Written evidence from Royal College of Psychiatrists (YDS0004)

Introduction

The Royal College of Psychiatrists (RCPsych) is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

Summary

- The young people’s secure estate is a challenging environment for young people. Staff provide support and supervision and aim to maintain everyone’s safety.
- The definition of solitary confinement is the forced ‘confinement of prisoners, for 22 hours or more a day, without meaningful human contact.’
- Though numbers in the young people’s custodial estate have fallen, so have the number of Young Offender Institutions (YOIs) and so there are a higher proportion of those with exceptional problems in each YOI.

Recommendations

- Solitary confinement for children and young people detained in the youth justice system should be abolished and prohibited.
- The government must introduce a minimum amount of time of meaningful contact offered for any young person detained in secure accommodation. This should be at the very least two hours but with an action plan to raise this statutory amount of meaningful contact over a specified period.
- Most reforms in the secure estate are dependant on staff. More staff are needed, particularly in Youth Offender Institutions, where solitary confinement is more likely to happen.
- Professionals working in custodial settings require support to develop individualised care plans for each young person. The NHS Secure Stairs initiative provides an opportunity to embed this work within each establishment.
- We continue to recommend ongoing expert clinical input into developing and providing basic training in mental and emotional health to staff working in youth custody settings.
- We ask that meaningful contact for each young person in segregation (and those who are otherwise on a limited regime and so have very limited contact with staff or other young people) in custody has an individual care plan to ensure that they have more than 2 hours of meaningful contact with another person each day.
- We ask that regulatory observational processes are also put in place to closely monitor compliance with the care plan.
- Restraint should only be administered via an individualised care plan specific to each young person, to include consideration of the potential for retraumatising in the context of a history of physical and sexual abuse and behavioural and emotional aspects of care.

1. Solitary confinement

1.1 The internationally recognised definition of solitary confinement is confinement of prisoners for 22 hours or more a day without meaningful human contact.

1.2 Not all segregation is solitary confinement, but we would dispute the Ministry of Justice’s assertion that no instances of segregation evolve into solitary confinement.
1.3 A young person is put into segregation in custody if they present with high risk of harm to others. This should not prevent the provision of meaningful contact but requires sufficient numbers of staff to offer meaningful contact. Solitary confinement should not be used as punishment.

1.4 In a secure hospital, those who present an immediate risk of harm to others may be placed in seclusion. They are reviewed every two hours by nursing staff and every four hours by medical staff and have a member of the clinical team observing them at all times (through a window or CCTV), which enhances opportunities for therapeutic interaction. There are no circumstances when a young person in secure hospital will be detained in what could be described as solitary confinement.

1.5 As there are not the same protections in the rest of the secure estate for young people, particularly in YOIs, a person’s meaningful contact may be severely restricted if they are on a restricted regime or in segregation.

1.6 It is the understanding of the College that YOIs are the least well-staffed of the four types of secure institutions where young people can be detained (YOIs, Secure Training Centres, Secure Children’s Homes and Secure Hospitals) which may contribute to the difficulties in providing meaningful contact for those on a restricted regime or in segregation.

1.7 Solitary confinement prevents a person from accessing education, which is an essential tool for successful recovery and rehabilitation.

1.8 When a young person with mental health and/or emotional difficulties is denied two hours of meaningful contact and so enters a state of solitary confinement, their mental health problems and/or emotional difficulties are likely to be significantly exacerbated. It may also lead to increased risk behaviours including self-harm, suicide-related behaviours or fire setting.

1.9 There are higher rates of ADHD, autism, and learning difficulties in secure establishments than in the community; these are specific risk factors for the exacerbation of mental and behavioural distress for those in solitary confinement.

1.10 Whilst some with Autism may find separation helpful at times, those with ADHD and learning difficulties often find it more difficult than other young people. For those with ADHD, it may trigger more impulsive risk behaviour that warrants further consequences and therefore trigger a downward spiral of behaviour that the young person cannot get themselves out of without support.

2. Restraint

2.1 Restraint should always and only be used as a proportionate response in order to manage high risk behaviours to self and/or others.

2.2 All attempts should be made to minimise the use of restraint. This requires individual analysis and formulation of an individual’s risk behaviours, including specific triggers.

2.3 The College has recognised the need to reduce the use of restraint, because of the physical and psychological harm to patients who are restrained and the staff who restrain. Any staff who restrain patients must use specific techniques via recognised training. Pain-compliance techniques should not be used.
2.4 There is mixed evidence about the use of prone (face down) over supine (face up) restraint. The duration of any restraint appears to be a more significant factor than prone v supine with regards to safety.

2.5 A comprehensive review of the evidence for supine over prone restraint is required; this should include analysis of use of restraint in high risk populations such as those cared for in forensic services and challenging behaviour units, particularly those who have previously suffered physical and/or sexual abuse associated with a particular restraint position (e.g. rape). While there are different risks involved in different forms of restraint, there is a danger that banning prone restraint would mean that some patients and staff are put at increased risk and emotional distress if options for appropriate restraint positions are limited.

2.6 The College’s Professional Practice and Ethics Committee is currently reviewing the evidence for the safety of supine over prone restraint to develop a professional and evidence-based position statement, which we hope will shape government policy.

3. Better support for young offenders with mental health problems

3.1 All age Liaison and Diversion services are being rolled out in police stations and courts and are currently expected to cover 82% of the population by the end of 2017/18 with a view to 100% coverage by 2021. These services identify and assess people arrested for an offence, including young people, who may have mental health or substance misuse issues, or other vulnerabilities, and aim to divert them into services and/or away from custody where appropriate.

3.2 Young people involved with gangs have particularly high rates of mental illness, which includes a range of conditions and vulnerabilities including conduct disorder, antisocial personality disorder, anxiety, psychosis, drug and alcohol dependence, and experience of trauma or neglect.

3.3 NHS England are introducing an integrated framework of trauma informed care planning, known as SECURE STAIRS, for all children detained in secure settings other than hospitals.

3.4 A core principle of SECURE STAIRS puts day to day staff at the centre of care, recognising their pivotal role in managing risk and promoting change for these children. In the community, commissioners and clinicians are developing Collaborative Commissioning Networks to improve the links and working practices between the commissioners and services for those children and young people who come into NHS England’s Health and Justice Pathway.

3.5 A national rollout of Community FCAMHS (Forensic Children and Adolescent Mental Health Services) is underway. These services seek to improve the identification, assessment, and care planning for young people with mental health concerns and/or emotional difficulties who present with risk of harm to others; this includes some young people who are at increased risk of placement in a secure establishment, some young people who have been subject to trauma and/or neglect, and some young people with high levels of social disadvantage. Many of these young people, particularly those who have high levels of mental health, emotional health, education, and social needs, require a multiagency approach to their care.

3.6 We look forward to seeing an evaluation of SECURE STAIRS.

The evidence for this submission was prepared by Dr Heidi Hales, Chair of the Forensic Adolescent Special Interest Group, Royal College of Psychiatrists, with the consultation with the executive of this Group.

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1 http://www.solitaryconfinement.org/mandela-rules