Submission to the Joint Committee on Human Rights inquiry on Mental Health and Deaths in Prison

by Her Majesty's Chief Inspector of Prisons

Introduction

1. We welcome the opportunity to submit a response to the Joint Committee on Human Rights inquiry on Mental Health and Deaths in Prison.

2. Her Majesty's Inspectorate of Prisons (HMIP) is an independent inspectorate whose duties are primarily set out in section 5A of the Prison Act 1952. HMIP has a statutory duty to report on conditions for, and treatment of, those in prisons, young offender institutions (YOIs) and immigration detention facilities. HMIP coordinates, and is a member of, the UK's National Preventive Mechanism (NPM), the primary focus of which is the prevention of torture and ill-treatment, in line with the UN Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

3. The following response is based on inspection evidence and survey data.[1] All inspections are carried out against our *Expectations* – independent criteria based on relevant international human rights standards and norms.

The appropriateness of prison

4. We compared the responses from our most recent prisoner surveys from adult men's and women's prison inspections with the survey responses from the previous time we inspected them. This gave us a picture of change between HMIP inspections.[2] The results are compelling, showing significant increases in levels of vulnerability, mental health and substance misuse problems, and safety concerns. While causal relationships are difficult to establish, it is not unreasonable to conclude that these issues are of great relevance to the levels of distress which may lead to self-inflicted deaths in custody. We set out the detailed results from this analysis in Annex I. When seen alongside the steep increase in numbers of self-inflicted deaths in both men's and women's prisons, as well as increasing levels of self-harm, our analysis presents a worrying picture.

5. While we welcome the increase in liaison and diversion services in the community, access to mental health beds continues to be an issue nationally. In 71% of prisons we visited in the last year, male and female patients waited far too long for transfer to mental health services, during which time they could not be treated appropriately under the Mental Health Act (MHA) and were held in an inappropriate environment.[3] While waiting for transfer they

[1] Survey data comparisons are tested for significance to 99%.
[2] This is different to change over time, as inspections occur at different intervals for different prisons.
[3] At HMP Durham (2016), most of the 13 patients transferred under the MHA since January 2016 had experienced excessive waits, which averaged 14 weeks. At HMP Wymott (2016), two prisoners had been transferred to a secure mental health unit during the previous six months, waiting eight and four weeks respectively. At HMP Eastwood Park (2016), we found women awaiting transfer to mental health facilities because they could not be diverted directly from court into appropriate mental health facilities.

require significant input from staff, which has an impact on the care staff can provide to others. Patients in these situations are essentially misplaced in prisons. Though it is not possible to measure the harm or suffering caused, we are concerned that it is significant.

6. There is clear consensus expressed in the Bradley Report, the Harris Review and by others that greater work is required to ensure the most vulnerable people are not sent to prison in the first place, as prisons are not places of safety or treatment. We urge that greater priority is given to ensuring those with serious mental health problems are diverted before reaching prison and to strengthening routes out of prison. This may require further training or resourcing for the police and judiciary, or possibly legislative changes. Where a custodial sentence is the only option for those who have recognised or identified mental health conditions, a full stakeholder partnership (similar to those seen in multi-agency public protection arrangements (MAPPA)) should support the individual and the establishment to ensure that adequate care and planning is in place.

Identification and assessment of risk

7. Systems for identifying risk need to ensure information from court and police custody is considered, but our inspections show that this does not always happen. We have been told that suicide and self-harm warning forms raised at court are not always considered on a person's arrival at prison. We do not know whether this is because staff are unaware of what to look for, or because they do not have sufficient time to consider all relevant documentation. Similarly, while held in police custody detainees may have had a mental health assessment, but this is not always effectively communicated on the Person Escort Record that travels with them to prison.[4]

8. Furthermore, there is still a need for better sharing of information relevant to prisoners' vulnerabilities or mental health when they are transferred between prisons.[5] This should include sharing of information held by agencies and others, including mental health practitioners in the community, and pre-sentence reports. This would require offender supervisors and managers, and health professionals, to be more proactive in contacting the new establishment to share information when someone on their caseload is transferring, as well as information to be shared as required on Person Escort Records and pre-sentence reports.

