

Government consultation – No voice unheard, no right ignored Response from the Prison Reform Trust

About the Prison Reform Trust

The Prison Reform Trust, established in 1981, is a registered charity that works to create a just, humane and effective penal system. The Prison Reform Trust aims to improve prison regimes and conditions, defend and promote prisoners' human rights, address the needs of prisoners' families, and promote alternatives to custody. The Prison Reform Trust's activities include applied research, advice and information, education, parliamentary lobbying and the provision of the secretariat to the all party parliamentary penal affairs group.

The Prison Reform Trust welcomes this consultation and, where we are able, we are pleased to respond.

In particular, we would like to highlight the importance of ensuring that people with autism, learning disabilities or mental health conditions in contact with criminal justice services are, where relevant, considered at every stage of this consultation. We are supportive of the newly evolving liaison and diversion services for children and adults (NHS England), which will help identify individuals with autism, learning disabilities or mental health conditions when they are first detained in police custody. It is important that, following identification, liaison and diversion staff can refer individuals to local services that will offer timely appointments and support, as required. Joint planning and commissioning of local services will be enhanced through data gathered by liaison and diversion services; while the inclusion of senior justice personnel on Health and Wellbeing Boards will help to ensure that individuals in, or on the edge, of the criminal justice system receive the necessary support. There is a need, highlighted in Lord Bradley's review into people with mental health problems or learning disabilities in the criminal justice system (Department of Health, 2009), for mental health and learning disability awareness training for criminal justice staff; there is also the need for front line health and social care staff to have an understanding of criminal justice. Shared local health and justice awareness training and workforce development has the potential to support early intervention for individuals engaged in potentially risky or offending behaviour, so helping to reduce and prevent their contact with criminal justice services; or, where appropriate, will ensure the holding to account of individuals through the justice process, with reasonable adjustments, as required.

Prisons are, generally, ill equipped to deal with people with learning disabilities, autism and certain mental health problems. Much can be done locally to help prevent their contact with criminal justice services and, where necessary, to provide robust community alternatives to custody.

Prison Reform Trust response to the consultation

Q1 The Care Act says that local authorities have to put individuals' wellbeing at the heart of what they do. We want to explore whether NHS commissioners should have the same duties, for example, for people with learning disability or autism who are at high risk of long stays in hospital in relation to their lifelong needs. What do you think of this idea?

The Prison Reform Trust (PRT) agrees that the Care Act provisions requiring local authorities to promote individual wellbeing should be extended to include commissioners of NHS services. This would support the objective of improving outcomes and quality of life for people with learning disabilities or autism. It would also help ensure a more joined up focus for people who are likely to require support from a range of health and care services. It would therefore be helpful if NHS commissioners were required to cooperate with local authorities and other public services to promote the principle of wellbeing, again mirroring the provisions of the Care Act in this regard. Such cooperation might cover sharing of information (with appropriate consents), joint assessment and care planning and liaison around key transition points – including, for example, when people are transferred between prisons or released from prison back into the community.

These duties should apply not only to NHS Clinical Commissioning Groups but also to NHS England and are particularly important in relation to NHS England's responsibilities to commission primary care health services for people in prison and approved premises. As highlighted by the Bradley report, evidence demonstrates higher prevalence among the child and adult prison population of people with mental illness or learning disabilities than in the general population. The prison environment can be detrimental to both mental and physical health outcomes. Again, it is essential that NHS England works with local authorities, prisons and other relevant local services to promote the wellbeing of people residing in custodial settings.

The duty to promote individual wellbeing and to cooperate with other public services should be extended to other local services, including police, prisons and probation services. For example, people should be imprisoned as close to home as possible, this is particularly important for people with learning disabilities and autism. As noted on p.17 of the consultation document, being far away from home and isolated from family and friends can have significantly detrimental impact on mental and physical health outcomes and can make reintegration into the community more difficult.

Prisons, NHS bodies and local authorities should work together to undertake a regular review of the prison environment to support prevention, independence and wellbeing objectives, drawing on the input of relevant local expertise, such as physiotherapy, occupational therapy and housing. This would also support the local authority to meet its obligations with regards to prevention and integration as required by the Care Act.

Q2 In determining living arrangements – (whether suitable accommodation or inpatient stays) – both LAs and NHS commissioner could have to have regard for factors which support inclusion in the community, staying close to home, links with family and friends and opportunities for participation and the least restrictive setting? What do you think of this idea?

