

# Suicide in prisons

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## Executive summary

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This report is a Royal College of Psychiatrists' response to the Thematic Review on Suicide in Prisons produced by Her Majesty's Chief Inspector of Prisons for England and Wales (1999) called *Suicide is Everyone's Concern*. The response makes 26 recommendations for the attention of the prison health care service, psychiatrists and Her Majesty's Government.

The College believes that the general principles of suicide prevention apply in all circumstances, including in prison. This report written by psychiatrists takes a clinical approach to the prevention of suicide and the treatment of suicidal thinking. A short synopsis of this approach is set out in Appendix 1.

Throughout it is emphasised that to carry out these recommendations new resources will be required. More beds and more staff are required in the National Health Service (NHS). More and differently trained staff are required in the prison service.

### Background

The most common method of suicide in prison is asphyxiation, usually at night. High-risk factors for suicide among prisoners are similar to those among other citizens, i.e. youth, male gender, depression, alcoholism and loss of a relative, friend or partner. There is some evidence that more supportive prison regimes may experience less suicidal behaviour than less supportive regimes. There is growing belief that self-help among prisoners is particularly important.

The Council of Europe Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has drawn out a number of important points from its visits to a wide range of European countries. The Committee noted that: careful statistics are important; seclusion is a poor means of managing suicidal prisoners; the identification of prisoners at risk requires special training; special emphasis should be placed on the early phases of imprisonment; the best means of managing a prisoner at risk of suicide is a constructive relationship with members of staff; prisoners with mental disturbance should not be placed in solitary confinement; and all prison systems should have a suicide-prevention programme clearly identifiable. (Gunn, 1996).

Previous systematic reports on suicide prevention in British prisons have been reviewed very briefly. These collectively recommend that the enhancement of a prisoner's life would be useful in the reduction of suicide risk, e.g. regimes including plenty of time out of the cell and good access to telephones and family and friends. There is also a need for adequate NHS provision. Seclusion should not be used as a method of managing suicidal prisoners. The young and the vulnerable should not be exposed to prison, if at all possible. All prisons need an enhanced psychiatric and substance misuse service. Training of all prison

staff, not just health care staff, in matters concerning suicide and self-harm should be an NHS responsibility.

The current English prison strategy includes four key elements of policy:

- (a) creating a safe environment;
- (b) special care for prisoners in crisis;
- (c) after-care for those affected by suicide attempts and self-harm;
- (d) the whole prison community being aware of the care of prisoners at risk of suicide.

There is a glossy, complex pack of information available to prison staff about suicide prevention containing 10 different leaflets. These include a comment on the Green Card, which can be given to individuals and which indicates how they can get immediate help at any time of the day or night. There is also significant new investment due to go into prisons to create 'in-reach teams'.

### **The Thematic Review**

In a preface to the Thematic Review, the Chief Inspector of Prisons asks for a ringing declaration from the Home Secretary that suicide and self-harm can, and will, be reduced and that accountability for delivering that reduction begins at the top and goes right down to the bottom. The College endorses these sentiments but believes that the call for the declaration should not just be to the Home Secretary but to the whole Government.

The Thematic Review implies that suicide rates are higher in prison than might be expected. The College accepts that suicide rates in prison are very high, indeed too high, but not necessarily higher than can be expected given the vulnerable nature of the individuals, at high risk of suicide, who are sent to prison.

This College response emphasises the importance of making accurate diagnoses, if applicable, in all prisoners, and noting the significance of multiple diagnoses. The College also stresses that the Care Programme Approach, which is the cornerstone of community practice, and section 117 of the Mental Health Act 1983 applies to prisoners as to all other citizens. Research should be undertaken to determine whether this is in fact happening.

The College notes the Chief Inspector's view that all new admissions should be held for 48 hours under close observation, but recommends that the induction period should be longer, up to 7 days. The College also believes that every prison should have a comprehensive primary care service with a secondary care community mental health team operating within the prison. It recommends that community drug teams should have access to prisoners and that all prison doctors should receive specific training in psychiatric and in drug misuse medicine.

The College also wishes to emphasise that drug withdrawal occurs when prisoners with problems of substance misuse are admitted to prison and this may play an important part in generating suicidal behaviour.

The College believes that the Thematic Review is successful at drawing attention to the huge impact that imprisonment has on a citizen and to the paradox of asking prison staff to manage a population which is particularly prone to suicidal behaviour. Like the Chief Inspector, the College does not believe that prisons are suitable environments for people under the age of 18 years. Offenders below this age should be admitted to specialised institutions. The College also recommends that anti-bullying programmes should be mandatory in all prisons.

A Thematic Review chapter on the aftermath of a death in custody usefully emphasises some of the mistakes that have been made in the past. The College agrees that more support and information about suicide should be given to families, but is concerned that the chapter probably overemphasises the negative aspects of prison staff behaviour in the difficult aftermath of a suicide. The College recommends that governors should have guidelines readily available on the procedures to be followed in such an event. It also recommends that there should be a mandatory requirement on the part of the senior doctor in the prison to initiate a multi-disciplinary clinical audit in the case of any unexpected death.

The College is less convinced than the Chief Inspector that the effectiveness of suicide prevention programmes can be measured accurately. Suicide rates are, even in prisons, too low to be taken as measures of effectiveness, except over several years. More routine measures of related phenomena, such as depressive symptoms, suicidal thoughts and lesser forms of self-destructive behaviour, would be required to test the effectiveness of suicide prevention strategies.

The College endorses the comments on the importance of data transfer between professionals and institutions and recommends a centralised computer system for that purpose. The College also wishes to draw attention to experimental suicide and deliberate self-harm prevention schemes (e.g. the Green Card scheme) that have been used within the NHS (Hawton *et al*, 1998). Such schemes should be evaluated in prisons.

In his chapter on local prisons, the Chief Inspector draws favourable attention to the situation in Rikers Island, New York, where the New York City Health Care Authority provides the health care and where suicide is said to have been reduced through prisoner observation schemes. The Chief Inspector recommends the prisoner participation observation scheme used in New York for consideration in Britain. The College suggests that other schemes should also be considered, e.g. the HM Prison Doncaster's 'buddy' scheme, which involves training selected prisoners in the support of distressed prisoners, and the Samaritan scheme, which is currently more widely available in the UK. The College is not aware of any data which distinguish between the various schemes, and it supports the notion that each of them should be examined thoroughly with skilled research.

The Thematic Review concludes with a chapter on healthy prisons, which is strongly endorsed by the College. The Chief Inspector's key constituents for a healthy prison are a safe environment, treating people with respect, a full constructive and purposeful regime and resettlement training to prevent reoffending. The College also strongly recommends that prisoners should have access to the same level of health care as those outside of prison; that the practice

of automatic detoxification of patients stabilised in the community on substitute prescriptions be discontinued; and that prisoners and their families are educated about the loss of tolerance following drug withdrawal programmes.

Overall, the Royal College of Psychiatrists welcomes the Thematic Review, but it also stresses further points.

- (a) Too many people with mental disorders are being sent to prison.
- (b) There is a need for a more appropriate model of mental health care delivery within prisons. There is a need for better screening for suicidal ideas and propensities at reception and for further assessment and treatment.
- (c) There are inadequate treatment facilities for offenders with mental disorders outside of prison, and mental health services in the community need to be amplified so that they can play a bigger role in the care of these offenders.
- (d) NHS authorities need to provide more beds for acute psychiatric care, to make court diversion schemes a practical possibility.
- (e) There needs to be a greater provision of secure beds in the NHS.
- (f) There needs to be greater and better liaison between the prison health care service and the NHS.

The College believes that staff training is a key issue within prisons. Each grade of staff should have training that is appropriate and always includes basic understanding of human psychology and psychiatry. The College recommends that the principle of continuous professional development be introduced into all categories of prison staff training, which would include a specific mental health component. Training for doctors and nurses in prisons should include special courses on the recognition of suicidal behaviour and its management, the understanding and management of depression and on the management of substance misuse of all kinds, including alcohol.

The College notes the continuing debate in prisons about the 'medical model', a model which is almost never endorsed by prison staff. The College believes that there is a serious danger in this debate of losing sight of the central importance of medical matters in suicide prevention. The importance of clinical skills and one-to-one management needs emphasis. It is further recommended that the training of all psychiatrists includes some experience of prison work and, in particular, an understanding of the limitations of psychiatric treatment within prisons.

As an aside, the College response draws attention to the fact that the whole of the criminal justice system, not just the prisons, is implicated in the mental health problems seen in prisons and that judges and other lawyers should learn more about psychiatry, psychology and criminology.

The College concludes by emphasising the mental hygiene issue of socialisation, which is so difficult in prisons, and the importance of ensuring that people with mental distress are not kept in isolation. Special attention is drawn to the need for all suicidal prisoners to be in close contact with other people.



# Introduction

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## Terms of reference

In June 1999, the Council of the Royal College of Psychiatrists established a working party with the following terms of reference.

‘The working party will examine the background to the continuing rise of the suicide rate in prisons. It will take particular account of the Thematic Review on this matter, which has been produced by HM Chief Inspector of Prisons for England & Wales. It will make recommendations to the reorganised Prison Health Care Service and to the membership of the College about actions that may be taken to reduce this rising death rate.’

The working party met eight times. One meeting focused on statistical matters and was attended by Dr Morven Leese, Senior Lecturer in Statistics at the Institute of Psychiatry, London and Dr Mike McClure, Consultant Child and Adolescent Psychiatrist and Honorary Senior Lecturer for Brent, Kensington & Chelsea and Westminster Mental Health NHS Trust, London.

## The extent of the problem

We are indebted to the Home Office Suicide Awareness Support Unit for the provision of data, which are shown in Tables 1 and 2 and Fig. 1. It is clear that the absolute numbers of deaths by suicide in HM Prisons for England and Wales have risen and Fig. 1 shows that the suicide rate had been rising at approximately 5.5% per annum until 1989, although there was a reduction in subsequent years. These figures have caused a great deal of alarm and The Royal College of Psychiatrists shares the general concern. The College supports any measures that can reduce this waste of human life. We have also included Table 3, which briefly shows the general positions in England and Wales, and we are indebted to Dr Mike McClure for this.

A more telling picture of the nature of the problem and a glimpse of the problems suffered by those who die by suicide is given by an audit carried out by one of the committee (M.P.) in her capacity as a member of the Prison Health Care Service. The audit was conducted in 1992–1993 and a summary is included here as Appendix 3. It illustrates the general points that those who die by their own hand in prison are disproportionately likely to have a violence charge or conviction, to have a psychiatric history, to have a mood disturbance, to be in receipt of bad news and to be alone at the time of their deaths. Not many are selected for NHS treatment. Only a few are selected for formal suicide prevention procedures.

**Table 1. Prisoner suicides (figures supplied by the Home Office)**

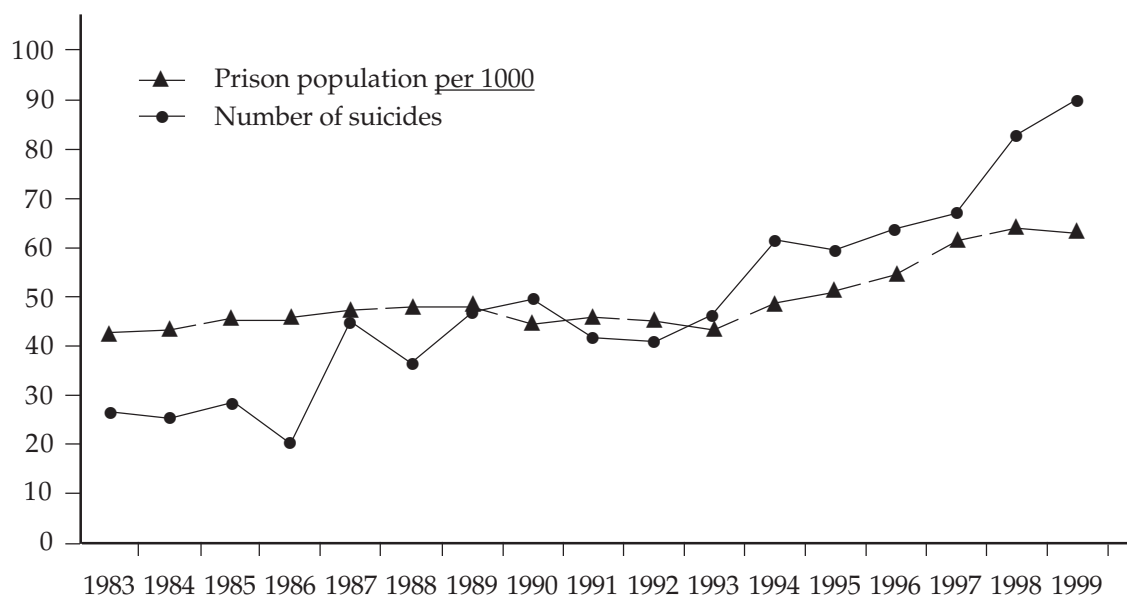
	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Total prisoners	43 500	43 300	46 233	46 770	48 425	48 872	48 500	45 636	45 897	45 817	44 565	48 794	51 047	55 281	61 114	65 500	64 800
Suicides	NK	NK	NK	NK	NK	2	2	4	4	10	9	7	4	5	8	11	13
Unsentenced	NK	NK	NK	NK	NK	2	2	4	4	10	9	7	4	5	8	11	13
Remands	NK	NK	NK	NK	NK	19	25	24	12	14	18	23	22	31	26	44	45
Sentenced	NK	NK	NK	NK	NK	16	21	22	26	17	20	31	33	28	34	28	33
Local prisons	NK	NK	25	16	25	24	34	NK	NK	NK	NK	NK	NK	NK	NK	NK	NK
Other establishments	NK	NK	4	5	11	13	14	NK	NK	NK	NK	NK	NK	NK	NK	NK	NK
Total suicides	27	26	29	21	46	37	48	50	42	41	47	62	59	64	68	83	91
Rates per 100 000	62	60	58	45	95	76	99	110	92	90	105	127	116	116	111	125	140

**Table 2. Prisoners and suicides by age (figures supplied by the Home Office)**

Age (years)	1995		1996		1997		1998		1999	
	% of deaths	% of population	% of deaths	% of population	% of deaths	% of population	% of deaths	% of population	% of deaths	% of population
15-17	2	3	2	4	2	4	4	4	4	2
18-20	12	13	17	12	12	12	13	13	13	14
21-24	18	20	16	19	19	19	11	18	14	14
25-29	24	22	27	22	22	22	21	21	23	23
30-39	36	26	20	27	28	27	40	28	36	36
40-49	5	11	13	11	12	10	8	10	7	7
50-59	3	4	5	4	4	5	2	5	2	2
60+		1	2	1	2	1	1	1	1	1

**Table 3. Suicide in England and Wales by all methods (rates per million) (figures supplied by M. McClure)**

Suicides	1990 <i>n</i> /million	1998 <i>n</i> /million	Change 1990–1998 <i>n</i> (%)
Males (all ages)	121	109	– 12 (–20%)
Females (all ages)	37	30	– 7 (–19%)
Males (20–39 years)	165	166	+ 1 (+1%)
Females (20–39 years)	36	35	– 1 (–3%)



**Fig. 1 Prison suicides in England and Wales, 1983–1999 (figures supplied by The Home Office)**

Nevertheless, we want to emphasise from the outset that in our view the stark figures given in their usual format here do not give a full picture of a very complicated problem. To put it briefly, we do not believe that the data available at the present time show whether the suicide rate is higher in prison than it is for equivalent individuals in the general community, or whether it is getting even worse than it used to be.

