Howard League for Penal Reform

Howard League for Penal Reform's response to the mental health and wellbeing plan discussion paper

7 July 2022

How can we improve the wellbeing of people that are more likely to experience poor wellbeing?

This submission focuses on the factors which could improve wellbeing and mental health in prison, based on insights from the Howard League's policy and membership work and its legal service for young people in prison.

As the Centre for Mental Health (2021) has argued, justice policies are:

"also mental health policies, and they affect people and communities facing the biggest inequalities and greatest mental health risks most acutely. Justice policies that prioritise rehabilitation, wellbeing and safety can help to improve mental health. Those that do not may ultimately carry a heavy cost for the people concerned, their families and their communities … [T]he policy of increasing the use of prison and expanding prison places by 20,000 (including 500 for women) is likely, ultimately, to do a lot more harm than good to mental health."

The Howard League believes that the wellbeing of people in prison can only be improved by addressing long-standing problems with prison culture, regimes, staffing, and the support available to people who are struggling; by diverting people in poor mental health from the criminal justice system wherever possible; and by the government dropping its counterproductive prison expansion plans.

The Prisons Strategy White Paper acknowledges that too many people with mental health problems *"trip up into prison, and too many are being made worse"*. Yet the government is simultaneously planning to push more people into prisons which compound the symptoms and root causes of their mental ill-health – for example, experiences of trauma and racism.

The discussion paper recognises that people who are contact with the criminal justice system are disproportionately likely to experience mental ill-health, and cites efforts to improve wellbeing in prisons in the Prisons Strategy White Paper. Yet many prisons are currently failing to provide even the basics, let alone the personalised and fulfilling regimes envisioned in the White Paper.

In a recent evidence session for the parliamentary Justice Committee, the Director General of Prisons admitted that unless the current trajectory *"improved significantly"*, the Prison Service would face *"a growing level of staff vacancy, not being able to recover from the pandemic properly, not being able to run prisons properly"*.

For the past decade, following stark cuts to prison staffing and budgets, people in prison have been trapped in unsafe and dehumanising conditions with little to do. The Covid-19 pandemic compounded existing problems in prisons, decimating regimes and leading to dire staffing issues.

During the pandemic, most of the 80,000 people who are held in English and Welsh prisons were locked up for 22 hours or longer each day. Restrictions did not ease in prison when they did in the community; even now, the system is facing such severe staff shortages that the Howard League frequently hears about prisons which are still providing no meaningful regime.

Earlier this year, the Howard League invited its members in prison, and young people who are in contact with its legal service, to share their experiences of imprisonment during the pandemic. People described the dire impact of conditions amounting to prolonged solitary confinement (or confinement with a cellmate in a tiny cell), in the absence of professional support, visits from family and friends or opportunities to keep busy.

For example, one woman explained that she now felt anxious around groups, because she had spent so long in isolation. Another felt that the restricted regime had prompted a mental health crisis. She described prisons as “warehouses of misery inhabited by human beings” and explained that mental health support was:

“almost non existent. Prison officers not trained to cope with ever increasing poor mental health of prisoners. Lack of medically trained staff. Dementia patients left in limbo between prison + social care, screaming, banging on doors, all adding to trauma of longterm restrictions in free association, exercise, education.”

What is the most important thing we need to address in order to reduce the number of people that are at greater risk of dying by suicide?

The rate of self-inflicted deaths among people in prison is ten times higher than the suicide rate in the community (HMPPS, 2021; ONS, 2021). The rate of self-inflicted deaths among people on remand is even higher (HMPPS, 2022).

In 2016, the Howard League and the Centre for Mental Health published two research briefings on preventing suicide in prison. The research found that, on average, someone died by suicide in prison every three days.

The number of self-inflicted deaths had risen significantly in the wake of cuts and – as more people were pushed into prisons which did not have space for them – increased overcrowding. In focus groups, people in prison spoke about the importance of trustworthy and caring staff, support with mental ill-health and the long-term impact of abuse and adversity, and sustained contact with the outside world.

The research suggests that a smaller, less overcrowded prison population, improved relationships with staff and more fulfilling regimes would help to reduce suicide.

What more can the NHS do to help groups who face additional barriers to accessing support for their mental health?

Poor communication and information-sharing are a barrier to mental health support in prison, when someone is transferred between prisons and on release.

When someone needs support or care in prison, they cannot approach healthcare directly: instead, they are reliant on prison application forms or on officers' assessment of the situation after they ring their cell bell. This means that staff who are not necessarily equipped to support people who are struggling with mental ill-health act as intermediaries between a person in prison and the NHS.

In its legal service for children and young adults in custody, the Howard League frequently supports young people who are leaving prison and transitioning back into the community. Howard League lawyers have found that there are significant shortcomings in transitions to community mental health services, particularly for people who are released at the mid-point of their sentence.

In one case, a young person was meant to have immediate support from community mental services on release, but this did not materialise – even though the service had been contacted in advance by children's services and the prison. The young person's mental health deteriorated to the point that he attempted suicide in the community, and he was later recalled to prison. In other cases, counselling has been recommended for a young person on release but there has been no clear pathway for them to access this.

What should inpatient mental healthcare look like in 10 years' time?