It can only be beneficial if commissioners of health and care services have an obligation to pay regard to wider factors relating to individual and community wellbeing particularly community inclusion. This would promote a more holistic response to people's needs that takes into account the totality of their lives and the importance of social inclusion, rather than

just a narrow focus on clinical need. As above, such duties would have particularly important resonance for people in prison, where opportunities for participation are limited and risk of social isolation higher due to the restrictive nature of their living arrangements. The duty to have regard for factors which support inclusion and participation should also apply to other local services, including prison and probation services.

Q3 What might the appropriate length of inpatient stay be where this should apply for the NHS?

Q4 What are your views on how this might impact on LAs or the NHS?

As set out above, the Prison Reform Trust agrees that it would be helpful for legislation to require that health and care commissioners as well as other local services including police, prisons and probation services should promote the principles of inclusion, choice and control. Meeting this requirement is likely to involve cooperation with other public services. For example, the NHS and local authorities have an important role to play in raising awareness of the needs of people with mental health problems, autism and learning disability and in helping to provide training to criminal justice staff about how these needs can be identified and addressed. This would support police and the courts to meet their duties with regards to making reasonable adjustments to support people with mental health needs, autism and learning disability.

One way of promoting wellbeing and inclusion is to encourage the use of Community Order requirements rather than prison sentences for offenders with identified mental health needs, autism or learning disability. These offenders are likely to need additional support to undertake Community Order requirements and offending behaviour programmes. Without appropriate support, it can be harder for them to meet the conditions of their order, which leads to a greater risk of breach and subsequently being sent to prison. Without recourse to options for appropriately adapted Community Orders, too often magistrates can feel they have no alternative but to send people to prison, an outcome which is clearly at odds with the principles of inclusion, participation and supporting people in the least restrictive setting, and results in higher costs for public services. Local authorities and CCGs have a role to play in working more closely with criminal justice services and in particular commissioning Mental Health Treatment Requirement services and forensic services to support the use of Community Orders as an alternative to prison sentences.

Q5 We think that local authorities and clinical commissioning groups could have to think about how to ensure there is enough community based support and treatment services (for example for people with learning disability or autism most at risk of going into hospital). What do you think of this idea?

Q6 What steps could we take to ensure such as duty is as effective as possible?

PRT agrees with the recommendation made by Sir Stephen Bubb that local commissioners should be “*more clearly incentivised to ensure there is adequate community-based provision.*” Not only would this prevent people having to go into hospital or institutional care, but it could also prevent people with learning disabilities or autism at risk of offending from coming into contact with the criminal justice system. Where people with learning disabilities or autism do come into contact with the criminal justice system, there should be local liaison and diversion services in place to ensure that they are supported through the criminal system pathway or diverted into a treatment, social care service or other relevant intervention or support service. This would directly support the recommendation of Sir Stephen Bubb. PRT welcomes the intention of NHS England to make liaison and diversion

available to 100% of the population by 2017/18; funding must be made available during the next Parliament to ensure this objective is achieved.

PRT also agrees that commissioners of local health and care services have a clear role in ensuring that people with learning disabilities or autism returning to the community from prison are offered the necessary support to prevent them from re-offending. This is in line with the duties placed on local authorities by the Care Act to take an active role in shaping their local market to ensure quality and diversity of service.

Q7 What is your view on the likely cost and impact on the NHS or local authorities?

It is important to consider the potential costs and savings in a holistic sense. For example, providing effective community based support to individuals with learning disabilities and autism and their families can help prevent people from coming into contact with the criminal justice system. KeyRing Living Support Network provides a positive example of how small amounts of financial investment can result in significant potential savings, and demands made on emergency services. Investing in more effective community based support for people with mental health needs, learning disability and autism can subsequently reduce costs for the public purse through savings by the police, courts, prison and probation services, as well as improving outcomes for individuals.

Q8 What do you think about the idea to change the information required by Mental Health Act regulations in the application for detention and supporting medical recommendations? This would mean that Approved Mental Health professionals and doctors have to consider and record whether assessment and treatment could be provided without detention in hospital.

PRT supports the general principle that people should be treated and supported as close to home as possible, and in the least restrictive environment, which is safe both for the individual concerned and society at large. Opportunities should be taken wherever people come into contact with public services to identify needs early and to put in place effective support – for example liaison and diversion services when people come into contact with the criminal justice system.

Q9 What is your view on the likely costs and impact of this idea?

Treating and supporting people closer to home, and in the least restrictive environment, where possible is likely to lead to better outcomes for individuals and reduced costs to health, care and other public services.

Q10 We want to explore whether a person and their family/carer or other nominated person, should be given clear, easy read or accessible information by a named professional about their rights. What do you think of this idea?