9. IT systems do not always facilitate identifying risk and sharing information and there is a great need to join up IT systems between different agencies, in particular between NOMS and the private sector.[6]

10. For all of the above, it would help if prison reception staff were better trained and prisoners were immediately assessed on arrival by health care staff with competence in mental health assessment, particularly in category B prisons. In addition, we find that work around prisoners' early days in custody is much better and more supportive where there is greater use of appropriately trained peer support workers (who may be Listeners) within reception and first night areas. [7]

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[4] See inspection report for HMP Leicester (2015) and HM Inspectorate of Prisons (2012). *A thematic review: The use of the person escort record with detainees at risk of self-harm.*

[5] The following fatal incident report highlights many of these problematic issues: Prisons and Probation Ombudsman (2015), *Independent investigation into the death of Mr Joshua Collinson, a prisoner at HMP Swinfen Hall on 3 September 2015*.

[6] For example, private sector prisons are not on the networked public sector system, so potentially have to check and populate two systems to share information. As a result, relevant information about a prisoner with mental health needs who is transferred from a private to a public sector prison, or vice versa, may not be shared. Electronic clinical records are now shared by all prisons on SystmOne but this does not necessarily contain all pertinent community and historical information, and does not incorporate relevant information that may be stored on CMS or P-NOMIS.

[7] HM Inspectorate of Prisons (2015), *Life in Prison: The first 24 hours in prison. A findings paper by HM Inspectorate of Prisons.* See also inspection reports for HMP Thameside (2015) and HMP Foston Hall (2015).

11. Relationships between staff and prisoners are fundamental to the identification of risk. Staff need to have sufficient time and training to be able to form close and effective relationships with individual prisoners, to enable the better identification of vulnerability including mental health problems.[8] We have found that regimes in many men's prisons are restricted in such a way that relationships have eroded, and the capacity for prison staff to create meaningful relationships with prisoners has been lost.[9] Mutual respect is too often replaced by a 'them and us' culture, which increases tension and leads to violence. This in turn forces management and staff to focus time and resources on managing conflict rather than on vulnerable prisoners whose state of anxiety increases in this environment. It also means no-one in authority observes changes in prisoners' behaviour that may indicate internal distress, which may take the form of enacting the distress in para-suicidal or self-destructive behaviour, or by self-medicating with illicit substances.

12. We sometimes find insufficient challenge of low-level bullying and negative behaviours. The zero-tolerance approach adopted widely tends to focus on higher-level poor behaviour, so lower-level and persistent poor behaviour and bullying (of which there is a lot in many prisons) tends to get ignored, even though it may escalate and cause distress.

13. The role of primary and secondary mental health practitioners is key. We expect to see them contributing to segregation visits, assessment, care in custody and teamwork (ACCT) reviews and safer custody and suicide and self-harm (SASH) meetings, so that there are official communication channels about prisoners at risk.

14. In many prisons we have inspected recently, the deterioration in safety levels has meant staff struggle to deliver basic responsibilities, resulting in a process-driven, tick-box approach to identifying and managing risk (i.e. ACCT processes), and in turn a failure to deliver the level of time and care needed.[10] Our monitoring shows that since April 2016, 44 of the 105 prisoners who have taken their own lives were on ACCT. We are concerned that the ACCT process needs to be used to manage risk, not simply to monitor those who are vulnerable. Specifically in relation to women on ACCT, we find the support provided is generally good, although there needs to be more consistency in case management and care.

15. Since the implementation of the Care Act 2014, we have seen improvements in awareness of social care requirements and the needs of the vulnerable who require adult safeguarding, but there is still some way to go to ensure that appropriate referrals are made and the assessments and resources needed to support vulnerable prisoners are always available. We have found that not all prisons have comprehensive safeguarding policies, and not all operational staff understand their prison's safeguarding arrangements. We also found that some prisons had no links with local adult safeguarding boards.

