Jane Mackenzie

November 16, 2014

Dear Lord Harris,

It was only within the last week, I was aware of the Independent Review under your chairmanship, in to the significant increase in suicides of young men, particularly those with mental health problems in prisons. Having been involved in this area for some time, seen the tragedies first hand and identifying many of the associated problems, I was so relieved that a major review was to be undertaken and it was a true thank the “Lord “moment !

I subsequently outlined a summary of the issues to forward to you and disappointingly, then found that submissions to the team had to be in by July 2014. I am not sure when the report is due to be published and suspect that my submission is now too late, however I am submitting the information, that may help to confirm some of the issues that you may already be aware of and I have also responded to your list of questions which I have attached.

Following a thirty five year career working in mental healthcare, I am now semi-retired and since my retirement 12 years ago, I have undertaken a number of clinical reviews of suicides of young men in prisons in England and Wales, on behalf of a Local Health Board and for Health Inspectorate Wales. I have seen the tragic stories behind the suicides and the devastating effects on families and the healthcare and prison staff, who in my experience are doing their very best to care for those prisoners with mental health problems, in extremely difficult and challenging circumstances.

Despite missing the deadline, I thought it may be helpful to highlight a number of issues that have emerged as common themes during the clinical reviews I have undertaken, but would add that my letter reflects my views and experiences and not those of the Welsh Health Inspectorate or the Local Health Board, on whose behalf I have undertaken the reviews (although their published reports and recommendations reflect many of the concerns summarized below)

On a wider note and perhaps outside the remit of your Inquiry, but in my opinion a key component of the increase of those with mental health problems in prisons has been the closure of large mental health hospitals and the subsequent and significant reduction in in-patient mental health service beds throughout the UK.

These people more often than not, because of the increase in shorter sentencing, and reduced mental healthcare provision available, end up in prisons for minor offending behaviours ,often a symptom of a mental illness, or a drug or alcohol related problem. For these people, prison becomes a haven and an “asylum” in the real sense and recidivism becomes the norm!

Community Mental Health Teams are woefully under resourced to deal with the increasing number of patients being discharged in to the community. Some prisons have mental health teams within the prison healthcare system and if the prison is lucky enough to have additional mental health

services, (a Mental Health In Reach Team), (MHIRT) provided by a Local Health Board, they are also under resourced and often overwhelmed with the sheer volume of prisoners with mental health problems.

Initial mental health and suicide risk assessments on a prisoners admission to prison are not robust, or evidence based and are mainly a tick box assessment requiring a yes/no response. A great deal of research has already been done in to suicide risk assessment in prisons and could contribute to the development of a more robust assessment process.

There are a limited number of Registered Mental Health Nurses (RMN's) to undertake these assessments and subsequently assessments are often carried out by people without the appropriate training, skills, qualifications, or supervision by a qualified nurse to enable them to effectively pick up the key risk factors or warning signs of suicide at that early and crucial stage.

In addition, one or two members of Healthcare staff often have to complete extremely high numbers of prisoners initial assessments in a short space of time,

(usually between 12 mid-day and 8 pm following the court sessions and sentencing, process) making it almost impossible to establish any detail, or to develop a rapport or relationship that would enable a prisoner to share their true thoughts or feelings, often responding to questions such as "are you feeling suicidal"? with a "no" answer, hiding their true suicidal intentions.

In the past three years, there has been a notable reduction in prison officers and subsequently prisoners are locked in their cells for most of the day, limiting conversation, observation of behaviours, or the opportunity to establish any sort of relationship, or trust, all essential in an ongoing and comprehensive mental health assessment process.

An excellent initiative, the personal officer scheme, where prisoners had named officers who took key responsibility for groups of prisoners, which clearly had a positive impact on the relationships between prison officers and prisoners and promoted continuity, has sadly discontinued in a number of prisons because of the shortage of staff.

Training and development for staff, particularly in mental health awareness, risk and suicide assessment, its management and prevention, is not always mandatory, limited in its scope and frequency and is not always robust or evaluated as to its effectiveness.

Record keeping is not always of a good standard and information sharing and communications between healthcare and prison staff can be ad hoc and often essential information is lost.

Because of the limited number of trained and qualified healthcare staff and poor communication processes, there is not always a multi-disciplinary/agency, or clinical presence at ACCT or other meetings where prison staff have to determine crucial decisions in further care or risk management.

There are a limited number of "safer" cells in prisons, (ligature free environment, no ligature risk assessments, limited safer bedding/ clothing, CCTV etc) and prison staff often have to juggle decisions about which prisoners are the highest risk and take priority for one of these cells .With hanging from beds and other ligatures in cells being the most common method of suicide, this is certainly an area that should be urgently considered for review throughout the prisons.

I realize that your Review will not be a panacea to cure all the ills and problems within the prison service, but these and other issues identified could at least establish a basis for a UK wide Suicide Prevention Strategy to be developed across the prison service. I am certain this will contribute significantly to the reduction of the risks and subsequently in the number of deaths of these vulnerable young men with mental health problems, who find themselves in the prison system.

I also have to mention that much effort has been made in individual prisons to improve service provision and that on the whole, I have found prison and prison healthcare staff compassionate, professional and devastated when a suicide occurs. I'm sure that like me, they will welcome this review and see it as a great opportunity to improve the service and support them in reducing the risks to this group of prisoners and providing increased opportunities for supporting their recovery and rehabilitation, surely a right for all members of a humane and civilized society.

Yours Sincerely

Jane Mackenzie