The Equality Act requires reasonable adjustments to be made to anticipate and prevent discrimination; providing accessible information is one example of such a requirement. It is vital that people with learning disabilities, autism and mental health issues are proactively provided with information about their care and their rights, in a way that is accessible and understandable for that individual. It would be helpful if information deriving from the various pieces of legislation referenced in the consultation document could be brought together in a way that is comprehensive and personally meaningful to that individual.

The ability to access clear and easily understandable information about a person's rights and his or her care must apply in all settings, whether in the community, secure inpatient settings

or in the criminal justice system. While in police custody and through the courts process, information should be provided to people in easy read and accessible formats, according to their needs. Prisoners with learning disabilities, autism and mental health conditions should have the same opportunities to access relevant information about their rights and their care, including their right to an assessment of their needs. Whether or not a person has eligible care needs, they should be provided with information about what support is available to them and their rights under the legislation listed.

The principle of equivalence now enshrined in the Care Act means prisoners should expect the same level of information and support as people living in the community. However, the recent joint inspection by HMI Probations and HMI Prisons of the treatment of offenders with learning disabilities within the criminal justice system found that “Prisoners with learning disabilities were often reliant on informal support from staff or other prisoners for information on prison procedures and help to access them. Formal support was not often in place. Even where a prisoner had a care plan, this was not always shared with all relevant staff.” The report also noted that “Even where a care plan was in place, most prisoners in our sample were unaware of the existence of a care plan for them, or its content.” (HMI Probation 2015).

Legislation to ensure people are provided with a named social worker or representative of their choice would mean there is clearer responsibility for the provision of timely and appropriate information and perhaps reduce the risk that people fall through the gaps, particularly where multiple public services are involved, for example in the criminal justice system. However, this should not undermine the need for all local organisations involved in a person’s care and support to be proactive in their promotion of a person’s independence, choice and control.

Q11 What do you think about the idea that local authorities and NHS bodies should have to seek explicit and documented approval or consent from an individual to admit them to an inpatient setting? This could include a record of discussion around options and risks.

Q12 What do you think about the idea of a gateway or approval mechanism for admissions to inpatient settings, in certain circumstances?

Q13 What would be the essential elements of such an approval mechanism?

Q14 If there were to be such a mechanism, should it be given statutory force?

Q15 What do you think of the idea of strengthening (for example in statutory guidance) people’s rights to request a transfer to a less restrictive setting or a setting closer to home or to ask for a discharge?

Q16 Do you agree that, as far as practicable, such decisions and discussions should involve professionals or staff based in the community or expert on community based options?

Q17 How can we strengthen provider and commissioner accountability in their approach to such requests?

PRT agrees with the introduction of any provisions that support the following key principles for people with learning disabilities, autism and mental health issues: That care and support should be provided in the least restrictive setting possible; that individuals and their families should be supported to participate as equal partners in their care and support; and that it should be assumed that an adult has capacity to make decisions for themselves unless it

can be shown that they lack capacity to do so at the time the decision needs to be made. These principles are enshrined in the Equality Act, the Mental Capacity Act, the Care Act and the UNCRPD and any practical solutions for how they can be applied to support people with learning disabilities, autism and mental health issues should be disseminated and put into universal practice. Admitting people into inpatient or long-term residential settings can often be the easiest option, particularly where staff are concerned about risk but it is often detrimental to the wellbeing of the individual and can diminish their capacity for independence and participation, as well as being a highly costly option.

Therefore, PRT agrees that local authorities and NHS bodies should have to seek consent from an individual to admit them to an inpatient setting and that discussions should take place with the individual, family, carers and advocate if involved prior to that consent being given. These discussions and the decision taken by the individual must be appropriately documented. There should also be arrangements in place for regular review with the individual and their family to ensure that they are content with care arrangements and to assess whether their needs or preferences have changed. Not only will this support the principles of independence and individuals being fully involved in their care, but it should also provide further safeguards against people being unnecessarily admitted to secure settings when they could be better supported in the community and closer to home.

PRT also agrees that where an admission is considered, there should be systemic arrangements put in place to provide robust challenge and to require the relevant NHS body or local authority to demonstrate that there has been a genuine and inclusive discussion of options, that other possible alternative options have been considered and to provide a clear explanation as to why there can be no alternative to admission to hospital or residential care at that time. Additionally, upon admission arrangements should be put in place for review of that person's admission, with the same requirements to demonstrate why that person cannot be treated or supported in a community setting.

As well as having in place arrangements for regular review, we also agree that the individual, their family or advocate should also have every right to change their mind later because something is not out working for them and to request a move, or a transfer to a less restrictive setting or to a setting closer to home or to seek a discharge.

