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Invited editorial

A Review of Services for Vulnerable People Detained in Northern Ireland Prisons: the impact of underfunding

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Northern Ireland is a distinct jurisdiction within the United Kingdom (UK), with a population of about 1.9 million. It has a 25% higher prevalence of mental ill-health than the rest of the United Kingdom (UK) (O'Neill & Rooney, 2018), attributed to the intergenerational trauma and enduring social deprivation of its post-conflict society. As might be expected, this higher level of need is reflected within its prison population of around 1400 men and 50-70 women at any one time (East, 2018). Between 2012 and 2019, there were 18 suicides and 5,217 recorded incidents of self-harm within Northern Ireland prisons (Northern Ireland Audit Office, [May] 2019). During the same period, a number of prison inspections and reviews reported that the care of vulnerable people in custody required significant improvement (Criminal Justice Inspection Northern Ireland and the Regulation and Quality Improvement Authority, 2014; European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment [CPT] 2017).

In November 2016, following the deaths of five prisoners in the preceding twelve months, and a Prison Ombudsman for Northern Ireland (2016) report which was highly critical of the care provided to a vulnerable prisoner, the Northern Ireland Ministers for Justice and Health made a joint announcement that there would be a review into services provided to vulnerable people in Northern Ireland prisons. Initial review work was undertaken by the Northern Ireland Prison Service (NIPS) and the provider of healthcare in prisons, the South-Eastern HSC Trust (SEHSCT), but this work did not progress to completion and it was subsequently deemed that a fresh independent review was necessary.

In July 2020, the Regulation and Quality Improvement Authority (RQIA) was jointly commissioned by the Department of Health and Department of Justice to undertake the Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons (RQIA, 2021). For the purposes of the review, a ‘vulnerable person’ was defined as “a person with mental ill-health at increased risk of self-harm or suicide”. In keeping with its terms of reference, review team members were primarily interested in whether the needs of people with mental ill-health and other vulnerability factors, known to increase the risk of self-harm and suicide, were being met by the existing arrangements for planning, commissioning and delivery of care.

Determining the prevalence of vulnerability factors amongst the NI prison population is beset with challenges due to the absence of a robust system for data collection and needs assessment. The self-reported level of vulnerability amongst this population, however, is high. Among pre-trial prisoners, 58% reported a history of substance misuse, 44% history of self-harm, 16% drugs or alcohol withdrawal and 36% that they

were receiving care from community mental health services; 1% were considered to require immediate attention by mental health services (Northern Ireland Audit Office, 2019). It should be noted that many people entering the prison system, have more than one vulnerability factor, in addition to co-morbidities, as measured against the United Nations Standard Minimum Rules for the Treatment of Prisoners, known as the Mandela Rules (United Nations Office on Drugs and Crime [UNODC], 2015). The scale and complexity of vulnerability highlights the need for high-quality mental health and addiction services, in addition to robust safety arrangements, for vulnerable people detained in NI prisons.

The RQIA Review Team found that, although the Northern Ireland Prison Service and health care provider (SEHSCT) had made progress in relation to safer custody arrangements and partnership-working and governance, improvement has been considerably constrained by limited resources. Prison healthcare in Northern Ireland is significantly underfunded when benchmarked against other regions in the UK, equating to a short-fall of approximately £4 million per annum (RQIA, 2021). This disparity has arisen because funding for Northern Ireland prison healthcare has been determined by a historical figure, supplemented by an annual uplift, rather than being founded on a meaningful formula or needs assessment. This occurred in spite of the higher need for mental health provision within the general Northern Ireland population, that would suggest that funding should even be uplifted beyond parity with the rest of the UK. Planning and commissioning arrangements were found to require substantial improvement.