### Prison staff

We also want to make it clear from the outset that we do not believe that the problem of prison suicides is related primarily to poor-quality staff. Prison staff are themselves victims of the prison system and the criminal justice system as a whole. It is worth noting, for example, that 51 prison officers killed themselves between 1990 and 1999. Prison staff have no choice in who is sent to them. They

are expected to care for a very vulnerable group of people, many of whom ought to be in hospital rather than prison. Those of us who are familiar with the prison system have been immensely impressed by the selfless dedication of many prison staff, in all disciplines, in looking after society's rejects. Later, we will make proposals for improved training of staff, but such proposals should not be added to the usual chorus of criticism aimed at prison staff.

### **A time of change**

The delivery of health services to prisoners has been a difficult and contentious issue for many years. Originally the prison service within the Home Office provided a specialised dedicated service to the prisons of England and Wales. This was supplemented by some contractual arrangements with local general practitioners (GPs) and local NHS psychiatrists. This service received many criticisms (for a history of its development, see 000, 1985), and recently it has been decided to attach prison health care closely to the NHS in England and Wales. A new Prison Health Policy Unit and Task Force has been formed, which reports both to the prison service and to the NHS Executive in England and Wales and is located within the Department of Health in London. It is too early to judge whether this will attract the resources required for better health in our prisons or prove to be an effective means of delivering health care to prisoners. It is, however, worth quoting the official preamble to the Prison Health Handbook:

'The health of prisoners is our business whether we work in the prison service or the NHS ... it has always been the aim to ensure that prisoners get decent health care to standards equivalent to those in the NHS. But it is generally recognised that this aim is not being met; in some places the gulf between NHS standards of care and prisoner care is very disturbing. In particular there are problems with inadequate provision for prisoners with mental health problems ... Effective health care delivered to a good standard while in custody, even for a short period can make a significant contribution to the health of individuals ... As many people are in prison for less than 6 months it is essential that we ensure better continuity and through-care if we are to meet our obligations to them' (Department of Health, HM Prison Service, The National Assembly for Wales, 2001).

Within the Royal College of Psychiatrists there is a dialogue continuing about how best to join with these aims. The dialogue arises in the context of community mental health services, which have insufficient resources (finance, hospital places and workforce) to meet current obligations. There is an element of this dialogue concerned with the process of delivering better psychiatric care to prisoners; should this be through the general community mental health teams, or through specialist forensic psychiatry services. This report clearly cannot resolve that dialogue. However, the College is committed to better mental health care for prisoners and also to more resources for prisoners, for community mental

health teams and for secure services; and it welcomes the support of the, then, Deputy Home Secretary for stronger links in general between prisons and the community.

### **Extent of commentary**

This response is to a Review that concerns England and Wales and has been written with that jurisdiction as its focus. The Royal College of Psychiatrists has not only English and Welsh divisions but also a Scottish division and an Irish division, which relates to the Republic of Ireland as well as to Northern Ireland. Furthermore, the UK belongs to the Council of Europe, which has a watching brief on standards of imprisonment throughout Europe. For this reason we have, as far as possible, incorporated advice and experience from other jurisdictions. It will be for practitioners and politicians outside of England and Wales to interpret how far our recommendations apply beyond England and Wales.

By contrast, we have not made comments on deliberate self-harm in the broad sense. This is for several reasons. The Chief Inspector's Thematic Review does not deal with it. Furthermore, although there is a closer association between all forms of self-harming behaviour and repeated non-fatal deliberate self-harm is a very high risk factor for suicide, the topic is a very large one that deserves separate treatment. Here we will be concerned with fatalities and their precursors; in this report we note that repeated deliberate self-harm (e.g. by overdosing or cutting) should raise awareness of a potential suicide.

It will be evident from the responses in this document that we are emphasising the role of psychiatry in the prevention of suicide. Perhaps, as we are psychiatrists, this is inevitable, but an underresourced profession does not lightly recommend an increasing role for its members in any activity if that can be avoided. We note the increasing tendency to say that most people who kill themselves do not have a mental illness and therefore the prevention of suicide should largely be the concern of non-medical staff. However, we are of the opinion that a shortage of resources has pushed this argument too far. Most people who kill themselves have mental disorders (e.g. depression, misusing drugs and alcohol), even if only temporarily, and such disorders are the concern of psychiatry.

It is important, however, to note that we do not believe an increase in the psychiatric assistance for prisoners can occur without a significant increase in the appropriate resources. Furthermore, we do not intend to imply in this document that contextual matters are less important than therapeutic ones. Socialisation, occupation, visits from families, good staff:prisoner ratios and decent accommodation are all key factors in suicide prevention in prisons.

### **Not a new problem**

One hundred years ago Z. R. Brockway, a New York prison governor, claimed to have solved the problem of prison suicides: 'suicide attempts were completely

stopped by notice in the institution's newspaper that thereafter they would be followed in each case with physical chastisement' (Hayes, 1995).

In contrast, in January 1919 the Executive of the Labour Research Department established the Prison System Enquiry Committee. The report was published under the editorship of Stephen Hobhouse and A. Fenner Brockway (no relation) (1922). Although it is a 'report', which often implies a tedious read, this book can be considered as a work of literature. It stands unequalled in its vivid descriptions of English prisons in the period immediately following the First World War, in its powerful insights into the effects of imprisonment on people, both staff and prisoners, and in its lucid analysis of the moral questions that necessarily surround the social institution of imprisonment. It deals with every aspect of prison life and has interesting chapters on mental deficiency, insanity and suicide.

In their conclusion the committee commented:

'It is noteworthy that ... direct physical injury has been discarded from the penal code. Modern methods of punishment take the form of deprivation of liberty and the denial of intellectual, emotional, and spiritual satisfactions. Stated in physiological terms, primitive forms of punishment consisted of the infliction of gross bodily hurt; modern penal methods are directed upon the higher functions of the central nervous system.'

They go on to note,

'the ratio of both insanity and suicide is incomparably greater in prison than in the ordinary population, and, whilst many criminals may have greater natural tendencies toward mental disorders and self-destruction than the law-abiding, it is clear that the regime is in large part responsible.'

The chapter in the report on suicide and attempted suicide quotes figures from the famous prison medical officer Dr Goring. He calculated the death rate from suicide to be 73 per 1000 prisoners. The general population figure of his time was said to be 17 per 1000 deaths. As already indicated, and as we shall see below, there is reason to consider that these figures do not represent the position entirely accurately but they do give a flavour of the extent of the problem at the beginning of the 20th century and the concern that suicide rates among prisoners was arousing. The Committee of Enquiry was at pains to indicate that in its view the death rate from suicide was only the tip of the iceberg and that there were in fact many more suicide attempts. The Committee noted that suicide was a particular problem among young prisoners, among criminals convicted of crimes of passion and was particularly prevalent in the early period of imprisonment, i.e. the first few weeks. They made a special note of the close connection as they saw it, between isolation and suicidal behaviour. They noted the good effects of associated labour in mitigating the 'evil effects' of separate confinement. They comment,

'in general, solitary confinement necessarily fosters the suicidal tendency by depriving the prisoner of the obvious safeguards inherent in useful

activities and more particularly in healthy social intercourse. There is little doubt that a word of encouragement or a sign of sympathy, if it reached the prisoner when he was brooding upon projects of self-destruction, might restore that minimum of hope without which the desire for life cannot continue.'

# Background

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## **Suicide prevention in the community**

We believe that the general principles of suicide prevention apply in all circumstances, whether in or out of prison. The individuals who go in and out of prison carry their problems through the gate, whichever way they are passing. It is important therefore to avoid developing strategies in prison that are at odds with good practice in other settings.

In response to the Department of Health's (1992) Health of the Nation objectives to reduce the suicide rate, one of us (H.G.M.) was involved in the production of an NHS Health Advisory Service Thematic Review on Suicide Prevention (Williams & Morgan, 1994). This review lists the correlates of suicide, which include being divorced, widowed or single; being unemployed or retired; having a history of deliberate self-harm; having a family history of affective (mood) disorder, alcoholism or suicide; being bereaved in childhood; and having a psychiatric disorder, especially depression, schizophrenia or substance misuse.

The Review, however, introduced a note of caution about these risk factors:

'Risk factors are correlates and associates, and not necessarily causes of suicide. They are more effective in predicting risk in the long-term rather than the immediate future. Prediction of suicide in the short-term, that is over the next few hours or days, is an important routine clinical task. Suicide risk in any individual can only be assessed effectively by full clinical evaluation consisting of a thorough review of the history and present illness, assessment of mental state, and then a diagnostic formulation.'

Techniques for interviewing potentially suicidal people are spelt out, for example 'interview techniques should aim to bridge the gap created by mistrust, despair, and loss of hope that anything can change for the better ... to reach out and listen is itself the first major step in reducing the level of suicidal despair'. It is emphasised that the basis of good practice is the formation of a supportive, understanding relationship with the patient. A written contract negotiated between a therapist and a suicidal patient can be a useful technique in suicide prevention.

A problem-solving approach is advocated in the Review. This depends upon a thorough knowledge of all the patient's life problems. It involves getting the patient to recognise and admit that problems exist, communicating them to others and helping to generate alternative solutions to those problems. A cognitive-behavioural approach to suicidal ideas is advocated within this framework (see for example, Linehan, 1993).

Hawton (1994) reminded us that:



'It is also important to be realistic and to recognise the limitations of suicide prevention. Suicide has existed throughout history and will never be totally eradicated. It is also important to acknowledge both the extent of risk of suicide in all psychiatric disorders, especially depression, schizophrenia, alcohol and drug abuse, and major personality disorders of an aggressive or impulsive nature, and the difficulty of assessing this risk in the individual. The aim of preventive efforts should be the reduction of suicides to the lowest possible level. At the same time, the fact that suicides will occur must be accepted. It is particularly important that those in the caring professions who are frequently doing their utmost to prevent suicide, often within services with meagre resources, are not subjected to automatic morale-sapping condemnation when a suicide occurs.'

A review by Gunnell & Frankel (1994) concluded that there is no single easily identifiable group upon whom we could focus intervention as a means of reducing the suicide rate. The one exception is the population of people who have harmed themselves already. In the year after an episode of self-harm the risk of suicide is 100-times the general population rate. A quarter of all suicides in the UK had been seen in a general hospital in the 12 months beforehand, after a non-fatal act of self-harm (Appleby *et al*, 1999a).

### **Suicide prevention in hospital**

As psychiatrists, we see many patients with suicide and self-harm problems. Our response to these patients is a clinical/individual one using a multi-disciplinary approach. It is this approach that informs our response to the Thematic Review.

A common response to a suicidal patient in the community is to admit them to hospital where observation, support and treatment can be provided most effectively. In this context it should be noted that prison health care centres are not fully equipped and staffed hospitals, but sick bays with some beds for overnight accommodation. These have a useful emergency role in prisons but full NHS hospitalisation needs to be used more frequently for seriously ill and suicidal prisoners. The principles of an individualised clinical approach are set out in Appendix 1.

We know that significant new investment is planned for prisons to create 'in-reach teams'. This is planned to occur over a 3-year period and is welcome because, clearly, unless services are resourced they are not services at all.

We recommend that in the majority of cases, suicide risk among prisoners continues to be managed by prison services. Nevertheless, primary care teams in prison should have the facility to refer persistently suicidal prisoners with significant mental health problems to a community mental health team for a further assessment. To achieve this, prison health services will require significant

new investment (financial and workforce) to ensure that prisoners who require it have access to a comprehensive prison-based community mental health team. We further recommend that such assessments should include consideration of transfer to NHS hospital care, in cases where the usual criteria for admission to in-patient care are met. We recommend that, for those prisoners with suicidal propensities who remain in prison, use be made of the clinical approach we have outlined in Appendix 1.