We agree that these kind of decisions and discussions should involve professionals or staff based in the community or expert on community based options. It is difficult to identify why such involvement would not be possible, therefore it should be a requirement, rather than just being undertaken where possible.

Q18 We want to explore how everyone can receive care planning and discharge planning from the time when they are admitted to hospital. One way we could do this is through new statutory guidance (complementary to the Mental Health Act Code of Practice). What do you think of this idea?

Q19 Should we require a care plan, including a plan for discharge, to be produced involving individuals and their family within a specified number of weeks of admission and to specify when it will be reviewed?

Q20 Could more be achieved through any existing policies or guidance on delayed discharge?

We agree that care planning and discharge planning should commence as soon as a person is admitted to hospital and that statutory guidance could support that aim. The care plan must be completed (or updated where a plan already exists) as soon as possible after a

person's needs or circumstances change. However, one concern with setting a statutory time limitation for completion of the care plan is that inevitably, completion will occur towards the end of that period. Instead, the care plan should be completed within a timeframe that best supports the person's health, wellbeing and inclusion in the care planning process.

The same requirements for care planning and discharge planning should be applied for people in prison with eligible care needs. In particular, it is vital that people with mental health needs, autism or learning disability receive effective support during and after transition back to the community, which in turn will reduce the risk of re-offending. We welcome the proposal from NHS England to put in place monitoring processes to ensure the discharge plan is followed – again this should apply for offenders leaving prison, facilitated through cooperation between the prison, the local authority with social care responsibility for that prison and the local authority receiving the individual on return to the community.

Q21 The Mental Health Act Code of Practice has just been updated. In line with this, we want to explore how people and their families can be more involved. One idea is that people and their families or advocates should be able to challenge whether an Approved Mental Health Professional has properly taken into account their wishes and feelings in the interview which takes place before they make an application for admission under the Mental Health Act. What do you think about this idea? (we would need to consult later on how the details of this process might work)

Unquestionably individuals, families and advocates should be able to challenge whether an Approved Mental Health Professional has properly taken into account their wishes and feelings before an application is made for admission under the Mental Health Act. We note the intention to consult further on this issue; two key principles should be applied: firstly, that individuals, families and advocates must be informed of their right to challenge and a record of this communication made; and secondly that however the right to challenge is taken forward, it should be as easy as possible for individual and families (who are likely to be in a position of less power) to make that challenge.

Q22 Which if these measures, [3 potential options for safeguards around renewal] if any, do you think would have the most impact?

Q23 Do you have any views on risks or costs presented by any of these options?

Q24 Do you have any views on the decision making processes around Community Treatment Orders and how they could be improved?

Questions 22-24 have not been addressed.

Q25 Guidance could say that only organisations that include self and family advocates in their governance should get contracts with the local authority or the NHS to provide services for people with learning disability or autism. What do you think about this idea?

We are concerned that this could become a tokenistic gesture and would prefer the requirement that organisations demonstrate a variety of ways in which people are involved.

Questions 26 and 27 have not been addressed.

Q28 What do you think about the idea that we should explore changing the law so that people choose their own “nearest relative” (retaining a hierarchical list to be used if necessary)?

PRT supports this proposal.

Questions 29-34 have not been addressed.

Concerning Chapter 3, ‘My rights under the Mental Health Act’, we agree with the consultation submission made by Alison Giraud Saunders, which – with her permission – is repeated below:

“I have a slight difficulty with the questions about application of the MHA. If I have understood correctly, currently anyone with a ‘mental disorder’ could be detained under S.3 if there is ‘appropriate medical treatment’ available (subject to the ‘learning disability qualification’). If the opportunity is being taken to consider whether learning disability and autism should be taken out of the definition of ‘mental disorder’, shouldn’t other conditions be reviewed at the same time? Para 3.1 lists dyslexia and stuttering, for example.

Before commenting on the options, it seems important to reflect on some of the reasons why people with learning disabilities or autism may get detained under the MHA (including S.135/136 as well as hospital admission):

1. for assessment out of their usual environment to try to work out what is going wrong for the person, why and what would help
2. for treatment of a defined condition
3. for a programme that is designed to help them change their behaviour, where the intensity or compliance would be very difficult to achieve in their usual setting (some people would call this treatment and others would not)
4. for their own protection, to remove them from a very risky situation
5. for the protection of others
6. because they have been accused or convicted of a crime and a decision has been made to divert them from the criminal justice system.

The paper rehearses many of the problematic aspects of use of the MHA (in situations where the person does not have a defined mental illness, with availability of appropriate treatment). There is one other issue, which is that the Mansell Reports called into serious question the effectiveness of interventions that are not focused on the individual *in their usual setting*. It seems to me that the real underlying problem in many areas is the lack of alternatives to detention.

