patient care. If people in prison are to be able to exercise their right to health and care, they need to know who they are dealing with and how they can trigger appropriate assessments and interventions.

6.4 Similar concerns apply with respect to remissions from hospital to prison. The guidance deals with this at section 5, which states:

> "Remission to prison may be requested under s50, 51 or 53 of the MHA if the responsible clinician, any other approved clinician or a Mental Health Tribunal advises the Secretary of State for Justice that:
> - treatment in hospital is no longer required or,
> - no effective treatment is available in the hospital where the patient is detained."

6.5 While this reflects the wording of those provisions, the guidance fails to emphasise the role of the patient in this decisions process, simply noting that the patient should understand what is happening to them by stating "it is essential that the patient understands and is involved in the remission process, particularly around s117 after care planning and knows what to expect at each stage."

6.6 Remission from hospital to prison can be one of the most counter-therapeutic processes and risks undoing the positive effects of treatment in hospital. The s117 discharge process referred to as part of the duty to understand the process should also involve an opportunity for the patient to make representations about whether the process should take place at all. This is clear from the Mental Health Code of Practice which states that:

> "1.7 Patients should be given the opportunity to be involved in planning, developing and reviewing their own care and treatment to help ensure that it is delivered in a way that is as appropriate and effective for them as possible...
>
> 1.8 A patient's views, past and present wishes and feelings (whether expressed at the time or in advance), should be considered so far as they are reasonably ascertainable…
>
> 1.10 Patients should be enabled to participate in decision-making as far as they are capable of doing so. Consideration should be given to what assistance or support a patient may need to participate in decision-making and any such assistance or support should be provided, to ensure maximum involvement possible…"

6.7 The decision to transfer from hospital to prison is likely to have a major impact on the care and treatment a patient receives, and so the above requirements are of particular importance in this context. In R (L) v West London Mental Health NHS Trust [2014] 1 WLR 3103 the Court of Appeal considered a transfer between medium and high security hospital absent urgency. It concluded that the "gists" of the letter of reference to the high security hospital by the hospital that wishes to transfer the patient and the assessment by the clinician from the high security hospital should be provided to the patient and/or his or her representative, absent a clinical reason precluding such notification, or some other reason such as the exposure of other patients or staff to the risk of harm: paragraph 99.

6.8 The guidance should reflect these duties and rights.

7. Concluding observations

7.1 The notion of revised guidance to ensure that people with mental health conditions get the most appropriate treatment and care is welcome but we consider that as presently drafted, this guidance requires significant revision to achieve that. We would be happy to discuss this with you further.

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