We recognise that for a proper implementation of the above recommendation enhanced resources will be required. Overburdened community mental health teams cannot simply take on extra prison work within current resources. For example, court diversion schemes cannot work effectively when there are more general acute psychiatric beds available. It is also clear that some of the prisoners that should be transferred on health grounds will pose security risks and will not be suitable for open accommodation. We recommend increased NHS in-patient capacity, funded by new investment, in open wards and in low, medium and high secure accommodation, in order to provide for those prisoners with mental illness who require hospital in-patient care.

### **National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness**

The National Confidential Inquiry was established at the University of Manchester in 1996, having previously been based in London. It is funded by the Department of Health.

In 1999, one of us (J.S.) was involved in the production of the first report of the National Confidential Inquiry, *Safer Services* (Appleby *et al*, 1999b). This report was a 24-month consecutive case-series of people in contact with mental health services. The Inquiry was notified of 10 040 suicides and probable suicides during the 2 years from April 1996. Twenty-four per cent of suicides had been in contact with mental health services in the year before death. This represented over 1000 cases per year. The most common drugs used in overdose were those prescribed to treat mental disorder (psychotropic drugs). The most common diagnoses were depression, schizophrenia, personality disorder and alcohol and drug dependence. About half also had a second (comorbid) diagnosis, indicating more complex treatment needs. Twelve per cent of the suicides had been in contact with mental health services in the week before death. Sixteen per cent of cases (4% of all suicides) were psychiatric in-patients and about one-third of in-patient suicides occurred on the ward itself. About a quarter of in-patient suicides were under special observation, either constant or intermittent. In almost a quarter of in-patient suicides, there were difficulties in observing patients because of ward design. Twenty-four per cent of suicides occurred within 3 months of discharge from in-patient care. Those post-discharge suicides were at a peak in the first week after leaving hospital; within the first week, the highest number occurred

the day after discharge. Forty-one per cent of post-discharge suicides occurred before their first follow-up appointment.

## **Suicide prevention in prison**

### *Suicide samples*

One of us (E.D.), while at the Institute of Psychiatry in London (Dooley, 1990), examined the case notes of 295 suicides (98.3% of the total) in prison in England and Wales between 1972 and 1987. The most common method of suicide was asphyxiation, usually at night. The dead prisoners frequently had a past history of psychiatric treatment and self-injury. People charged with, or convicted of, violent or sexual offences were overrepresented among the suicides, as well as those serving life sentences. Some suicides occurred many years after reception into prison.

### *Prison size*

Lloyd (1990) suggested that correlates of suicidal behaviour should be considered as indicators, rather than foolproof predictors. He said that there is some suggestion in the literature that smaller, more supportive prison regimes may experience less suicidal behaviour. He noted that the report into HM Detention Centre and HM Young Offenders' Institution, Glenochill (Chiswick *et al*, 1985) proposed dividing young offender institutions into smaller units of 30–40 inmates, each providing a different distinctive regime (see below).

### *Self-help*

Lloyd (1990) said that some commentators have stressed the importance of contact with family and friends. However, the finding that many suicidal prisoners may be single and without such relationships underlines the importance of other sources of contact from outside prison, such as the Samaritans. Lloyd emphasised that the majority of commentators reject the use of any form of isolation for potentially suicidal inmates. Most advise location in a ward or dormitory accommodation, under intense supervision for severe cases. Otherwise, for less serious risk, cell-sharing with selected inmates is advocated.

An extension of this self-help notion has been reported from the USA. In a New York City scheme, inmates are selected and paid by the Board of Corrections to monitor other prisoners for possible suicidal intentions. The aides are required to patrol the housing area and report unusual behaviour and inmate depression to correctional officers. They are therefore trained how to identify such behaviour and how to talk to prisoners who are depressed and suicidal. Advantages of these schemes are that they are comparatively cheap and inmates may feel more able to confide in prisoners than in officers. Furthermore, the effect of helping other inmates may be beneficial for the aides themselves. However, the problem

with such schemes is their potential for threatening the existing power relations between staff and inmates. Electronic monitoring has been introduced in the USA in the form of television and audio equipment, but some observers believe that this results in decreasing contact between staff and inmates and dehumanisation.

### *Suicide prevention programmes*

White & Schimmel (1995) claimed that the Federal Bureau of Prisons suicide prevention programme has been extremely successful in that during the period of its implementation there was a 43% decline in suicide rates. However, the authors are careful not to claim cause and effect and it is clear from the data provided by Hayes (1995) that there was a general reduction in suicide rates during this period in both the state and federal systems. Nevertheless, it might be worth noting the policy that the American federal system has adopted. This is a five-point programme that involves:

- (a) initial screening of all inmates;
- (b) treatment and housing criteria for suicidal inmates;
- (c) development of standardised record-keeping, follow-up procedures and systematic data collection;
- (d) staff training;
- (e) periodic reviews and audits.

Psychologists do the initial screening, by interview within the first 14 days of admission. Any inmate who is considered suicidal is removed from the general population and placed on suicide watch. Suicide watch is virtually continuous monitoring by trained inmate companions or staff; the inmate is never left alone. The psychology services are required to use a series of standardised forms for these watches, which are later used for analysis. The cornerstone of the programme is considered to be the training of the staff. Training is provided 'semi-annually' to physician assistants and correctional counsellors.

Training for inmate companions focuses on ensuring that inmates understand the procedures necessary to summon staff assistance should there be any attempt at suicide. They are also given training in understanding suicidal behaviour, empathic listening and other techniques for building communications. It is thus hoped that the companion can provide the suicidal inmate with a ready source of peer support.

A fruitful source of information for Europe is the regular reporting by the Council of Europe Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), which visits all countries that belong to the Council of Europe to examine the institutions where people are held against their will. These are prisons (civil and military), police cells, psychiatric hospitals and immigration detention centres. It is recognised that such institutions have high levels of suicidal behaviour and varying degrees of success in coping

with this. Our review of the reports concerning Denmark, Finland, the Federal Republic of Germany, Iceland, Italy, Portugal, Switzerland and the UK draws out the following points:

- careful statistics on suicide are important
- seclusion is a poor means of managing suicidal prisoners
- identification of prisoners at risk is of critical importance and requires special training
- special emphasis should be placed on the early phases of imprisonment in this respect
- the best means of managing a prisoner at risk of suicide is the establishment of constructive relationships between staff and inmates, which again requires special training
- prisoners with obvious mental disturbance should not be placed in solitary confinement and should be managed by closer supervision and support instead, combined, if necessary, with medical care and sedation
- physical restraints should never be used in security or seclusion cells
- closed-circuit television may have a role to play in monitoring suicidal behaviour
- all prison systems should have a suicide prevention programme clearly identified and widely available.

For the UK, specific points were made by the CPT in 1991 (Council of Europe, 1991) as follows:

‘The central plank of the suicide prevention programme must be to address the problems of overcrowding, lack of integral sanitation and inadequate regimes. It may be true that conditions found in many local prisons will rarely be the sole and unique cause of a suicide; however for someone who is already predisposed to taking his life, they might often prove the last straw. Another key element of suicide prevention is the establishment of constructive relationships between staff and inmates, as well as between inmates. As far as the delegation could see, contacts between prison staff and inmates tended to be impersonal. Staff will have to possess good interpersonal communication skills for there to be a significant improvement. Steps to improve the general level of prison conditions and staff inmate relations must be accompanied by more specific measures aimed at identifying those most likely to commit suicide. In this connection it should be noted that adolescents as a group constitute a population at risk. Further, all prison staff, whatever their precise job, should be on the lookout for (which implies being trained in recognising) signs of suicidal behaviour. Of course persons identified as a suicide risk should be subject to special precautions. In particular they should not be placed alone in a cell with easy access to means of killing themselves (cell window bars, broken glass, belts or ties), should benefit from counselling, support and

appropriate association, and should, for as long as necessary, be kept under a special observation scheme.'

The NHS Health Advisory Service's Thematic Review (Williams & Morgan, 1994) mentioned above has a short piece on suicide prevention in prisons:

'A number of key factors need to be addressed in considering suicide prevention in prison. In certain circumstances, prisoners experience gross overcrowding and this may well be a factor leading to an increased suicide rate. Rates might be reduced if periods of remand were to be shortened and transfers to psychiatric hospitals, when appropriate, were made without lengthy delays. All staff members should have adequate training in the psychological care of prisoners and, in particular, the assessment and management of suicidal prisoners. Improvements in the rapport and trust between staff and prisoners are likely to foster suicide prevention. The recent innovation that has made the Samaritans process of befriending available to prisoners is a most welcome development. HM Prison Service has recently embarked upon an enlightened training programme for its staff, one of which emphasises assessment and support, which includes psychosocial as well as medical and psychiatric approaches. Suicide risk should always be considered in planning the design and regime of a prison, in order to minimise the means of committing suicide. Given the preponderance of hangings among prisoners who commit suicide, it is important to ensure that, for example the prison environment presents as few opportunities for this method as possible.'

### *Training programmes*

Lloyd (1990) gave considerable emphasis to training programmes. The best described such programme is from Canada (a private report, see Lloyd, 1990). Selected prison staff were given five modules of education, including specialised knowledge about suicide and skills for intervention. Between January 1984 and June 1986, 661 staff were trained. The staff liked the programme and used the skills gained. The referral rate to psychologists within the experimental prisons rose and the suicide rate fell.

We have examined a number of previous reviews concerning the prevention of suicide in British and Irish prisons. In 1990, His Honour Judge Stephen Tumim, the then Chief Inspector of Prisons for England & Wales, published a review of suicide and self-harm in prison service establishments in England and Wales (Her Majesty's Chief Inspector of Prisons for England and Wales, 1990). One of us (D.C.) chaired a working party that looked at the suicide precautions at HM Detention Centre and HM Young Offenders' Institution, Glenochill in 1985 (Chiswick *et al*, 1985). Another of us (J.G.) conducted a personal enquiry into the Scottish suicide prevention system in 1996 (details available from author on request). These reports produced the following findings.

- (a) Good prison regimes, which include occupation, time out of cell, good access to telephones and information and good access to family and friends have been highlighted by all reports as aspects of prison life that could act to generally enhance prisoners' lives to reduce risk of suicide.
- (b) There is a need for adequate NHS provision, so that patients with mental illness needing observation or treatment should transfer promptly to an NHS facility.
- (c) Prisoners requiring enhanced observation because of their suicide risk should have such observation provided in a humane way through enhanced human contact with nursing staff within a safe (ligature-free) cell.
- (d) Seclusion is not a good method of managing suicidal prisoners.
- (e) Reports agree that, where possible, young people and vulnerable people should not be exposed to prison if at all possible. This indicates an NHS responsibility to ensure that there are adequate and timely screening procedures in the community at the point of arrest or in court (police or court liaison schemes) to ensure that consideration is given to diversion prior to remand to prison.
- (f) Training of prison staff (not just health care staff) in the recognition of suicide potential and training in basic approaches to management of suicidal people is recommended as a way of enhancing the total prison response to the problem.
- (g) Prisons need an enhanced substance misuse service, as this emerges as an important factor relating to suicidal behaviour in prison populations.

A report of the National Group on Deaths in Prisons in Ireland (Department of Justice, Equality and Law Reform, 1999) provides a statistical and policy update on the problem of prison deaths, particularly suicides. This is essentially an update of the previous Report of the Advisory Group on Prison Deaths, which was published in 1991 (Government of Ireland, 1991) and was the first such report looking at the phenomenon of prison suicides in Irish prisons.

As Appendix 2 shows, the Irish prison system has been lucky enough not to have encountered an increase in prison suicides. It may be worth offering possible reasons that may have had some influence on this situation:

- The Irish prison system has a very high ratio of prison officers to prisoners (probably the highest in the world, at over one officer to every prisoner). This means that there is always staff available to prisoners. It also has indirect benefits in facilitating increased out-of-cell time, visits, etc. Furthermore, there is relatively little overt conflict between prisoners and staff (until 2000 a serious assault on staff by prisoners was almost unknown).
- Prisoners enjoy a fairly liberal regime with reasonable access to visits. More particularly, the chronic overcrowding of the prison system has led

to an operational system of constant shedding (either temporarily for days or weekends, or full release before expiry of sentence).

- Overcrowding within the prison system has led to a situation whereby there is a significant amount of multiple occupancy of cells. While such overcrowding is not fundamentally desirable it is possible that it has, to some degree, had the effect of limiting opportunity to self-injure.
- There is a serious lack of therapeutic resources so these are unlikely to be a significant preventive factor for prison suicides.

### *The English and Welsh prison strategy*

The England and Wales prison service launched a new strategy for prisoners at risk of suicide in April, 1994. The authorities took particular note of a statement in the report by Her Majesty's Chief Inspector of Prisons for England and Wales (1990) stating, 'the danger of targeting suicide prevention as primarily a medical problem is that the service may have become conditioned to the view that all the answers lie with the doctors. This is not the case. Prisoners, staff, families, visitors, the regime, the environment, all have parts to play.'

The new strategy is outlined in detail in a guidance pack for staff and is underpinned by a comprehensive modular staff-training programme. The key elements of the policy are:

- primary care – creating a safe environment and helping prisoners to cope with custody
- special care – identifying and supporting prisoners in crisis and treating them with dignity
- after-care – caring for the needs of those affected by suicide and self-harm
- community responsibility – involving the whole prison community in the awareness and care of prisoners at risk of suicide.