The safety of the prison environment

16. HMIP has reported on its concerns around safety in prisons extensively throughout its inspection reports. Too often we find that establishments react punitively to behaviour rooted in vulnerability. Standard systems and procedures are often not effective in managing

[8] It is our view that the model proposed by the Harris Review (recommendations 15, 60). whereby a new, specialist role whose responsibility it would be to build a supportive relationship with prisoners, oversee their security and well-being, and ensure their health, education, social care and rehabilitation needs were met would be a sensible approach to follow, not just with young adults but with all prisoners.

[9] See inspection reports for HMP Wandsworth (2015) and HMP Pentonville (2015).

[10] See inspection reports for HMP Channings Wood (2016), HMP Hewell (2016) and HMP Winchester (2016).

prisoners who are vulnerable and struggling with mental health issues.[11] We encourage greater use of individualised behaviour management plans informed by mental health specialists within the prison.

17. As proposed in the Bradley Report, there should be greater focus on the identification and support of those with learning difficulties. These prisoners are often vulnerable and find prison a disorienting and particularly distressing experience.

18. Similarly, we think greater awareness of the impact of head injuries on behaviour is needed. At Hindley in 2014, we spoke to a boy who described emotional and anger management problems arising from a head injury. He felt that wing staff misunderstood him and failed to take account of the cause of his behaviour. We are aware of some initiatives to create guidance notes for staff on how to support boys with such injuries, which we view positively.

19. Given the levels of mental health need and vulnerability, we would welcome more discrete units within the prison estate with staff who are specially trained to deal with these issues, are focused on keeping prisoners both safe and purposefully occupied, and also on providing a decent regime.[12] We occasionally inspect prisons where wings are applying for the Royal College of Psychiatry Enabling Environments award, or where some staff have had trauma-informed training. We welcome these positive developments, but there appears to be no strategic approach to equip prison officers in these ways.

20. We have identified good practice on safer custody in some women's prisons, where work is multidisciplinary and involves all departments in the prison. This means that information from prisoners, security incidents and all other departments is coordinated and assessed to build up as full a picture as possible about any safer custody implications. This often happens in multidisciplinary meetings: we have seen meetings attended by mental health services, social workers, psychology teams, drug workers and voluntary agencies alongside prison staff. We hope that this approach will continue.

Access to specialist mental health services and other treatments/interventions

21. The incidence of mental health problems is greater in prisoners than in the general population, and they die more prematurely than the general population.[13] In many prisons there is a further group of prisoners with severe behavioural problems, including para-suicidal prisoners who do not have a mental disorder but who prison staff label as having 'mental health' problems as their behaviours are so abnormal.

22. NHS England service specifications for commissioning health services in prisons include the provision of mental health services. These usually take the form of primary mental health (usually from the physical health service provider) and secondary (in-reach) mental health services (usually from a local NHS mental health trust), with visiting psychiatry and forensic

[11] For example, a prisoner refusing to go to work because he is scared of physical violence may be put on a basic regime, reducing his opportunity to interact with staff, other prisoners and in many cases his family and friends outside the prison.

[12] For example, the psychologically informed planned environment (PIPE) unit at HMP/YOI Swinfen Hall had a multidisciplinary approach to managing complex prisoners and we found that as a result, everything (accommodation, behaviour, safety, relationships) was better in this unit than in the general units. We also found that levels of self-harm tended to be very low at HMP Grendon and HMP Dovegate, even though men have often been multiple self-harmers in the past.

[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565232/health_and_justice_annual_review_2015_to_2016.pdf page 39 [accessed 07/03/17].

psychiatry. However, we frequently find capacity to assist prisoners with emotional and mild to moderate problems is inadequate, such as at HMP Cardiff in 2016 where up to 33% of patients had ongoing, unmet needs.

23. Sometimes there are gaps in service at primary level as there are insufficient staff due to recruitment difficulties, or because mental health staff are deployed to cover physical health duties, or because services lack integration and communication is poor. This is particularly the case where substance misuse services are estranged from health. At HMP Wymott (2016), we found 160 prisoners waiting for primary mental health services. The longest waiting time had been 37 weeks. We do see signs of mental health and substance misuse becoming integrated (for example HMP Exeter (2016)), which we welcome.

24. Where working relationships between prison and mental health staff are effective, and where prison officers are trained in mental health awareness, we find an increased number of referrals for mental health assessments (HMP Pentonville (2017)).