The Howard League agrees that people should have the least restrictive care possible, and that hospital-based mental health care should be healing, trauma-informed, high-quality and safe. There must also be enough inpatient beds for acutely unwell people who need to move from prison to hospital, and for people who may end up in the criminal justice system if they do not receive hospital care.

Longitudinal research by Keown et al (2019) shows that transfers from prison to hospital have typically increased after a decline in the number of available (non-secure) psychiatric beds. This suggests that people who require specialist care and treatment in hospital end up receiving prison sentences when beds are scarce.

There are also too few inpatient beds for timely transfers from prison to hospital, and it is unclear whether the new statutory time limit proposed in the Draft Mental Health Bill will resolve the problem. While the Howard League has seen how damaging delayed transfers from prison to hospital can be in its legal work, the new time limit could – as the Royal College of Psychiatrists has warned – unhelpfully disincentivise psychiatrists from recommending hospital care if it is not properly resourced.

Prison inspection reports often find that the time limit for transfers has been exceeded, but that this is about a shortage of secure beds rather than the failings of healthcare staff. For example, HMI Prisons' recent report for The Mount prison found

that: *“There were usually four to six Mental Health Act transfers in hand at a time, all of which exceeded the 28-day transfer guideline, even though mental health services were assertive in progressing transfers.”*

What needs to change in order to realise that vision?

Alongside investment in community mental health services and early intervention, inpatient care must be properly resourced.

How can we improve the immediate help available for groups who face additional barriers in crisis?

The Howard League welcomes proposals in the Draft Mental Health Bill which seek to end the use of prison as a place of safety, and to remove archaic provisions which allow courts to remand people on mental health grounds.

The practice of remand for ‘own protection’ or (for children) ‘welfare’ illustrates how people in crisis can be failed despite the involvement of multiple professionals: a person who has been remanded for their own protection will likely have encountered police officers, court probation staff, lawyers (e.g. a duty solicitor) and a bench of magistrates. The rollout of liaison and diversion services is a welcome step towards a system which can recognise and meet people’s mental health needs, so that they do not receive counterproductive criminal justice sanctions.

However, the government should also consider whether its sentencing policy is undermining this positive work on diversion and mental health support. For example, many people who are charged with or convicted of assaulting an emergency worker – an offence which now carries a two-year prison sentence, following changes in the Police, Crime, Sentencing and Courts Act – are in mental distress.

In the Howard League’s research on arrests of women, a police force told us about an example where their officers had stopped a woman who had gone missing and was shouting and disturbing residents (Howard League, 2021). After being detained to ‘prevent breach of the peace’, the woman allegedly kicked an officer and was arrested for assaulting an emergency worker. Transform Justice’s recent research on assaults against emergency workers (2022) similarly found that:

“Lawyers told us that most assault on emergency worker court cases involve a defendant who is neurodivergent or has a mental health condition or cognitive impairment, and that this was often a relevant factor in the incident. In theory, the police, prosecution and court can take this into account, but lawyers told us this rarely happens. Defendants fall foul of the system’s “hard line” stance on assaults on emergency worker offences, and the paucity of information available to police and prosecutors about the person’s mental health. Existing tools for identifying mental health conditions at the police station are inadequate, meaning many mental health conditions are overlooked.”

Researchers from the College of Policing and the University of Exeter examined over 45,000 police records to explore the factors which increase assaults against police (College of Policing, 2020). They found that officers were more likely to be assaulted if they had used force themselves, and that officers were more likely to use force against someone who was perceived to have a mental health condition.

The Howard League believes that prosecutions and convictions of people who lash out because they are in crisis – and who may be responding to force used against them – conflict with the aspirations set out in this discussion paper.

What 'values' or 'principles' should underpin the plan as a whole?

The Howard League agrees with the statement from the Lived Experience Advisory Network, which calls for:

"needs based, not diagnosis-based, care and treatment … an NHS and social care system which is focused on and curious about a whole person and their needs for recovery, considering both their strengths, as well as the wide range of factors which might impact their mental wellbeing, including their physical health."

People in prison must not be excluded from this shift towards more responsive and person-centred care. At present, the needs of people in prison are neglected, their strengths are overlooked, and the factors which cause poor wellbeing are (as explained above) only becoming worse. The prison environment routinely retraumatises the significant number of people in custody who have experienced abuse in childhood and/or as adults, and leads to anxiety and paranoia for people who know or fear that they are at risk of violence.

Even more troublingly, the prison system too often punishes people for their needs. People who are thought to have "behavioural" problems, rather than a mental health diagnosis, receive little care and can languish in segregation units. Many of those who remain in prison on an imprisonment for public protection (IPP) sentence, long over tariff, have been refused release partly because of mental health needs which have been exacerbated by the sentence itself.

The mental health and wellbeing plan could build on the principle of "equivalence of care" – that healthcare in prison must be an equivalent standard to healthcare in the community – by ensuring that its proposals on wellbeing, suicide prevention, access to mental health support and inpatient care, and immediate help for people in crisis benefit people in prison. The Department of Health and Social Care could also consider routinely evaluating how the policies of other departments impact its aims on mental health and wellbeing, including criminal justice policy.