The strategy is based upon seven principles:

- (a) suicide is not inevitable
- (b) change is always possible
- (c) awareness of suicide can significantly reduce the risk
- (d) the person at risk of suicide must consent to the help that is offered
- (e) positive listening alleviates despair
- (f) some suicides will still occur despite excellent care
- (g) staff need support.

In practice, the strategy is delivered locally at establishments through a multi-disciplinary suicide awareness team, the responsibility of which is to develop local policy, maintain staff and prisoner awareness and review incidents of self-harm. Each prison has to establish a team and membership includes prison staff, prisoner representation and external organisations such as the Samaritans. The procedural system for supporting prisoners identified at risk has been broadened from a simple referral system to a case conference approach requiring the drawing



up of an action plan. Any member of staff can initiate the process if a prisoner is thought to be at risk of self-harm. The system encourages a multi-disciplinary response in identifying the level of support appropriate for the individual and the most suitable location, whether in the residential unit or in the health care centre. The approach discourages the use of isolation and rigid observational routines as a sole method of caring for prisoners at risk of suicide. The shared community response to caring for those at risk has been developed to include visiting agencies such as the Samaritans befriending prisoners, and also peer group support in the form of listener/befriender schemes run by selected prisoners who are trained by the Samaritans. Such schemes are now operating in over half the prisons in England and Wales.

The pack referred to is glossy and complex and contains ten different leaflets. The seventh leaflet includes a comment on Morgan's Green (or Contact) Card, which is given to people in the community to show them how they can get immediate help at any time of the day or night if they feel despairing or have thoughts of self-harm (Morgan *et al*, 1994; Evans *et al*, 1999, 2000) and it suggests that a similar approach could be used in prison.

### **The College's comments**

These reports from England, Wales and Ireland within the area covered by the Royal College of Psychiatrists set the scene for the most recent Thematic Review by the Chief Inspector of Prisons for England and Wales. It could be argued that the reports quoted have had insufficient impact as the suicide rates, in Great Britain at least, seem to keep rising. Who knows if it would have been worse without the reports? Certainly the Chief Inspector is not ploughing untilled soil.

#### *Prevention of Suicide and Self-Harm in the Prison Service – An Internal Review*

Just as we were finishing work on this document, the Home Office produced yet another review of suicide prevention policy (HM Prison Service, 2001). It does not actually say that it too was stimulated by the Chief Inspector's Thematic Review but it notes some of its findings. We have not had time to do justice to this further review but note that it does not conflict with the recommendations made here. The principal recommendations of the new review include developing a new 3-year strategy beginning in November 2000. The strategy will include dedicated drug detoxification units and mental health teams. Enhanced training of staff in 'high-profile locations', including refresher courses on suicide prevention and mental health is to be introduced. There will be a strengthened and renamed Suicide Prevention Policy Group with a strong research base and better links to statutory and community bodies, particularly the Samaritans. Each region is to have a nominated suicide prevention officer, and each high-risk prison, a full-time dedicated Suicide Intervention Coordinator. We were particularly pleased to see recommendation 2.15, which says that stripped cells and segregation units should not be used for the actively suicidal.

## The Thematic Review

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In May 1999, Her Majesty's Chief Inspector of Prisons for England and Wales (Sir David Ramsbotham) published a Thematic Review called *Suicide is Everyone's Concern*. In his preface to the report, Sir David said:

'Death and bereavement inevitably touch us all in some way, and, when a prisoner dies in prison, his or her family are bereaved in the same way as anyone else. But there is an added dimension to a death in prison. First, family and friends do not just lose a loved one, they lose him or her in very painful circumstances, separated from them and in conditions they do not fully appreciate. In addition, staff and prisoners, living and working with the person, are also deeply affected, and have to come to terms with their bereavement as well as that of the family. Thus the impact of a death in custody is compounded by a number of additional factors and emotions, which must be acknowledged, but are difficult to understand objectively. In the course of our work it became very clear that the vast majority of self-inflicted deaths occur in local prisons, which contain a very wide mixture of prisoners – remand, convicted but unsentenced, life, long-, medium- and short-sentenced, mentally disordered, and, in some cases, women, young offenders, and children. They are invariably overcrowded, holding, on average, 126% of their certified normal accommodation, with an average throughput in excess of four times their population every year. Central to my recommendation is the need for a ringing declaration from the Home Secretary, through the Director General, to everyone in the prison service, that suicide and self-harm can and will be reduced, and that accountability for delivering that reduction begins at the top and goes right down to the bottom.'

### *The College's comments*

We fully endorse the sentiments and aim of this Thematic Review, as set out in its preface. We believe that the call for the declaration should be addressed not just to the Home Secretary (although that is important); it should be to the whole Government, i.e. the Cabinet, including the Prime Minister. Health is a general political topic. Reduction of suicide rates is already a Government objective. Mental health issues of this kind involve health policy, criminal justice policy, housing policy and family policies, to name a few of the important areas. Thus, the Home Office has to take a lead but the Department of Health, the Lord Chancellor's Department and the Department of the Environment (which is responsible for housing) are also intimately involved. We particularly welcome the title, which indicates that suicide prevention is not the province of any one

professional group and indicates that general prison ambience is a very important suicide prevention factor.

The Thematic Review is set out in seven chapters, a set of recommendations and some appendices. We will comment on these in turn.

## **Chapter 1. Background and context**

The Review says that:

- suicide in prison custody has to be understood in relation to suicide in the community
- the overall suicide rate in England and Wales is reducing, except for men aged 25–34 years and women aged 15–24 years. For these groups the rate continues to rise. Suicide rates are significantly higher in those local authority areas with high levels of deprivation
- the rate of self-inflicted deaths in prison more than doubled between 1982 and 1998; the increase in the rate of self-inflicted deaths in prison is larger than would be expected from the rise in the prisoner population
- a significant proportion of self-inflicted deaths are by those with violent offences
- there appears to be an overrepresentation of White prisoners among those who commit suicide
- about 60% of self-inflicted deaths take place in the first 3 months after arrival in an establishment
- most people who attempt suicide in prison have experienced a wide variety of adverse life events, particularly violence and sexual abuse
- about three-quarters of people who take their own lives in prison have a history of substance misuse.

The text also draws attention to the study by the Office for National Statistics (Meltzer *et al*, 1999), which indicated just how common parasuicidal thinking and behaviour is among prisoners: 12% of men and 23% of women had suicidal thoughts; 15% of men and 27% of women had made previous suicide attempts; and 5% of men and 9% of women had carried out previous deliberate self-harm.

### *The College's comments*

We are much less certain of the statistical background to this topic than is the Chief Inspector. We are concerned that the usual statistical deductions that are drawn from the raw figures could be misleading. To take one important but usually neglected matter, the denominator for the calculation of the suicide rate in the figures quoted here is the daily average population of inmates in all categories. This is the usual denominator but many inmates do not stay for a 12-month period and a 12-month figure based upon an average daily prison population is a considerable underestimate of the number of people passing

through the prison system in that year. To calculate the rate more accurately we would need to know the number of individuals who have been imprisoned in any given period and the length of time they stayed in prison. These figures are not readily available.

A further confounding factor is that prisons are importing highly vulnerable people who are not representative of the general population. Their age structure is skewed towards youth, there are a disproportionate number of males, they have a high rate of psychiatric disorder, especially substance misuse, including alcohol, they come from disorganised backgrounds, are often highly impulsive and have quite severe personality difficulties. Most of these characteristics are also risk factors for an increased rate of suicide. We do not know therefore whether a similarly matched population in the community has the same rate of suicide as those in custody. Furthermore, we do not know whether the rate of suicide among an equivalent group of people in the community is increasing. Gore (1999) has drawn attention to the high rate of opioid use in prisoners and calculates that individuals of the same age and degree of opioid use in the community can be expected to have higher rates of suicide than those discovered in prisons.

To emphasise this point we include two summary tables (Tables 4 & 5), which come from two national surveys of prisoners in England and Wales in the last decade of the 20th century (Gunn *et al*, 1991; Singleton *et al*, 1998).

Methods of suicide within prison are limited and the majority of people kill themselves by asphyxiation. It has been drawn to our attention by Dr Mike McClure that the rate of self-asphyxiation (or 'hanging', as it is often called) in the general community has doubled as far as men are concerned and trebled among women during the past decade or so. We have no idea whether this 'fashion' in suicidal behaviour in the general community has had any impact on prisoner behaviour, but we are grateful to Dr McClure for raising this idea. More details about this can be obtained from him.

It is often said that the most common way that prisoners die is by 'hanging'. We have tried to avoid this term because it does not properly describe the common prison means of death; indeed it gives a false impression of a body dropping from a height as in a judicial execution and the means of death being a broken neck. Prisoners die by a slower means, which is best called either asphyxiation or strangulation. The usual method is to place a ligature or noose around the neck and tie it to a fixed point, which will bear quite a lot of weight. The person then leans forward, producing impaired blood flow to the brain with a loss of consciousness. The leaning body now produces further dead weight on the trachea, which is closed so that the unconscious individual asphyxiates. Many individuals die like this in a sitting position.

One important significance of this is that individuals do not die immediately when hanging in such a ligature. Resuscitation may well be possible if the asphyxiation process started only a few minutes previously. Artificial respiration and electrical re-starting of the heart are distinct possibilities in some cases.

It seems that standard mortality ratios for prisoners are lower than for an equivalent population matched for age and gender, maybe because imprisonment is acting as a protective factor against the high rate of accidental death in this population or because alcohol consumption is lower, or because those involved in crime are likely to be physically fit. The increase in death by suicide does not outweigh this protective factor (Clavel *et al*, 1987).

It is clear, therefore, that any numerical statements about suicidal behaviour in prisons have to be made with extreme caution. At first sight it may not seem to be necessary given that everyone is agreed that there is a high rate of suicide and that it needs to be reduced. The particular problem to which we draw attention, however, is that the current data on prison suicide rates are inadequate as a measure of the success or otherwise of any given prison suicide prevention programme.

We believe that much more effort should be made to collect meaningful figures for suicidal behaviour both in the community and in prisons. The reduction of suicide rates is, after all, one of the Government's health objectives (Department of Health, 1992). Even with improved data, however, we would still urge caution in using suicide rates as a measure of the success or otherwise of a suicide prevention programme. As suicides, even in prison, are a comparatively rare phenomenon, small changes in the numbers of deaths in either direction do not necessarily indicate a statistically significant change that will be sustained over time. Observations over several years are needed to be sure that a slight shift in rates is a real trend. In the short term it is better to measure features which are linked to suicide rates but of much greater frequency, for example rates of deliberate self-harm or level of depressive symptoms. We agree that it is important to highlight that 43% of all suicides occur within the first month of imprisonment.

## Chapter 2. Understanding suicide

The Thematic Review says that:

- suicide is a means of escape from unbearable emotional pain when there seems to be no other option
- unimaginable circumstances might be bearable to one person but may bring overwhelming feelings upon another; this could be any one of us
- most suicidal people give some signs of their intentions
- those close to the person find such depth of despair very difficult to comprehend; ambivalence is a known feature of being suicidal, i.e. wanting to die and at the same time wanting to be rescued
- background history may make someone vulnerable to suicide. A range of events may trigger suicidal feelings. There is no foolproof means of predicting who will commit suicide or when
- listening and encouraging exploration of suicidal feelings with a sympathetic person, in a safe environment, reduces distress

**Table 4. Prevalence of psychiatric disorder in 1769 prisoners (Gunn *et al*, 1991)**

Diagnosis <sup>1</sup>	<i>n</i>	%
Psychosis		
Schizophrenia	21	1
Affective	7	0.4
Paranoid	6	0.3
Total	34	2
Neurosis	71	4
Adjustment disorders	34	2
Personality disorders	177	10
Sexual 'deviations'	38	2
Substance misuse		
Alcohol	203	11.5
Other drugs	204	11.5
Total	407	23
Organic disorders		
Epilepsy	8	0.5
'Mental retardation'	7	0.4
Total	15	1
Uncertain	18	10
No diagnosis	1117	63

1. Up to 3 diagnoses (ICD-9) per prisoner were allowed.

**Table 5. Rates of psychiatric disorder among prisoners in England and Wales (Singleton *et al*, 1998)**

	Males		Females	
	Remand (%)	Sentenced (%)	Remand (%)	Sentenced (%)
Personality disorder	78	64	(50)	(50)
Psychosis	10	7	(14)	(14)
Neurosis	59	40	76	63
Suicidal ideas (ever)	46	37	59	52
Suicidal ideas (past year)	35	20	50	34
Suicide attempt (ever)	27	20	44	37
Hazardous drinking	58	63	36	39
Drug misuse (past year)	73	66	66	55

- of current prison populations an average of 640 men and 37 women are likely to kill themselves at some point in their lives.

### *The College's comments*

The brief chapter on understanding suicide is, we believe, largely accurate but it does not sufficiently recognise that clinical skills also have a role to play. In addition to the important points mentioned in the Thematic Review, we would add the psychiatric problems experienced by many prisoners, for example underlying personality problems, serious difficulties with substance misuse and, on occasions, serious mental disorders, such as depression and schizophrenia. For these people the clinical approach (Appendix 1) is a significant part of a good suicide prevention programme.

We were puzzled by paragraph 2.5, which led to the final bullet point in the summary for this chapter that an average of 640 men and 37 women are likely to kill themselves at some point in their lives. It relates to a paper by Williams (1997), but that paper deals only with borderline personality disorder and as indicated in the tables above, there are many other conditions which are serious risk factors for suicidal behaviour that also need to be taken into consideration. We think therefore that the figures given in the summary to this chapter could be misinterpreted.