I am attracted to Option 1, because it seems to me wrong that a person can be detained under the MHA who does not have a mental health problem that is amenable to treatment. I am concerned, however, that this would leave people with learning disabilities who are accused or convicted of offences to go through a criminal justice system that signally fails to respond to their needs (although the new Care Act duties regarding prisoners have some potential to help with this). This might suggest I should choose Option 3. However, this simply postpones the question of ‘what is an appropriate response to/support for’ the individual and the challenges and risks associated with their behaviour. With regard to people with learning disabilities the Bradley Report never answered satisfactorily the question ‘diversion to what?’.

There are examples elsewhere (e.g. New Zealand) of separate legislation focused on offenders with learning disabilities, providing for them to be diverted from prison to undertake

programmes in other settings. It would be useful to know how this is working in practice. I have a concern that, however such legislation is framed, there would be substantial opportunities for arguments over who did or did not meet the criteria. Thinking about the evidence on people currently in the prison system, there would be high numbers who might fall just outside the 'Valuing People' definition of learning disability, yet are extremely vulnerable and disadvantaged in the prison system. For example, the usual threshold for people to be considered for NOMS intervention programmes is IQ 80.

On balance therefore I am inclined to say that:

- there should be a serious look at the MHA wording in relation to conditions that are not treatable mental illnesses (to include learning disability, autism, dyslexia, etc)
- there should be careful consideration of the options for vulnerable defendants going through the criminal justice system (to include people with learning disabilities or autism, but thinking more widely about others whose capacity to understand and cope with the criminal justice process and system is seriously impaired)
- the main effort (in policy and service development) should focus on creating the alternatives to detention or custody that are clearly required."

Q35 We propose to clarify in law that the Mental Health Act Code of Practice should apply to clinical commissioning groups and NHS England commissioning. What do you think of this idea?

PRT supports this proposal.

Q36 What is your view on the proposal that children and young people aged under 18 detained under sections 135 or 136 should never be taken to police cells?

PRT supports this proposal.

Q37 What is your view on the proposal that the use of police cells for people aged over 18 should be more limited in terms of frequency and length of time they can be detained?

PRT supports this proposal.

Q38 What is your view on any other recommendations in the Review?

Q39 What is your view on the review proposal to create powers for professionals other than the police to be able to take a person from a public place to a place of safety?

Q40 Are there any practical considerations we should take into account during further developmental work and implementation of the Review proposals?

Concerning Questions 38-40, we agree with the consultation submission made by Alison Giraud Saunders, which – with her permission – is repeated, in part, below:

"A serious issue raised by the police in respect of S.136 detentions is the lack of follow-up support. Examples are cited of multiple call-outs to take the same person to a place of safety, time after time, without the reason for their distress or risky behaviour being properly investigated or addressed.... Attention needs to be focused on the development and delivery of adequate support."

Q41 Do you think it would be desirable in principle to amend the MHA to enable restricted patients to be discharged by the Secretary of State for Justice or a Tribunal subject to conditions amounting to a deprivation of their liberty?

Q42 Does the MHA need to provide for another form of detention for patients who do not need to be in hospital but who must be in effect deprived of their liberty in order to be discharged from hospital into a community based setting?

Concerning Questions 41-42, we agree with the consultation submission made by Alison Giraud Saunders, which – with her permission – is repeated, in part, below:

“...there needs to be action to create the option of balancing ‘less restrictive’ settings with provisions to manage risk and protect others, which might amount to deprivation of liberty outside hospital. How this is achieved depends on how the question about the MHA is resolved. Whatever route is followed, the process of agreeing to a move to a less restrictive setting should be designed to avoid the current problem that a person on a restriction order must have a fixed address in order to be discharged, but often housing cannot be arranged until discharge has been agreed.”

Questions 43-45 have not been addressed.

Q46 We could seek to set up and mandate specific pooled funding, with joint planning, to help people with learning disability and/or autism get discharged from hospital or help prevent them being admitted. This could include specialised commissioning funding. What do you think of this idea?

While we are generally in favour of pooled funds we are wary of making this mandatory; perhaps what should be mandatory is a requirement placed on authorities to develop joint plans and show how they will make the money work to support those plans, including use of pooled budgets where appropriate. This approach should also apply within a criminal justice context; for example, ensuring services to divert people away from criminal justice, where appropriate; to help prevent a prison sentence where a Community Order, with the necessary support might be more appropriate; and on release from prison.

Question 47-49 have not been addressed.