Appointed by Ministers under the Prison Act 1952, Independent Monitoring Boards (IMBs) are an integral part of the independent oversight of prisons.

Summary

Boards have for some time raised serious concerns about the prevalence of mental illness in the prison population, and the inability of mental health services to meet the need. This is manifested, for example, in high levels of self-harm, particularly among women, and results in long stays in segregation, partly because of delays in transfers to secure mental health facilities. During the COVID-19 pandemic, the lengthy periods locked in cells without purposeful activity, and with limited healthcare provision and social contact, exacerbated these concerns. Initially there were high levels of self-harm in many women's prisons, and there is increasing evidence of the cumulative impact on well-being and mental health throughout the prison estate.

The prevalence and impact of mental health

Pre-COVID

The high level of mental illness among prisoners is well-known. The Board at Guy's Marsh reported that around 40% of prisoners had complex and challenging mental health problems; at Wandsworth, there were 300-380 monthly mental health referrals out of a population of approximately 1,450.

These levels of need are often not matched by resource. Some Boards, for example at Gartree and Whitemoor in the high security estate, reported an improvement in mental health staffing and provision. However, other Boards in local prisons, like Bullingdon and Wormwood Scrubs, reported that mental health services struggled to meet demand; and in-patient units, as at Belmarsh, were predominantly occupied by mental health patients.

This was a particular concern in women's prisons, where prevalence is even higher. The Boards at Low Newton and Bronzefield reported that the inpatient healthcare units had been near or at full capacity with mental health patients, even though there had been an increase in staffing and in-reach therapy at the latter. At Eastwood Park, the Board reported that the complex needs unit for women with serious mental health concerns was often full, leaving other women with similar conditions on normal wings, without this specialist support. At Styal, the board noted that a single day's psychiatry clinic each week was inadequate, given the number of women with severe mental ill-health.

One of the consequences of mental ill-health can be self-harm. Boards in a number of men's local prisons, such as Birmingham, Exeter, Manchester and Pentonville, reported increased levels of self-harm; at High Down, levels had steadily increased over the previous three years.

This is again even more prevalent in women's prisons, where many Boards reported repeated and frequent self-harm by a small number of women with very complex needs. The Bronzefield Board reported an increase in the monthly average of self-harm incidents, up to 141 from 91 the previous year. At Peterborough, there had been an 80% rise in incidents, with nearly three-quarters being usually attributable to

no more than ten women with complex needs; at Styal, between 64% and 85% of incidents involved between 9 and 12 women who self-harmed frequently; at Eastwood Park, 13 women accounted for 149 out of 196 incidents in one month.

Boards monitoring prisons holding young people (under 18) and young adults (18-21) frequently noted the high level of mental health need, which could not easily be met. At Werrington, 60-70% of the young people had mental health issues; though there had been increased psychology, mental health and learning disability resources. However, at Wetherby, where there were similar concerns, over half the mental health posts were vacant. At Feltham, the Board reported that many young adults had a history of mental health problems and were already habitually self-harming prior to prison; the highest proportion of outpatient appointments (44%) was for mental health support. While self-harm and self-isolation in these prisons tend to be associated with fears of bullying and intimidation, this also creates or exacerbates mental health issues.

Post-COVID

Mental health issues were intensified during the COVID lockdowns, as prisoners spent up to 23 hours a day in cell. Prisons did their best to mitigate the impact of this, through additional phone calls and welfare checks by prison staff. However, at the same time, as reported earlier to this Committee, Boards noted that for some months specialist mental health support was restricted to only crisis interventions. At Lewes, on average prisoners were waiting up to nine weeks for a psychiatrist appointment, with a waiting list of 96 in August, and there was limited face-to-face work.

In the women's estate, there was an immediate and noticeable impact, with many boards reporting increases in self-harm, and noticeable spikes at Bronzefield, Eastwood Park and Foston Hall. In Bronzefield, monthly incidents averaged 224 a month between March and July. Though Foston Hall introduced additional welfare checks, they were halted due to staffing shortages. Askham Grange women's open prison had the first self-inflicted death for 13 years.

In the men's estate, it appears that there may have been a cumulative and perhaps more hidden effect. The Board at Springhill open prison reported a marked increase in the number of men transferring from closed prisons who required mental health referrals. Pre-COVID, the highest figure had been 2.7% of arrivals; in June 2020 this figure was 27%, in September 20% and in October 17%. A recent survey by the prison found 34% of men needing mental health support, compared to 9% in a survey four years ago.

By March-April 2021, a number of men's prisons, including Isis, Brixton and Wormwood Scrubs, were reporting significant rises in self-harm. At Bullingdon, the Board expressed concerns about an increase in the number of prisoners who frequently self-harmed and the lack of mental healthcare provision. On one day in

April, there were 42 prisoners on an open ACCT (self-harm and suicide support) plan, five on constant watch and five serious self-harm incidents.

In the youth estate, a number of Boards were particularly concerned about the withdrawal of specialist psychology services for the first three months of lockdown. Although levels of self-harm appeared to decrease, the lasting impact on young people's mental health remained a major concern. The Board at Cookham Wood praised the provision of dedicated health and wellbeing therapists on each landing, who advised officers but had limited face-to-face contact with young people themselves.

Use of segregation and transfers

Boards throughout the prison estate have expressed great concern about the use of segregation, sometimes for very lengthy periods, for prisoners who are clearly mentally unwell and sometimes suicidal. These are inappropriate settings in terms of the physical environment and lack of specialist staff expertise. There are two issues here: the length of time to transfer a prisoner who has been assessed as needing treatment in a secure psychiatric facility; and the fact that some very unwell prisoners fall outside the scope of such assessments, because their behaviours, however extreme, are deemed not to derive from treatable mental health conditions.

Boards continue to report very long stays in segregation. At Cardiff and Exeter, two prisoners were, respectively, held in the segregation unit for seven months and 18 weeks awaiting transfer to a secure mental health hospital. The Manchester Board reported that four prisoners were on constant watch (because of imminent suicide risks) for between two to six months while awaiting transfer.

The Board at New Hall women's prison also reported delays in transfers, though they were reported as more timely at Foston Hall. During COVID, the Board at Eastwood Park noted that waiting times for transfers were exacerbated by the impact of the pandemic on the availability of community-based secure mental health services. The Bronzefield Board reported that of 39 transfers during the year, only 14 had been achieved within the recommended 14 days from the second assessment.

This was an acute issue in the youth estate, due to the national shortage of secure mental health beds for young people. Boards reported that those with complex mental health needs were held for extremely long periods in separation units. At Feltham, a young person on remand spent several months in the unit before a place became available. The Board at Wetherby reported problems identifying placements for older teenagers, because children's secure hospitals do not accept young people aged over 17.5 years.

The second issue is that prisoners who are clearly mentally unwell and with a range of disturbing behaviours fall outside of a diagnosis under the Act. Particularly in the high security estate, they form part of a 'merry-go-round' of transfers between segregation units. In its recent annual report, Wakefield IMB highlighted the fact that a prisoner there had cumulatively spent 949 days in segregation, and three others had spent up to 300, 200 and 100 days respectively. We are also aware of a

prisoner in the women's estate with an acquired brain injury who has spent over 900 days in segregation. In spite of the efforts of local staff, it is clearly not humane to hold prisoners with complex needs in solitary confinement for these extended periods, and this is not solved by simply moving them from one segregation unit to another.

Dame Anne Owers

National Chair

Independent Monitoring Boards

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