Overall, we believe that the chapter supports the position we have emphasised earlier that prisons are importing large numbers of people at risk of suicide. Although no exact quantification can be made about these numbers they are probably sufficiently high to indicate that prisons are repositories of psychopathology and particularly psychopathology which leads to suicide. We recommend that in any national policy or programme to reduce suicide, prisons must be a particular target zone.

Another matter pertinent to a discussion about suicide in prisons is the small but significant population of prisoners who act highly impulsively and kill themselves in situations where even with the best possible scrutiny, they did not appear to be contemplating their own death. Some of this impulsiveness could be due to recognisable clinical conditions being missed.

A further particular problem for prisons is that the vulnerable individuals they house have often learnt to signal their distress by behaviour rather than by words and may, for example, take an overdose or damage themselves with a sharp object. This is clearly risky behaviour but does not often cause death. Such opportunities for lesser forms of deliberate self-harm may be reduced by prison conditions. No prisoner, particularly an adolescent one, should believe that the only way to signal their distress is to put a noose of some sort around his or her neck. It is imperative that all self-harming behaviour and threats of self-harm are taken very seriously by all categories of staff.

We believe that greater understanding of prison suicides would be obtained by differentiating different groups of prisoners who could have different problems:

for example young people, women, recently admitted prisoners, prisoners about to be discharged, or prisoners addicted to drugs or alcohol may all have different seriously worrying and depressing problems.

We also believe it is worth drawing attention to the recent finding (Meltzer *et al*, 1999) that prisoners who attempt suicide attract multiple diagnoses such as personality disorder, psychosis, hazardous drinking, drug dependence and neurosis. Almost 70% of male remandees who had attempted suicide in the previous year attracted three or four diagnoses. This clearly indicates that these men had multiple health care needs and they need to be attended by a multi-disciplinary team, preferably the local community mental health team.

We recommend that there should be a joint Home Office/NHS strategy on prison health care to ensure that there is a well-funded and organised multi-disciplinary team in prison able to deliver effective assessment and/or treatment, including rapid transfer to the NHS in appropriate cases.

### **Chapter 3. The impact of imprisonment**

The Thematic Review says:

- the belief that imprisonment and punitive regimes will cure crime and make society safer misjudges the impact of custody
- imprisonment has to achieve different objectives for different groups of prisoners
- the prison service's duty of care requires staff to sustain prisoners' mental well-being and to protect them from themselves and from others
- the prison population includes many groups at high risk of suicide
- some suicides will always happen despite the best efforts of staff
- many prisoners who are distressed are supported by staff every day as part of their regular work
- self-mutilation can be a sign of distress and potential suicide so staff must persevere to help prisoners find better ways of coping
- there are combinations of many issues that can cause prisoners to consider suicidal behaviour
- the blame-culture confuses staff about how they should work with the suicidal.

#### *The College's comments*

We thought that chapter 3 of the Thematic Review was particularly good at drawing attention to the huge impact that imprisonment has on a citizen, particularly if that citizen has pre-existing psychiatric problems or other vulnerabilities. Prisons are expected to manage a population that is particularly prone to suicidal behaviour. This is a highly paradoxical situation because not only do prisoners have an increased likelihood of suicide but also the prison may further increase suicidal propensity in vulnerable people. Prisons house



distressed, often aggressive, individuals in close proximity, they remove all possible avenues of flight, are stigmatising and demoralising. They may exacerbate depression and anxiety; they may induce drug-withdrawal states. To compound this problem prisons are then insufficiently equipped to deal with this serious rise in suicidal thinking and behaviour.

There is a high rate of suicide in the first 4 weeks of imprisonment and among prisoners with a history of substance misuse. It is possible that drug withdrawal may make a contribution. For example, a report on suicides in Cornton Vale Prison, Scotland's only women's prison, indicated that drug withdrawal played an important role in the majority (Social Work Services Inspectorate for Scotland, 1998). Prisoners may be in withdrawal from alcohol, stimulants, opiates and tranquilisers alone or in combination. All of these withdrawal states can cause dysphoria and a variety of psychiatric symptoms. Prisoners often receive inadequate medication to relieve these symptoms.

Children and adolescents who are causing serious social problems may need to be removed from their immediate environment, they may need to be carefully supervised and retrained to reduce their dangers to others. This should be carried out in specialised institutions. The work being carried out by local authority secure care units and young offenders institutions should have a strengthened mental health input. It is better to put resources for young people, under the age of 18 years, into these facilities than into the adult prison system. We recommend that no person under the age of 18 years should be admitted to an adult prison.

The College wants to stress that many other young people, particularly those aged 18–21 years, are also very vulnerable, being especially prone to sudden despair, hopelessness and anger. Their special needs should be catered for in prison. We recommend that prison officers expected to have care of people aged 18–21 years receive special training about young people's needs and reactions.

The Children (Leaving Care) Act 2000 recognises the need for support for those who have been in care up to the age of 21 years. The focus of developments for those aged 18 years and younger is being given to the Youth Justice Board. It is crucial that resources and regimes offered to young adults are developmentally appropriate.

One omission from this chapter that we noted is bullying. We have referred to the particular nature of the population admitted to prisons. They are prone to attacking not only themselves but also others, particularly the weaker others among them. The best prisons have elaborate and usually effective anti-bullying programmes. We recommend that anti-bullying programmes should be mandatory in all prisons.

#### **Chapter 4. When a prisoner dies**

The Thematic Review says:

- the full impact on relatives of a death in custody must be more fully understood

- effective contingency plans are required for the way in which family and friends are to be informed of a death in custody and how they are to be supported. An identified member of staff should work with the family
- prison service investigations into deaths in custody should look into how families are supported and assisted
- there should be a clear prison service policy about the information which should be given to families after an investigation
- guidance for relatives involved in the coroners' courts should be available
- coroners should be kept up to date on prison service policies
- the good work of staff in dealing successfully with cases of determined suicide attempts is recognised
- the prison service strategy of care for staff is endorsed
- contingency plans should support prisoners directly affected by a suicide
- the shock to the establishment of a death in custody must not deflect the governor and staff from providing support for relatives.

*The College's comments*

We largely agree with the content and emphasis given in chapter 4 of the Thematic Review to procedures following the death of a prisoner. The Review rightly emphasises the harrowing nature of some mistakes that have been made and those illustrations may in themselves be a prompt to all prison staff to follow the set of guidelines outlined here; guidelines that we fully support. We particularly agree that more support and information should be given to families about suicide and we liked the idea of a link person whom families can contact. It seems absolutely right that families should be able to meet friends of the deceased and to have a memorial service.

Our one concern about this chapter is that it probably overemphasises the negative aspects of prison staff behaviour in the difficult aftermath of a suicide. We believe that the bad practices drawn attention to in this report are offset by many good practices within the prison service, and we are aware of examples of more sensitive behaviour on the part of prison staff after unexpected deaths.

One practical point that we would like to be considered concerns the provision of an emergency procedures pack of guidelines for prison governors faced with death in custody. Suicides in prison are still unusual events and governors can go months or years without encountering one, and therefore will not necessarily have guidelines readily accessible. We recommend that governors should have guidelines for the management of the aftermath of a suicide readily available.

We recommend that there should be a mandatory requirement on the part of the senior doctor in a prison to initiate a multi-disciplinary confidential clinical audit in the case of any unexpected death. (This is in addition to the governor's audit.) That is now standard NHS procedure and clearly makes good sense. It can be carried out in a constructive manner in confidence without using fear and blame, so that lessons can be learnt for the whole service each time an unexpected

death occurs. We recognise that it is policy for governors to conduct a more open audit and we endorse that as well. We would like to see a series of such audits analysed as pointers to prevention.

## **Chapter 5. The effectiveness of current practice**

The Thematic Review says:

- the prison service strategy 'caring for the suicidal in custody' was basically well conceived but failed to give sufficient attention to the particular needs of women, young prisoners and those in local prisons
- the implementation of the strategy failed because there was inadequate commitment and detailed attention from senior managers
- the effectiveness of suicide awareness teams was variable
- communication among staff about prisoners who were suicidal was generally poor
- there was too much emphasis on filling in form F2052SH rather than ensuring the proper care of the suicidal
- training of staff should not just be about equipping them to assess risk of suicidal behaviour; it should also enable them to see that there are forms of support they can offer
- managers at all levels have failed to recognise the scale of the cultural shift that was needed to equip prison staff to care for suicidal prisoners to the extent that was expected
- support plans were often inadequate and in only half the cases were conferences held
- the work of the Prison Services Awareness and Support Unit (SASU) has been impressive
- although a vital part of suicide prevention is for officers to respond promptly to cell call-bells, during inspections we have found long delays before staff have responded
- if the current strategy is properly implemented, it remains appropriate for adult training prisons.

### *The College's comments*

We have some difficulty with the title of chapter 5. It implies that there is some way of measuring the effectiveness of a suicide prevention programme. This is simply not possible at an institutional level because the base rate for suicide is too low. It is also impossible to make simple comparisons between one institution and another because they take such differing populations. It may just be possible to measure effectiveness for the service as a whole but even that is dealing with small numbers. We believe that if effectiveness is to be measured over the short-term it should be in terms of related phenomena such as depressive symptoms, suicidal thoughts, lesser forms of self-destructive behaviour, subjective measures

of stress and so forth. Such measurements would, of course, be costly and require skilled research workers.

We do largely agree with the comments in the first part of chapter 5. We would like more emphasis to be given, however, to the thorny but central problem of data transfer between professionals and institutions. We believe this can be divided into two types of problem. The first, and perhaps easier to tackle, is information transfer within the prison service such that prisoners who are moved from one establishment to another have the fullest possible information about their care, particularly their health needs, moved at the same time as they move. We recommend that a centralised computer system, such that medical data can be accessed from more than one point, be introduced.

A much more difficult problem is the question of transfer of information from the NHS to the prison service. We understand the reluctance of health professionals to move information into a setting that they are unfamiliar with. We recognise that sometimes prisoners will refuse to give permission for such data transfer, and yet, we also recognise that it is simply dangerous to fail to communicate vital health information, such as suicide potential, from one caring service to another. In this respect we believe that much more use can be made of the Care Programme Approach. It could embrace prison staff as well as social workers and other community care staff, in appropriate cases. We also believe that the College policy on confidentiality needs to address this particular problem urgently. As an interim position we take the view that it is entirely in the patient's interest, and therefore to be encouraged, maybe even in the face of patient resistance, for health care professionals in the NHS to communicate quickly and freely with their equivalent colleagues in the prison service. It is not clear in the Review who should be responsible for checking the mental state of prisoners, nor how it is done.

One scheme, in Exeter, which has been awarded Beacon Status, is the identification of the local mental health team as a link person who has access to the computer systems of local services.

Proper implementation of the Care Programme Approach would also cause effective supervision at the end of a prison sentence. It also occurs too frequently that patients are released without the prison staff informing the local mental health team or substance misuse team of the impending discharge.

One of us (H.G.M.) has been involved in the development of a card that is given to potentially suicidal people. It has telephone numbers to call in a crisis. We understand that an experimental scheme of using such 'Green Cards' has been tried in HM Prison Manchester. Recent evaluation of the Green Card scheme in the NHS suggests that it could be useful in people who have no previous history of deliberate self-harm. However, on present evidence, it is advisable to avoid using it in those who have previously harmed themselves, because it is possible that they may react with an increased tendency to harm themselves as a result of receiving the Green Card (Evans *et al*, 1999, 2000). This suggests that there is plenty of scope for experimental suicide prevention to be tried and

evaluated within the prison setting. Other schemes that might also be considered are befriending or problem-solving therapy. We therefore recommend that research into ways of reducing self-harm and suicide in prison should be undertaken.

From the College's perspective it is timely to remind doctors working in the NHS that the same principles apply in other parts of the mental health services. The principles outlined in the College's community care document (Royal College of Psychiatrists, 2000), including the Care Programme Approach in England, should also apply in English prisons. We want to emphasise, therefore, that when someone who has been treated in the community is sent to prison then full communication, including transfer of appropriate information, should take place between mental health services and the substance misuse services and the prison. For remanded prisoners and other short-term prisoners this communication should be maintained throughout the period in prison. It is helpful, here, to remember that the Mental Health Act (1983) (section 117) says that: 'this section applies to persons who are detained under section 3, section 37, section 47 or 48', i.e. offender patients. This section has been amplified by circular HC (90)23/LASSL (90)11 which sets out the Care Programme Approach. We recommend that research be established to see whether the Care Programme Approach and section 117 of the Mental Health Act 1983 are actually being applied to prisoners.

## **Chapter 6. Local prisons**

This chapter of the Review focused on the particular difficulties in local prisons related to overcrowding and increased time spent by inmates in their cells. More self-inflicted deaths occur in local prisons than in other prisons. In recent years, the proportion occurring in local prisons has ranged between 64% and 86%. The chapter describes the pressures in local prisons and the policy of overcrowding local prisons in order to protect regimes in training prisons. An average local prison runs at 112% of normal capacity. There are three imperatives: (a) to avoid locking prisoners in police cells; (b) to avoid escapes and loss of control; and (c), to reduce costs.

The situation in New York prisons is also described, where there are:

- minimum standards for mental health
- contracting-out of health care
- a commitment to reduce suicide and self harm and a strong sense of accountability at all levels
- staff training of 40 hours on mental health
- issues concentrating on symptom identification.

The chapter ends with a description of a new strategy for preventing suicide in local prisons:

- total commitment to decreasing suicides from government ministers and prison boards
- better staff training on risk factors
- better initial risk assessment in reception (including obtaining information from other services)
- all receptions placed for 48 hours in an induction area (cells free of ligature points)
- at-risk prisoners to be assessed and supported by specialist staff
- all at-risk prisoners should have a care plan
- more use of prisoners to assist staff in suicide prevention
- good communication between specialist staff and others.