25. Usually prisoners can self-refer to mental health services by filling out an application form, although prisoners believe the system is open to abuse. Additionally, prisoners can approach a primary care nurse who can task mental health to see the prisoner, or another staff member who can make a referral. There are targets for response times. Generally we see good access for prisoners to mental health services but the response may be sluggish.

26. Access to secondary mental health is usually via a joint referral meeting between primary and secondary mental health, although some prisons have other models.

27. There is no national, standard approach to the provision of emotionally supportive services in prisons and our inspections show that it usually falls to the chaplaincy to assist those in distress. The chaplaincy may or may not buy in professional counselling (usually limited to loss and grief reaction work); counselling is rarely provided by the NHS.

28. There does not appear to be a systematic approach to inpatient beds in prisons; where they exist we find they are dominated by patients with mental health problems, many of whom are awaiting transfer to an external mental health service. The close proximity of highly disturbed individuals is not conducive to good care of those inpatients undergoing physical health treatment.

29. Given that many women serve very short sentences, it is our view that women's prisons must provide a wide range of mental health and substance misuse interventions at different intensities.[14] Where the length of time a woman stays in prison prohibits the effective delivery of services, the formulation should be completed in prison for community services to deliver. The provision of specially targeted therapeutic interventions for women on ACCT needs to increase, with particular attention given to dealing with traumatic incidents such as bereavement, rape, abuse and human trafficking.

Maintaining family relationships

30. Maintaining family contact, with appropriate safeguards, is a key source of support and hope for prisoners during their time in custody and on their release. Approximately half of men and women in prison report having children under the age of 18, but women are more likely to be primary or sole carers.[15]

[14] We saw a good example of this at our inspection of HMP Holloway (2015).
[15] HM Inspectorate of Prisons (2016), *Life in prison: Contact with families and friends*.

31. Generally, we find that family work in women's prisons is stronger than in men's prisons, with good provision for visitors and good support for family contact, although there is room for improvement across the board. All women's prisons have NOMS-funded family workers, which has enhanced provision greatly.

32. We find arrangements to help prisoners maintain and strengthen crucial family relationships are variable. We recently published survey data showing that only 30% of prisoners reported that it was easy or very easy for family to visit them at their current prison, and 16% said they did not receive visits.[16] Although this may be for a range of reasons, a common barrier is the distance a prisoner is held from their home area and/or the remote location of the prison.[17] We have found that family visits were not available at all prisons and, even where they were available, demand was often higher than availability, or they were inappropriately linked to the incentives and earned privileges (IEP) scheme, which meant they were not always available to those on the basic or standard level.

33. We have noted good practice in a number of prisons. At HMP/YOI East Sutton Park, a recent inspection found that a specialist family engagement worker liaised closely with agencies inside and outside the prison and was pivotal in building a network of support for the women, their children and families. As well as this, release on temporary license (ROTL) was used effectively to support family relationships.[18] We were also impressed at HMP/YOI Drake Hall, where in the open unit there was a facility enabling children to stay overnight on visits.[19] HMP/YOI Parc had some of the best families work we have seen, integrating the importance of families and children across the prison through award-winning, innovative programmes in their family interventions unit. [20]

34. We have made a number of specific recommendations to improve family contact, which we think would contribute to improving the mental health of prisoners as well as their rehabilitation. These include improving access to telephones, reviewing the possibility of offering outside contact through online platforms such as Skype, ending the practice of restricting family contact as punishment or earned privilege, and improving visitor consultation and experience. We also recommended that all prisons should have staff with a specific family support role (as is the case in women's prisons), overseen by a senior governor, as well as greater availability of family visit days.[21]

Purposeful activity

35. Excessive time locked in a cell can lead to deterioration in mental health. We expect prisoners to be unlocked for 10 hours a day, but our annual report shows that last year only 14% of men and 13% of women in prison said this was the case, and most of these are in open prisons. The lack of time out of cell was particularly marked in local prisons and young adult prisons.[22] We also expect prisoners to have the opportunity for one hour a day in the open air, but most could only have 30 minutes, and only 47% of men said they went outside for exercise three or more times a week.