Given the shortfall in funding for health services in prisons, mental health teams lack

the capacity to meet the needs of prisoners, with waiting times for urgent and routine mental health assessments falling significantly below regional and national standards. Clinical psychology provision was one aspect of such shortfall specifically cited, with one locum clinical psychologist covering all three prison sites for just one working day per week also falls significantly short of what is required. Together these shortfalls are in stark contrast to the Mandela Rules which state that prison healthcare teams should “encompass sufficient expertise in psychology and psychiatry” (UNODC, 2015). Provision is insufficient to meet the needs people with illnesses or personality disorder or organic brain disorders. During the review, we found a lack of specialist support for those with intellectual disabilities, ADHD, autism and/or dementia, despite the well-recorded prevalence of these conditions amongst prisoners (Chaplin et al, 2017, 2021; Brooke et al, 2020). In the absence of a formal mechanism to screen for these conditions, or to assess the need and commission services accordingly, it is likely that some prisoners from these vulnerable groups remain unidentified and without care. The absence of a specific treatment pathway for personality disorder, in particular, indicates a lack of focus on the needs of prisoners, given the high prevalence of these conditions recognised amongst prisoners worldwide (Fazel & Baillargeon, 2011). It is, thus, likely that many people who have a history of complex trauma and/or developmental disorders go undiagnosed and untreated within the Northern Ireland prison system. It follows that there is a need for introduction of planned therapeutic interventions and psychologically-informed planned environments.

In addition to difficulties accessing treatment for personality disorder in prisons, it is hardly easier for people with such problems to gain access to mental health services in the wider community. Service developments must be improved in wider community

settings as well as prisons. Aside from direct benefits for people suffering with personality disorder, these may also have a positive impact upon offending behaviour, and result in fewer people with personality disorder entering or re-entering the prison system. We hope that the Northern Ireland Mental Health Strategy 2021-2031 will help fill this gap in community provision (Department of Health, 2021).

One finding by our RQIA team was that people with acute mental ill-health were often being managed in Care and Supervision Units (CSU) – that is, segregation units - rather than receiving the hospital treatment they require. This problem, which has, at least in part, arisen because of the lack of suitable alternatives, raises human rights issues - including freedom from torture and inhumane or degrading treatment, and the ability to access effective remedy in circumstances where rights are violated under the Human Rights Act 1998 (see also *Keenan v UK*). There are no inpatient facilities within prisons in Northern Ireland, and waiting times for transfer to secure hospital beds are unacceptably long, mainly because of a regional shortage of forensic and acute mental health beds. We heard examples of prisoners accommodated within segregation units whose mental health and addiction needs had gone unidentified. In prisons in England and Wales an 'Initial Segregation Health Screen' is required under Prison Service Orders (<https://www.gov.uk/guidance/prison-service-orders-psos>), but this is not the case in Northern Ireland. This requires urgent change and it is hoped that sharing such learning from elsewhere in the UK will benefit the systems for improving prisoner safety in NI.

Equally, benchmarking with the rest of the UK is helpful in highlighting where services can be better planned, commissioned and delivered. Although additional funding

would undoubtedly benefit the provision of care to vulnerable people in prison in Northern Ireland, it is important to note that underfunding is not the only problem. At a political level, there has been a lack of sustained interest in improving criminal justice and mental health outcomes for people detained in Northern Ireland prisons and a government-led strategy is now needed to improve the quality and accessibility of mental health services there to reduce the risk of self-harm and suicide while detained and, probably, reduce reoffending. It is vital that this is based on sound needs assessment and bench-marking; and underpinned by robust accountability and reporting arrangements to assure the quality of services delivered.

The capacity of prison mental health and addiction services to meet the needs of Northern Ireland's prison population needs considerable improvement – to ensure not only that prisoners with more acute problems are provided with appropriate specialist treatment within acceptable timescales but also that both the prison environment, and the available support are conducive to the needs of people with personality disorders. Segregation in Care and Supervision Units should be used only for the shortest time possible, and as a last resort. Further, whilst a longer-term strategy is required to increase the number of mental health beds across NI, we recommend that medium-term solutions are essential to reduce delays in transfer to appropriate secure hospitals. This may be at least partially achieved through strengthening links between prison and community services to enable both rapid response to acute problems and to improve transition of care and treatment at the time of increased risk upon release from prison.

Our RQIA review made 16 recommendations in total. If fully implemented, they should deliver the necessary improvements in services and support available to vulnerable

people in custody in Northern Ireland, in turn promoting better outcomes including the avoidance of harm. We recognise that this is a challenging undertaking in a complex system with limited resources, but the relatively small size of the system compared to most countries, where it really is possible for all key partners to know and respond to each other also offers an opportunity for building a service which could be a model for other jurisdictions. Sustained success will require commitment at all levels from across the criminal justice and health and social care systems and there will be a continued role for the RQIA, in partnership with Criminal Justice Inspection Northern Ireland, to monitor and drive improvements in the quality of care provided to people in custody.

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