The Review goes on to describe the role of the suicide support workers:

- available 24 hours a day
- draw up care plan for those at risk
- review inmate daily and revise care plan
- good communication and work with other staff.

The summary indicates:

- local prisons and remand centres have a significantly higher rate of self-inflicted deaths than training establishments
- the rapid turnover of the population, the known vulnerability of prisoners to harm themselves soon after entering custody and conflicting operational demands mark out these prisons as requiring special attention
- the current suicide prevention strategy is not appropriate for local prisons
- similar problems to those found in English local prisons were experienced in the New York City Corrections Department, for which a specific strategy was drawn up. This has been effective in reducing suicides and has been considered as a way forward for local prisons in England and Wales
- a wholehearted determination on the part of Ministers, senior managers and all prison service staff to reduce self-inflicted deaths can be effective in reducing suicides in local prisons
- a set of principles for a new strategy to meet the needs of local prisons and remand centres is presented
- practical suggestions for implementing the strategy are given.

#### *The College's comments*

We accept that there are differences between local prisons and other prisons, largely in the huge turnover of prisoners that occurs in local institutions. This makes it difficult to gain personal knowledge of each prisoner. We do not believe, however, that the principles underlying good mental health care for prisoners will be different: they will just be more difficult to implement. We were interested to note that the Chief Inspector said that 'the current suicide prevention strategy

is not appropriate for local prisons' but did not go on to suggest an alternative. We believe that it is important to try other strategies and we would commend, for example, the High Risk Assessment Team approach that is currently used in Doncaster Prison, which one of us (J.G.) has visited fairly extensively.

We agree with the Chief Inspector's view that an important resource in suicide prevention in a prison can be other prisoners. We know of three different ways of using prisoners.

The first is a listeners' scheme set up by a local Samaritans' group. The listeners are carefully selected prisoners who are trained by these Samaritans and who provide an entirely confidential service to other prisoners, perhaps with some supervision of a general nature from their Samaritan trainers.

The second system is the 'buddy' scheme, which is well established at HM Prison Doncaster. In this scheme prisoners are told on arrival that they can, if needed, ask for a buddy and that they can also ask to be selected to be a buddy. It is made clear from the outset, however, that the scheme is not confidential and is part of the prison management arrangements. The buddies are a carefully selected group of prisoners who are given a training course over a short period and a brief examination. They are then assigned to a supervisor. In Doncaster this is usually a psychologist working in the High Risk Assessment Team. They are expected to respond to prisoner requests for help and counsel. They have a maximum number of cases they can each manage and are expected to make notes on their encounters with these prisoners, discuss their work with their supervisor and, in particular, indicate evidence of bullying, suicidal ideation or other prison dangers.

The third scheme is an American system and is the one highlighted by the Chief Inspector in his report as worth introducing. The basis of the New York scheme is that prisoners are recruited to act as the eyes and ears of prison managers in respect of suicidal behaviour. They are given instruction in things to look for, they have much greater freedom of access to various parts of the prison than is normal for prisoners and they are paid for their work, which consists of this observational exercise. Each section of the prison has a list of suicidal risk factors to be looked out for posted on its notice board. One of us (J.G.) recently visited Rikers Island, which is the main centre for corrections in New York City. He encountered a certain air of cynicism from some senior staff about the scheme. One experienced official said, 'It's very simple. We pay some prisoners to snitch on others.' Prison staff also implied that it did not work well with juveniles. Nevertheless, we like the idea that the New York City Department of Health is responsible for the mental health of prisoners.

Our view is that it is now evident from various schemes that prisoners can be used as one tool in a good suicide prevention strategy. We are not aware of any good data that distinguish between the various schemes. We support the notion of introducing at least the three schemes mentioned on an experimental basis so that data are collected in respect of each of them. It may be found in the long run that different schemes are applicable to different institutions.

We welcome the establishment in 1999 of the scheme for Counselling, Assessment, Referral, Advice and Treatment of drug users (CARAT). We believe these workers could play an important role in preventing suicide in this group.

We note the Chief Inspector's view that all new receptions should be held for 48 hours under close observation in a dedicated induction area. We partly support this idea but we would go further. We recommend that the induction period for new prisoner receptions should be 7 days; during that period close observation and assessment should take place in a dedicated area. Close observation means that the prisoner should not be isolated and should always be in visible proximity of responsible others.

No mention is made in this section, or in any others, of staff training in resuscitation. We believe that a fully comprehensive suicide prevention approach will include a crash procedure for cutting down people in the process of killing themselves and the immediate instigation of resuscitation measures. Regular training is required to ensure that these measures can be effected swiftly and efficiently in emergencies, which are in fact quite rare. We welcome pilot schemes to train prisoners who misuse drugs in techniques of resuscitation. Although primarily aimed at preventing death by drug overdose after release, this knowledge could also be valuable in preventing suicide in prison. We recommend that staff training should include techniques of resuscitation.

For local prisons, it is particularly important that outside bodies such as psychiatric multi-disciplinary teams ensure that information is sent into the prison health care system and that statutory procedures such as the Care Programme Approach or section 117 of the Mental Health Act 1983 are adhered to when someone moves to prison. This point has been made above; it is repeated here for emphasis.

The cornerstone of health care in prisons must be a comprehensive primary care service with appropriate secondary care community mental health teams operating within the prison. We recommend that community drug and alcohol teams should have access to prisoners, and that all prison doctors should receive specific training in psychiatry and in drug misuse medicine. We also recommend that community learning difficulties teams have access to prisoners.

Procedures for rapid assessment and triage during the induction period following remand to prison will go a long way to ensuring that there is recognition of those who have mental disorders and are in need of treatment.

The number of people with severe mental illness in prison is intimately linked to the provision of care within the NHS. The current national problem of finding a secure bed for people who are deemed to require urgent admission to hospital under section 47 of the Mental Health Act 1983 is a reflection of a lack, at all levels, of security within the NHS, intensive care, low security, medium security and high security. We do not regard it as acceptable for people with serious mental illnesses and who are deemed to require urgent medical treatment to remain in prison for very long periods because the NHS is unable to provide a bed. This has a significant impact on local prisons and is important in relation to



an effective system of suicide prevention within prisons. It is encouraging that health authorities are now being involved in needs assessment within prisons and addressing the needs of prisons within health improvement programmes.

NHS staff complain frequently that when they are willing to see prisoners in prison, they often have to wait for long periods at the gate and are not given satisfactory facilities within the prison adequately to examine patients. This is clearly not conducive to good mental health care for prisoners. We recommend that prison authorities discuss with local psychiatric teams methods by which prisons can be made more accessible, in a variety of ways, to mental health teams.

## **Chapter 7. Healthy prisons**

Chapter 7 concludes the Thematic Review by stressing the importance of the prison environment and of the interaction between vulnerable people who are sent to prison and the environment:

*'It is hard to imagine living in an environment where you have little control or influence, where you are forced to live with, and feel yourself to be at the mercy of, other prisoners, where you are forced to rely entirely on the integrity of the staff, where you feel there is no privacy, where the apparently trivial feels overwhelming, where you are deprived of normal family contacts and where scope for choosing what you do at any time is severely restricted or denied altogether. The effects of custody can be very destructive.'*

The Review goes on to describe the factors that indicate a healthy prison. The weakest prisoners feel safe. It has an effective anti-bullying programme, good prison records and incentive schemes. Prisoners are treated with respect; there is active health promotion within the prison. Prisoners are occupied and are allowed to forge or keep good links with their families. Staff feel safe because they are treated with respect by management, are informed and consulted, well led, and management has high expectations of them. In this chapter the Chief Inspector emphasises that suicidal behaviour is not just a function of an individual's vulnerability but is also influenced by the quality of prison regimes. A change of culture in prisons to a more prisoner-centred model is required. Prisons could and should provide positive experiences for prisoners including, for example, education. Staff morale is also of crucial importance.

The summary indicates that:

- the total experience of imprisonment affects suicidal behaviour
- in every prison there must be an appropriate balance between security, control and justice
- a healthy prison is one in which prisoners and staff can remain healthy.

The key constituents of a healthy prison are:

- a safe environment
- treating people with respect
- a full, constructive and purposeful regime
- resettlement training to prevent reoffending
- the essential elements of a healthy prison will form the foundation of future inspections.

#### *The College's comments*

We strongly endorse the principles set out in this final chapter of the Thematic Review. We believe that the Chief Inspector is correct to regard his standards of a healthy prison as standards to be attained across the whole prison estate and to indicate that he will use these standards as a yardstick in future inspections.

We believe that these characteristics of a healthy prison environment will go some way to producing an atmosphere that is much more conducive to the identification of mental disorder and the prevention of suicide. We also believe that the introduction of healthy prison standards will enable better individual and psychiatric work within the prison system, which is required to have a significant impact on the rising tide of suicides. In line with this, we would like to see the principles of a healthy prison include good one-to-one working relationships, for example in personal officer schemes. We further believe that a healthy prison atmosphere is, in itself, a suicide prevention factor. Indeed, some of our members argue that a major impact on deliberate self-harm and suicide could be brought about simply by improvements in the general regimes of prisons, and that negative and punitive attitudes are important sources of distress.

We strongly recommend that prisoners should have access to a level of health care equivalent to that offered outside prison. For those who misuse drugs, this should mean treatment that complies with the Department of Health's clinical guidelines (Department of Health *et al*, 1999). This would include effective detoxification regimes and, in appropriate cases, maintenance medication with methadone or similar drugs, usually under conditions of supervised consumption. We note that the Scottish prison service has sanctioned the continuation of methadone for prisoners on short sentences or on remand where supported by the prisoner's GP, but we understand that in practice this rarely happens. The Advisory Council on the Misuse of Drugs (2000) has also recommended continuation of prescriptions in these circumstances. We recommend that the practice of automatic prison detoxification of patients stabilised in the community on substitute prescriptions be discontinued. It adds both to the risk of suicide in prison and to the risk of overdose after discharge. Special treatment/rehabilitation programmes need to be devised in prison for long-term prisoners. On occasions this should include drug maintenance programmes that are available in the NHS.

We believe that a healthy prison will adequately prepare prisoners for release. A significant proportion of drug-related deaths are caused by loss of tolerance in prison and subsequent over-indulgence after release. For example, among 64 fatal drug misuse overdoses in greater Glasgow in the first 9 months of 1999, 24% occurred within 2 weeks of release from prison (Greater Glasgow Drug Action Team, 2000). We recommend that the education of prisoners and their families concerning the danger of loss of tolerance to addictive drugs should be undertaken by CARAT workers, who should also ensure rapid transfer to substance misuse services.

## Overall comments

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We very much welcome the Thematic Review as a stimulus for discussion and action for both politicians and professionals. We have indicated some areas of disagreement, particularly in respect of the statistics, a failure to acknowledge sufficiently the importance of clinical skills, and the overemphasis, in places, of negative staff attitudes. We have no doubt that the prison suicide rate in England and Wales is far too high. We are also aware that sometimes the attitude of prison staff leaves a lot to be desired, but they are an extremely important resource that needs to be encouraged with as much positive reinforcement as possible. In any case, positive staff attitudes may more than make up for the negative ones.

It cannot be overemphasised or stated too often that psychiatric services, both within prisons and in the community, are grossly overstretched. Everything in this document, especially the rising prison suicide rate, and our recommendations have to be read in that context. Recommendation 1 sets out our philosophy; it is impossible without implementing recommendation 2 (p. 54).

In essence, there needs to be a much more appropriate model of mental health care delivery within prisons. There is a need for better screening for suicidal ideas and propensities at reception; we know there is a significant hidden psychiatric morbidity within the criminal justice system (Gunn *et al*, 1991; Birmingham *et al*, 1996; Shaw *et al*, 1999). If serious mental illness, including suicidal ideas, is detected at reception, there has to be a comprehensive system enabling further assessment and treatment. There are several current problems with this. First, in many local prisons there are no satisfactory ways of getting information from other agencies about prisoners at risk. Often, where systems are in place, there are delays in getting information quickly. There often needs to be a much more satisfactory method for transferring information into prison from court diversion schemes and hospitals, GPs and social and probation services. In many local prisons, even if serious mental illness, including suicidal ideas, is detected, the avenues for further assessment and treatment are limited. After screening, prisoners at risk should be supported by a community mental health team (either a team from the local community or a similar prison team), including a psychiatrist, a nurse, a psychologist and a personal officer, and with good communication between professionals and a reduction in bureaucracy. Additionally, in view of the turmoil of local prisons, with multiple transfers to court and other prisons, a care coordination role should be developed along case-management lines. This latter suggestion would require further evaluation. If these steps were taken together with the recommendations of the Thematic Review, we believe that better mental health care for prisoners would be achieved with a possible knock-on effect on suicide rates.

None of this should detract, however, from our main concern that too many people with mental disorders are being sent to prison, that there are inadequate treatment facilities for offenders with mental disorders outside of prison, and that the transfer of such offenders from prison to the NHS is too difficult and too slow. We emphasise that mental health services in the community will need to be amplified for them to play a bigger role in this work.

We recognise that the improvement of mental health care arrangements can never operate in a vacuum, and we want to stress that the prison ambience has to be appropriate for them to flourish. Good ambience is difficult to prescribe; it is related to staff attitudes, staff ratios, staff training and preoccupation with the hardware of security. We are impressed that our neighbour, the Republic of Ireland, has no recent increase in prison suicide rates. Could that be related to the more relaxed atmosphere of Irish prisons?