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[16] HM Inspectorate of Prisons (2016), *Life in prison: Contact with families and friends*, p.10.
[17] Since the closure of HMP Holloway, for example, distance from home has increased for some women. At our recent inspection of HMP Eastwood Park, we found over a quarter of women held had not received a visit since being at the prison and only 18% said it was easy or very easy to get visits.
[18] HMP/YOI East Sutton Park inspection report (2016).
[19] HMP/YOI Drake Hall inspection report (2016).
[20] HMP/YOI Parc inspection report (2016).
[21] HM Inspectorate of Prisons (2016), *Life in prison: Contact with families and friends*, p.17.
[22] In 31% and 38% respectively prisoners said they spent less than two hours out of cell on weekdays.

36. Our inspections and most recent annual report highlight concerns with insufficient activity places, poor use of the places that do exist, staff shortages and insufficient priority given to education, training and work. This is not a recent state of affairs.[23]

37. More needs to be done to ensure prisons have enough education, work or training places for their population. In 2015–16, 10 out of the 34 adult male prisons we inspected had too few. The ability to be kept busy in good quality work, training and education gives prisoners hope for the future and contributes to making prisoners safer. In addition, prisons need to make sure that the activity places that do exist are fully utilised.[24]

38. We find a number of reasons for poor attendance at activities. Most often, we find shortages of uniformed prison staff make it impossible to unlock and supervise the movement of prisoners. We also find provider staff shortages can lead to cancelled lessons and training sessions, a situation which has got much worse since benchmarking.

39. HMIP has called for education, training and work to be given a higher priority by leaders and prison managers.[25] We have long highlighted our concerns around poor purposeful activity, and welcomed the government's increased focus on education in prisons as a result of the review by Dame Sally Coates. In the last year we have noted a slight improvement in the quality of learning and skills and work activities, but progress is still required and we encourage further action, particularly in addressing the limited availability and accessibility of activity places.

40. We are also concerned by the impoverished regimes provided to prisoners in segregation units, which were inadequate in two-thirds of the prisons we inspected last year. Most prisoners were locked up for more than 22 hours a day with nothing meaningful to occupy them.[26] It is rare that any exceptions to restrictive regimes in segregation units are made for those segregated for their own protection, or those who have other vulnerabilities.

41. Similarly, we have concerns about the levels of provision of suitable activities for prisoners on ACCT. At a recent inspection of a women's prison, we were told that over a weekend when craft activities and competitions were organised, no self-harm occurred.

Segregation/solitary confinement and appropriate use of restraint

42. In general, we think there is still insufficient understanding of behaviours that may be present in those with mental health issues. Such behaviours, and the absence of alternatives to prison for those with serious or complex needs or alternative mechanisms to deal with difficult behaviours, have often led to the use of restraint and segregation.[27]

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[23] In 2014–15 we reported a 'dismal picture' for purposeful activity, and in 2013–14 we reported some fragile improvements, but a decline in outcomes towards the end of the year.

[24] For example, at HMP Wormwood Scrubs (2015) we found there were only around 500 full-time activity places for over 1,200 prisoners. Allocation was poor, and only 25% of prisoners were engaged in activities at any one time. Almost 600 prisoners were unemployed.

[25] For example, when we inspected HMP Onley (2016), we found that prison managers had prioritised other regime activities, such as the gym, over learning and work, and attendance rates has declined as a result.

[26] For example, at HMP Nottingham (2016), we found an impoverished regime and some men, including those with significant mental health issues and/or awaiting assessment or secure hospital beds, who were unable to participate in it at all because of their very difficult and disruptive behaviour.

[27] This was seen acutely at HMP Nottingham (2016) where we found a number of men with complex combinations of vulnerability and problematic behaviour. We were told that, typically, more than half of the population in the segregation unit had enduring mental health needs. Individual support plans had been raised for a few prisoners, but these were

43. There is a need for better mandatory mental health awareness training for all staff who work on residential and segregation units. Staff working in segregation units sometimes fail to understand the detrimental impact of restrictive regimes on prisoners' mental health.