### **The medical model**

The issue of the 'medical model' is raised several times in the Review. This was dealt with fairly extensively by one of us (J.G.) in an earlier report (Gunn, 1996). In that enquiry, it was discovered that many staff thought that the medical model is no longer appropriate and should not be used for the prevention of suicide. In fact, the term medical model has no well-recognised or consistent meaning in the literature. It is sometimes used, as a pejorative term, to criticise what is believed to be an organic or physical view of mental disorder. For some staff, however, it means a uniprofessional approach to suicidal behaviour. Some observers have indicated that they were alarmed by the way in which some doctors used medical confidentiality as a device to avoid passing on important, perhaps life-saving, information about particular prisoners' mental states. Some doctors in Scotland were particularly cynical about the use of the term and regarded the antagonism to the medical model as simply an antagonism to doctors in general.

Thus, it might be that the apparent rejection of the medical model is in fact a rejection of a unidisciplinary approach by doctors, with confidences being encouraged and retained in the doctor's office, coupled with a physical approach to the management of disorder with the use of medication. This caricature of medical practice probably never really existed or if it did, was rare, and it is certainly not a method of approach that would be recognised by most modern practitioners. Some observers said that the term did not include the notion of a psychiatric model, the idea being that psychiatrists have psychotherapeutic and other skills that amplify their somewhat mechanistic medical skills. It seems, therefore, that when the medical model is being rejected, it is old fashioned and non-psychiatric management that is being found unacceptable.

The danger of the rejection of the term medical from the language of suicide prevention is that medical does in fact embrace psychiatric, and its rejection devalues the distress, the pathology and the danger that is inherent in a prison setting. Medicine is concerned with matters of life and death, as well as matters

of health and well-being. To regard suicidal behaviour as outside the medical framework is obvious nonsense. Doctors still have a central role in any suicide prevention policy. Even when the medical model is in disfavour, it is nearly always doctors who decide when it is safe to relax suicide precautions. Furthermore, pharmacological agents can be effective at relieving depression, morbid thoughts, paranoid ideas, delusions and anxiety.

An interesting sidelight on this strange debate is the way in which a number of people in Scotland expressed enthusiasm for an increased psychiatric input into prison work and, particularly, for an increased sophistication in psychiatric understanding. A senior member of the Scottish prison staff pointed out that on a number of occasions prisoners who had been identified by lay people as clearly having mental disorders, when referred to the doctor were classified as 'normal' or as having 'no formal mental illness'. One governor said that he had had experience of a case of successful suicide in which the dead person had been expressing strange ideas of a paranoid nature for some time before the death occurred, but this had not been thought abnormal by the medical staff. He wondered whether a broader view of mental disorder would be appropriate for prisoners (Gunn, 1996).

These observations could identify some central problems. Perhaps modern psychiatry is narrowing its focus; perhaps psychiatry is becoming preoccupied with labels, as opposed to functional analyses, and the rejection of people with behavioural disorders. This narrowing tends to mean that psychiatry is concentrating on psychotic disorders at the expense of neurotic ones. Within a prison, symptoms are much more difficult to evaluate than in a domestic environment. For example, it is natural to feel depressed by imprisonment, yet such depression could still have pathological significance. A prisoner may report that other prisoners are surreptitiously harassing them; they could be right, they could be deluded, or they could be both. A correct evaluation will depend on time, skill and an awareness that paranoid ideas may mimic reality.

A study carried out within the Department of Forensic Psychiatry at the Institute of Psychiatry in London (Gunn *et al*, 1991) has shown that in the case of serious mental disorder (seriousness being defined in terms of need for transfer out of prison into an NHS hospital), prison doctors across England and Wales were failing to recognise psychiatric disorder at all in about a third of the cases identified by the research team (23 cases out of 63).

A central complaint about the medical model was that doctors are reluctant to transfer information they obtain from inmates to other disciplines. Presumably the perception arises from the fact that doctors, even in prison, try to give their patients a privacy which is outside the ordinary disciplinary process. For the effective practice of medicine, such confidentiality is essential and always occurs between patients and doctors. However, confidentiality is a tool that is used for the benefit of patients; it does not have other higher moral value and new guidelines might be needed for the prison setting. In any case, frank discussions between professionals about matters that are of critical importance for an

individual's health are an essential part of medical management; they occur in the best-run hospitals and should occur in prisons. This is not to say that there is no such thing as medical confidentiality in a prison, and of course doctors' judgements about how much to transfer and when will vary, but the general principle of multi-disciplinary working and of sharing critical information is now standard practice in all other settings. In our experience, in most cases, prisoners are entirely agreeable to useful information transfer. They do want to be asked, however.

We believe that it is imperative that the prevention of suicide is recognised for what it is, i.e. the prevention of mortality from psychological distress. Nothing could be more medical than the saving of lives; yet serious medical tasks of this kind are shared with other staff and require high levels of sophistication. Psychiatry, a branch of medicine, should be the repository of that sophistication. Psychiatric medicine, psychiatric nursing, clinical psychology, social work, occupational therapy and lay counselling all have important roles that need to be coordinated in the reduction of psychological distress and the prevention of suicide.

None of this should be taken to mean that only doctors can manage suicide. In an institutional setting, an institutional approach is essential; this will mean involving all care staff (i.e. all staff in a prison), governors and prison officers, as well as psychologists, doctors and nurses. That in turn implies that all staff require training in appropriate aspects of health care, especially mental health care management (see below).

### **'Forensic' v. 'general' psychiatric evaluations**

We do not make recommendations about the specific roles of forensic psychiatrists and general adult psychiatrists. Patterns will differ in different localities. Although forensic psychiatrists have access to secure in-patient facilities and may be asked especially about the risk to others, any psychiatrist should provide advice and support to prison staff about immediate and short-term management, and give comprehensive advice about the risk of suicide and strategies to reduce the risk. Forensic psychiatrists have greater experience in the management of the patients in secure facilities. General psychiatrists have more experience in the management of patients in the community. Whatever the background of the psychiatrist who first sees a patient, it should be recognised that the psychiatrist may need rapid and strong support from colleagues in the other specialities in particular circumstances.

### **Effecting change**

The big question is 'why is it so difficult to effect change in prisons if so much is known about the correct approach?' It is a major paradox that the worsening suicide problem in recent years has also seen an unprecedented senior

management and policy concentration on this dilemma. This leads to four hypotheses:

- (a) the recommended strategies are ineffective;
- (b) the strategies are effective, and whereas management is under the impression that they have been implemented at local level, they have not;
- (c) the strategy is effective and implemented, but because of the large number of vulnerable individuals at risk the failure rate remains high;
- (d) extraneous suicidogenic factors are increasing and offsetting improvements in other aspects of prisoner care.

Perhaps there are confounding local problems in the prisons, all more or less tied up with staff training and supervision. First and foremost, there is the attitude of prison staff. Second, there are widespread misconceptions about the nature of risk of self-harm. Third, prisons (like all large organisations) tend to substitute paperwork and form-filling for good communication. Fourth, an increasing preoccupation with the hardware of security is leading to less attention being given to the 'software' of security, i.e. personal relationships, flexibility and staff intelligence/observation.

There is still a widespread stereotype about self-harm, which is that there are a few people who are 'genuinely' suicidal, whereas the majority is just trying to manipulate or work the system in some way. These attitudes are common to the NHS and the prison service. The reality is that it is not possible to dichotomise the population in this way. Many suicides are not linked to major mental illness and, in the end, many acts are impulsive or barely premeditated. It is not motivation that is important as much as the propensity to harm oneself for whatever reason. Impulsiveness under stress is a very important factor and attracts very little research. So there is a need for training to change attitudes and behaviours as well as to increase knowledge.

We were pleased to note that the Thematic Review did not put too much emphasis on actuarial risk assessment. To reiterate a point made earlier (pp. 17–18) on the assessment of patients in hospital, individual risk assessment is an important part of suicide prevention and it may in itself be therapeutic (depending on how it is carried out); however, it should be acknowledged that questionnaire-screening by reference to group norms is hopelessly inaccurate as a means of determining how people should be treated. In fact it may be counterproductive.

We are aware that there are terminological problems here. We strongly support the practice of assessing the ever-changing risks, for all sorts of behaviour, within an individual to assist with flexible individualised clinical management. As previously indicated, we prefer to call this the clinical approach to behaviour management. Risk assessment can be taken to mean a bureaucratic checklist of factors, derived from statistics within retrospective studies to determine an individual's score, and thus placement within a high-risk or a low-risk group. The problem is that the scores are accurate for groups and not for individuals. Many individuals in the high-risk group will not carry out the behaviour



concerned and *vice versa*. To compound this difficulty for the assessment of suicide risk in prison, we know that the factors that select for imprisonment (youth, male gender, drinking, drug-taking) are also factors that select for suicidal behaviour. It could be argued, therefore, that all prisoners are in the category of high risk for suicide.

We are not opposed to risk assessment screening questionnaires as a means of collecting some useful initial information but they should not be used as a substitute for clinical assessment, and repeated clinical assessment at that. We recommend that assessment of suicide risk in prisons should include an individual clinical assessment by staff who have been trained by, and who are supervised by, mental health professionals.

There is a lack of understanding, sympathy and respect between staff and inmates in the less-good prisons. One way to assist in breaking this down might be to encourage prisoners, as well as staff, to communicate better. We believe that a more imaginative approach, making more use of videos and audiotapes as well as literature in the induction programme, would help to get issues more out in the open. Completing forms such as 2052SH should be a means of recording actions, but in many cases it seems to become the action taken. One reason is the poor design of the form – overcomplex and bureaucratic-looking. It would never form the basis for genuine care-planning. What staff need is some simple means of recording action plans with names and times against them, similar to the better care programme appraisal forms in the NHS.

The Thematic Review does not emphasise sufficiently for us the importance of linkages between the prison service and the NHS. Prisoners should be regarded as citizens with NHS rights. The vast majority of prisoners will return to the community. The quality of medical care in a prison will depend to a large extent on the quality of its surrounding NHS services. The prison may have contracts with local GPs and/or psychiatrists. The prison will return its inmates with mental disorders to local psychiatric services, whether they are general psychiatry or forensic psychiatry services.

Good mental health programmes in the prison will depend on these services and effective linkages. To reiterate for emphasis, nothing much can improve in this respect unless local services are better resourced; there is no spare capacity in local services for prison work.

We endorse national policy as set out in *The Future Organisation of Prison Health Care* (NHS Executive, 1999) that health authorities should be responsible for commissioning secondary mental health care in prisons. We recommend that secondary mental health care in prisons becomes an integral part of the NHS mental health services of the catchment area, both general adult and forensic psychiatry services. We recognise that considerable new resources would be required and that this must be a long-term objective. We further recognise that community mental health services will need strong support from forensic psychiatry services for prisoners who pose special risks.

The Thematic Review does not mention one other health matter that we consider to be of importance. It is fairly obvious and implicit in the Review that prisons are not suitable places to house and treat people with serious mental disorders and people who are contemplating suicide. Within prisons there is often a system of moving such prisoners from ordinary locations to part of the prison that might be known as the health care centre or the hospital. This part of the prison is frequently under the direct control of medical and nursing staff, and disciplinary staff have less say in its management than they do elsewhere in the prison. This is a useful, sensible approach to some of the minor difficulties that prisoners encounter during their incarceration. However, the terminology is misleading. These centres are not really equivalent to hospitals, they are not approved for care under the Mental Health Act 1983 and we believe that they should be seen only as an interim arrangement for prisoners who are seriously in need of full hospital care. We believe that most prison staff understand this quite well, but we have experience of quite a number of instances in which people were not moved from one of these health care centres into a psychiatric hospital in the NHS because they were considered to be in hospital already. We recommend that the training of all psychiatrists includes some experience of prison work and, in particular, an understanding of the limitations of psychiatric treatment within prisons, including within the health care centres.

### **The criminal justice system**

The Thematic Review does not emphasise sufficiently that the rest of the criminal justice system also needs to be considered. Courts, which send large numbers of vulnerable people to prison, are contributing to the problem. We recommend that judges and prosecutors should learn more about psychiatry, psychology and criminology and personally evaluate prison conditions on a regular basis. In the same vein, we emphasise that more effective court diversion schemes should be available. Effective implies that NHS authorities provide an adequate number of properly staffed beds to prevent diversion schemes being little more than revolving doors.

### **Training**

We give strongest endorsement to the Review's recommendations on staff training. We believe, however, that these could be highlighted more and given much greater emphasis. We would also include public education and training for both doctors and prison staff. The topics for such education should include basic human psychology, basic psychiatry, interviewing skills, counselling techniques and attitudinal issues. We recommend a system of continuing professional development for all grades of staff within prisons.

Training should clearly aim at increased suicide awareness among all prison staff. There is a specific need for training of all staff about mental illness, risk

factors for suicide and symptoms. One of us (J.S.) has looked at training, knowledge and attitudes of criminal justice staff towards prisoners with mental illness. She found that the majority of staff have received no training on mental health issues. With her colleague Dr Pearson, she is in the process of developing a training package for prison staff and designing a research project to evaluate the outcome of training.

It is an apparent paradox that the concerns about the medical model mentioned above could best be dealt with by providing all prison staff with much higher levels of knowledge about mental health matters and some simple clinical skills (e.g. interviewing). This would enable symptoms and stress to be identified earlier and tackled immediately. Referrals to mental health professionals would also be more appropriately and efficiently made.