44. We reported last year that in two-thirds of prisons we inspected, use of force was increasing and/or high. We were not always assured that use of force was warranted, proportionate or de-escalated quickly enough. We found inadequate governance of use of force in half of the prisons we inspected. However, we did find some good governance and practice in prisons and YOIs such as HMYOI Brinsford, HMP Manchester, HMP Rye Hill and HMP Wealstun. This is of particular concern in the cases where force is used against prisoners who are vulnerable.

45. We continue to have concerns about the use of segregation and special accommodation, and as part of a joint project with the UK's National Preventive Mechanism have reported on wider concerns about the formal *and* informal practices which leave prisoners isolated and with insufficient safeguards against harm.[28]

46. In around a third of prison inspection reports, we were critical of inadequate governance and oversight of segregation. We continue to find high use of segregation, and were not assured that all uses were warranted. We were concerned by the cases we found where prisoners engineered a stay in a segregation unit (by getting involved in incidents at height) in an attempt to get some time off the main wing or secure a transfer to another prison. We have reported that too little was done to understand and address the issues underlying this.

47. The practice of transferring prisoners from one segregation unit to another masks the dangers of long-term segregation and does not always take account of the impact on mental health. We often see cases where there has been a deterioration in mental health caused by prolonged periods of relative isolation, and in turn risk is increased (For example, see inspection reports of HMP Lindholme (2016) and HMP Swaleside (2016).

Learning lessons for the future

48. The scale of the issue of mental health in prisons is enormous and needs to be understood better and articulated more clearly. As the Committee has indicated, a number of authoritative reports and reviews have already made worthwhile and important recommendations for future actions, and our reports provide up-to-date insight and recommendations on many of these topics. It is our view that there needs to be greater effort to take forward these existing recommendations.

49. Some of these recommendations call for significant changes, including improvements to the prison environment and changes to the organisation of the prison estate. It is our view that changes need to be made with the specific needs of the many prisoners with mental health problems at the forefront. This could include creating smaller and quieter units, supported by multidisciplinary teams, with more predictable regimes. We would encourage greater

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superficial and did not focus adequately on planning day-to-day care. Segregation unit staff were kind and caring but clearly overwhelmed and unable to meet the complex needs of some prisoners.

[28] National Preventive Mechanism (2017), *Guidance: Isolation in detention* http://www.nationalpreventivemechanism.org.uk/wp-content/uploads/2017/02/NPM-Isolation-Guidance-FINAL.pdf [accessed 07/03/17] and National Preventive Mechanism (2015), *Sixth Annual Report*, http://www.nationalpreventivemechanism.org.uk/wp-content/uploads/2015/12/NPM-Annual-Report-2014-15-web.pdf [accessed 07/03/17].

learning from community provisions, with a view to emphasising treatment, engagement and activity.[29]

50. Addressing the level of need in prisons will undoubtedly require better investment in recruitment, officer training, remuneration and staffing levels (as recommended in the Harris Review). As our submission shows, it will also require better diversion from courts and, in prisons, the provision of specialist services, delivering purposeful regimes and ensuring staff can take time to listen and help with problems.

51. Our inspections also highlight the risks of a negative culture in which challenging behaviour is automatically attributed to rebellion or 'badness', when there may be mental health issues behind it. Behaviour management schemes are too often punitive and do not recognise 'difference'. Education and management of offers should include increased tolerance of mental capacity, maturity, learning disability and other issues, and there should be stronger challenge to those who ignore or refute the mental health needs of those in their care, which can cause further stigmatisation and lead prisoners to take desperate measures as a way to cope.

52. We would encourage the new HM Prisons and Probation Service to develop a clear strategy for addressing the needs of prisoners with mental health issues as one of its first priorities. We consider that there has already been sufficient study and recommendations for them to take forward concrete actions.

53. We are aware of the importance of eliminating any barriers that stop prisoners being in the most appropriate location to receive the care they need, and in the context of plans to increase the autonomy of prison governors, we encourage the new HM Prisons and Probation Service to keep open pathways that make sure individual prisoners can access specialist services and appropriate care.[30]

54. Though we are aware that significant changes will be introduced to prison policy, by eliminating a number of the existing Prison Service Instructions and Prison Service Orders, we are not aware of the overarching strategy for these changes, nor how they may change existing interventions and safeguards that support and protect vulnerable prisoners. We would welcome further explanation of this, and would hope to be consulted on the review or elimination of any policies.

55. HMIP will continue to examine and make recommendations on issues of mental health and deaths in prisons during inspections. With a view to encouraging better learning of lessons, HMIP has recommended to the government that it include a statutory requirement to respond to HMIP recommendations in the Prison and Courts Bill.

56. I hope that you find this information useful and should you require anything further, please do not hesitate to contact me.

Peter Clarke CVO OBE QPM
March 2017
HM Chief Inspector of Prisons

[29] The enabling environment at HMP/YOI Swinfen Hall is a good example.
[30] For example, at HMYOI Werrington (2015) we heard that one disturbed and unwell boy had to remain in segregation because an establishment with 24-hour health care refused to take him because 'they were not a national resource'.

Annex I. Analysis of HMIP survey data

1. We have compared the responses from our most recent prisoner surveys (with reports published between 1 April 2016 and 31 March 2017) from adult men's prison inspections with the survey responses from the previous time we inspected them.[31] We also looked at selected survey responses from all women's prisons visited from January 2015 to December 2016, and compared them with the previous inspection of each of the prisons in the sample.[32]

2. Care should be taken when interpreting the data from this analysis. As not all prisons were included in the comparators, it is not representative of all prisons.[33] The analyses do not show change over time, but rather change between HMIP inspections, which occur at different intervals for different prisons.

3. Nevertheless, the results are compelling and show significant increases in levels of vulnerability, mental health and substance misuse problems and safety concern. While causal relationships are difficult to establish, it is not unreasonable to conclude that these are of great relevance to the levels of distress which may lead to self-inflicted deaths in custody.

4. Our survey data suggests that men and women arriving in custody are more vulnerable than previously. In our most recent samples, 71% of men and 80% of women arriving in the prisons reported having problems, significantly more than the 67% and 72% respectively at previous inspections.

5. Significantly more men and women told us they had arrived in prison feeling depressed or suicidal. For men this was 22% compared with 17% previously, and for women, 39% compared with 34%. Similarly, significantly more men and women told us they had arrived with mental health problems – 26% compared to 17% for men, and 37% compared with 29% for women. Women in prison are significantly more likely to report these types of vulnerabilities than male prisoners.[34]

6. We also ask prisoners whether they have emotional well-being or mental health problems at the time of completing the survey. The most recent data showed that 61% of women and 42% of men reported these problems, compared to 52% and 33% respectively at the previous inspection.

7. Many more prisoners report drug and alcohol dependence and problematic substance use than people in the community, and in our survey consistently more women than men report drug and/or alcohol issues. Our comparison of survey data suggests an increase in the number of women and men arriving in prison with drug problems (41% of women compared to 36% previously, and 30% of men compared to 26% previously), and an increase in the number of women arriving in prison with alcohol problems (31% compared to 25% previously).

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[31] This comparator uses survey data from 36 adult men's prison inspections whose reports were published between 1 April 2016 and 31 March 2017. The 'last time' comparator comprises survey data collected at the most recent previous inspections of the same prisons. HMP Hindley and HMP/YOI Thorn Cross, though published within the 2016–17 reporting period, have been excluded from this analysis due to both having been re-roled since their previous inspection.

[32] Prisons in the sample were HMP Eastwood Park (2016; last inspection 2013), HMP/YOI East Sutton Park (2016; last inspection 2011), HMP/YOI Drake Hall (2016; last inspection 2013), HMP & YOI Foston Hall (2016; last inspection 2014), HMP & YOI Bronzefield (2015; last inspection 2013), HMP & YOI New Hall (2015; last inspection 2012), HMP & YOI Holloway (2015; last inspection 2013).

[33] The 'last time' comparator in the analysis includes surveys conducted between 2011 and 2014. Some of the prisons included may have been inspected more than once over this time, but only the most recent previous inspection's survey data has been included.

[34] HM Inspectorate of Prisons (2016). HM Chief Inspector of Prisons for England and Wales Annual Report (2015–16).