### **Socialisation and seclusion**

It is quite evident that humans are intensely social animals. In normal healthy circumstances we live in a variety of complex overlapping groups that are mixed-gender, mutually supportive, provide division of labour and that slowly develop hierarchies. For the most part these groupings are stable, with slow changes occurring and with an inherent ability to absorb stresses, such as bereavements, separations, illnesses, accidents and the other standard problems of existence. It is also evident that some people are more skilled at managing within these social systems than others. For a wide variety of reasons some individuals become particularly hostile to their groupings and find themselves excluded from many, or all, of their potential social groups. Many such individuals will end up in the criminal justice system and some will be sent to prison.

Prisons are artificially constructed environments in which large numbers of people, who have often found great difficulty in socialising in their natural groupings, are thrown together in a closed institution that has a rapid turnover of individuals. Given the vulnerability of the population admitted to such an institution and the artificial nature of that institution, it is hardly surprising that symptoms of despair, hopelessness, depression, anxiety and a wish to die are fairly common. In such circumstances the road to health will require, among other things, some socialisation. This socialisation will be difficult to supply in a prison environment but prisoners will require support, companionship and conversation to at least the same extent as people living in more normal social circumstances require. It seems reasonable to suppose that the greater the degree of despair and hopelessness that has been engendered by the potent mixture of socialisation difficulties and a prison environment, the greater the need for support. It could be of some interest in this regard that during the first half of the 20th century, when capital punishment was still used, condemned men were never left alone in their cells at any time. Indeed, they usually had two prison officers to sit with them. As Hobhouse & Brockway (1922) note, 'this extraordinary surveillance has as its chief object the maintenance of the majesty of the law by

preventing the suicide of its victim'. In that cameo, we can see that it was clearly understood that men facing the death penalty were at high risk of suicide and it was also understood that the way to reduce that risk was to provide company and support by a form of sociable contact.

It is all the more strange, therefore, that the same prison system (in common with many other prison systems) has also developed the notion that prisoners serving terms of imprisonment, rather than facing the death penalty, and who are thought to be suicidal are best managed in isolation. This is clearly the opposite of what is required.

After a visit to New York in 1842 Charles Dickens wrote:

'I paid a visit to the different public institutions on Long Island. One of them is a lunatic asylum. In the dining room, a bare, dull dreary place, with nothing for the eye to rest on but the empty walls, a woman was locked up alone. She was bent, they told me, on committing suicide. If anything could have strengthened her in her resolution it would certainly have been the insupportable monotony of such an existence' (Dickens, 1842).

This observation is supported by figures from the Home Office Suicide Awareness and Support Unit that suicides occur much less commonly in accommodation with other people than in isolation (Table 6).

The code of practice that accompanies the Mental Health Act 1983 says, *inter alia*:

'Seclusion should be used as little as possible and for the shortest possible time. Many hospitals have discontinued its use. Seclusion should not be used as a punitive measure or to enforce good behaviour ... *It should never be used where there is a risk that the patient may take his own life or otherwise harm himself* [emphasis added]; its sole aim is to contain severely disturbed behaviour which is likely to harm others ... a nurse should be readily available within sight and sound of the seclusion room at all times throughout the period of the patient's seclusion ... a documented report must be made every 15 minutes ... if seclusion needs to continue, a review should take place every 2 hours, carried out by two nurses in the seclusion room, and every 4 hours by a doctor. If seclusion continues for more than 8 hours consecutively, or for more than 12 hours intermittently over a period of 48 hours, an independent review must take place.'

In other words, seclusion is a technique that is used as a last resort, for patients who are destructive to others, never for those who are destructive to themselves alone, and under the most intensive scrutiny possible.

Although some might argue that this code is not relevant to the prison setting, because it is concerned with hospitals, such an argument is extremely weak. When prisoners are secluded for mental health reasons such as suicidal ideation, then principles of good mental hygiene and the appropriate techniques of

**Table 6. Location of prison suicides, 1996–1997 (Data from Home Office Suicide Awareness Support Unit)**

Location	<i>n</i>	%
Single cells	80	63
Double cells	36	28
Wards/dormitories	12	9

management should be used in the prison just as they are in the hospital. There can be no justification for saying that techniques that are deleterious to people who are psychologically distressed in a hospital are acceptable for people who are psychologically distressed in a prison, simply because it is a prison.

We believe that the seclusion option in a prison setting may not be derived simply from a therapeutic approach. Seclusion has traditionally been used in most prison systems as a punishment under the label 'solitary confinement'. Punishments of this kind are a way of controlling difficult prisoners; it is therefore easy to see how this technique may have become generalised into a means of controlling all difficult prisoners, even when it is acknowledged that they need care rather than punishment. Prisoners are likely to interpret a period in a stripped cell as a punitive response to their distress, even if it is carefully explained that this is not the case.

In a previous survey, one of us (J.G.) was repeatedly told that some staff will not identify patients as suicidal when they believe that the consequence could be seclusion, and that this withholding of clinical information can also occur among prisoners themselves. It is fairly obvious that seclusion increases a prisoner's distress (that is what it is designed to do when it is used for punishment). Miller (1994) obtained psychometric confirmation of this. Taylor *et al* (1993) reviewed the history of seclusion and some of its recent literature. They pointed out that it is close to sensory deprivation, with all that implies for an individual's mental state. It is even possible that some of the 'prison psychoses' noted in the 20th century were induced by the excessive use of seclusion. In the 19th century the 'silent system' had to be abandoned because of the number of psychotic breakdowns it induced. It is still believed that seclusion may have a beneficial effect in patients with schizophrenia, but then only with strict nursing procedures and for short periods of time.

We strongly recommend that the use of seclusion and stripped cells for the management of suicidal prisoners should be stopped. We very much welcome the news, therefore, that came at the end of our work that a strong management directive has been issued within the prison service that suicidal prisoners shall not be secluded. The old management by seclusion should be replaced by close observation and, in some cases, removal to NHS hospitals.

## Recommendations

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1. We recommend in the majority of cases that suicide risk among prisoners continues to be managed by prison services. Nevertheless, primary care teams in prison should have the facility to refer persistently suicidal prisoners with significant mental health problems to a community mental health team for a further assessment. To achieve this, prison health services will require significant new investment (financial and workforce) to ensure that prisoners who require it have access to a comprehensive prison-based community mental health team. We further recommend that such assessments should include consideration of transfer to NHS hospital care, in cases where the usual criteria for admission to in-patient care are met.
2. We recommend that, for those prisoners with suicidal propensities who remain in prison, use be made of the clinical approach we have outlined in Appendix 1.
3. We recommend an increase in NHS in-patient capacity, funded by new investment, in open wards and in low, medium and high secure accommodation, in order to provide for those prisoners with mental illness who require hospital in-patient care.
4. We recommend that in any national policy or programme to reduce suicide, prisons must be a particular target zone.
5. We recommend that there should be a joint Home Office/NHS strategy on prison health care to ensure that there is a well-funded and organised multi-disciplinary team in prison able to deliver effective assessment and/or treatment, including rapid transfer to the NHS.
6. We recommend that no person under the age of 18 years should be admitted to an adult prison.
7. We recommend that prison officers expected to have care of people aged 18–21 years receive special training about young people's needs and reactions.
8. We recommend that anti-bullying programmes should be mandatory in all prisons.
9. We recommend that governors should have guidelines readily available for the management of the aftermath of a suicide.
10. We recommend that there should be a mandatory requirement on the part of the senior doctor to initiate a multi-disciplinary confidential clinical audit in the case of any unexpected death. (This is in addition to the governor's audit.)
11. We recommend that within the prison service a centralised computer system be introduced that allows access from more than one point to medical data.
12. We recommend that research into ways of reducing self-harm and suicide in prison should be undertaken.

13. We recommend that research be established to see whether the Care Programme Approach and section 117 of the Mental Health Act 1983 are actually being applied to prisoners.
14. We recommend that the induction period for new prisoner receptions should be 7 days of close observation and assessment in a dedicated area. Close observation means that the prisoner should not be isolated and should always be in visible proximity of responsible others.
15. We recommend that staff training should include techniques of resuscitation.
16. We recommend that community drug and alcohol teams should have access to prisoners, and that all prison doctors should receive specific training in psychiatry and in drug misuse medicine. We also recommend that community learning difficulties teams have access to prisoners.
17. We recommend that prison authorities discuss with local psychiatry teams ways in which prisons can be made more accessible to mental health teams.
18. We strongly recommend that prisoners should have access to an equivalent level of health care as those outside prison.
19. We recommend that the practice of automatic prison detoxification of patients stabilised in the community on substitute prescriptions be discontinued.
20. We recommend that the education of prisoners and their families concerning the danger of loss of tolerance to addictive drugs should be undertaken by CARAT workers, who should also ensure rapid transfer to substance misuse services.
21. We recommend that assessment of suicide risk in prisons should include an individual clinical assessment by staff who have been trained by and who are supervised by mental health professionals.
22. We endorse national policy set out in *The Future Organisation of Prison Health Care* (NHS Executive, 1999) that health authorities should be responsible for commissioning secondary mental health care in prisons. We recommend that secondary mental health care in prisons becomes an integral part of the catchment area's NHS mental health services, both general adult and forensic psychiatry.
23. We recommend that the training of all psychiatrists includes some experience of prison work and, in particular, an understanding of the limitations of psychiatric treatment within prisons, including within prison health care centres.
24. We recommend that judges and prosecutors should learn more about psychiatry, psychology and criminology and personally evaluate prison conditions on a regular basis themselves.
25. We recommend a system of continuing professional development for all grades of staff within prisons.
26. We strongly recommend that the use of seclusion and stripped cells for the management of suicidal prisoners should be stopped.

## Appendix 1. A clinical, one-to-one approach to the management of suicide risk

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The best course of action in any clinical setting is to deal with individuals as individuals. Assessing and then managing risk is necessarily an individual task using relevant clinical skills. The clinical approach inevitably depends heavily upon face-to-face contact with the individual at risk. Information from other people who know the person is also vital. Distinct skills are needed to ensure that such an approach is valid and reliable.

There is probably no single clinical stereotype of the suicidal individual, and level of risk cannot be gauged entirely from one-to-one clinical assessment of mental state; other factors such as changes in treatment compliance, use of alcohol, environmental hazards and stresses in relation to others also need to be taken into account. Nevertheless, the reliable evaluation of suicidal ideation and intent through direct interview is of great importance in assessing relevant risk. Such an exercise depends considerably on our ability to encourage the person at risk to share these ideas, and this in turn relates closely to skills in fostering trust and a sense of support through trying to accept and understand, rather than judge critically and perhaps unfairly.

Interview technique to reveal and assess the severity of suicidality is not acquired easily. To be effective, the professional needs to feel confident in opening up and exploring such a painful and sensitive topic. The various hazards that may beset and mislead the unwary need to be understood. These include denial of suicidal intentions by the most determined, marked variability in severity of suicidal feelings (related to the ambivalence of any suicidal individual towards dying, or chance encounter with stressful events), uncooperative and perhaps even aggressive behaviour, or behaviour that seems to indicate that the individual is merely 'manipulating' rather than being at significant risk of committing suicide. Certainly, some individuals can deliberately use the threat of suicide in an attempt to exert some control over their situation, but to dismiss such behaviour as irrelevant to real risk is always hazardous. Clinical care might sometimes have to set limits on difficult behaviour by placing emphasis on personal responsibility for it. This is one of the most difficult of all clinical skills, and should never be embarked upon unless evidence is adequate and the individual's problems have been given the fullest possible consideration. It is easy to fall back on attitudes that are negatively judgemental and possibly unfair; competent clinical skills should guard against this. The suicidal are the first to detect such negative attitudes in those who set out to care for them. A state of terminal alienation occurs in a proportion of suicides, related to failure on the part of others to remain sympathetic in the face of recurrent relapses or uncooperative and perhaps aggressive behaviour. On occasions it may be necessary to insist



that an individual takes a major degree of responsibility for risk-taking behaviour, but this is one of the most challenging of all clinical tasks a professional has to face and mistakes can be made.

Assessment should pave the way towards deciding on a care plan. Some diagnostic categories such as schizophrenia, certain personality disorders, alcohol/substance misuse and depressive disorder lead the field in denoting a possible increase in suicide risk, although like all risk factors, in themselves they are no more than mere indicators to be interpreted in the light of the overall picture.

### **Assessment of risk**

Comprehensive assessment should involve the widest possible collection of information about an individual from both the past and present, encompassing all relevant disciplines.

The identification of socio-demographic factors that denote increased risk of suicide helps to focus attention on vulnerable groups. Yet major limitations of this approach need to be kept in mind. All such factors are of low predictive value at the individual level, particularly in the short-term and if relied upon too much can lead to many false positives and false negatives. No clinical strategy should depend primarily on this approach, which is best seen as no more than a backup to one-to-one assessment, evaluation of relationship problems and control of environmental hazards.

The clinical skills involved in assessing and managing suicide risk are in the main pragmatic, having been developed in the light of clinical experience concerning patients who have come into contact with psychiatric care. Their purpose is to help professionals to reach out to persons at risk, and so bridge the gulf generated by mistrust, fear, misunderstanding and the sense of alienation that invariably in some degree complicate the problem of suicidal despair. They are set out here with particular reference to patients who have been admitted to in-patient care. There is a recognised association between aggressive behaviour and suicide, and in clinical situations the two always need to be considered together.

### **Management of risk**

Once significant risk has been identified in the in-patient setting, then a clear-cut plan of action needs to be agreed. This should be fully understood by all those who participate in the individual's ongoing care and good communication between all such persons should be maintained for as long as risk continues. Care should ideally be based on a close series of one-to-one relationships between the individual at risk and those who provide clinical care. This is not always easy to achieve. Furthermore, suicidal ideation can at times reach such an intensity that it may overwhelm any resolve to accept help. In recognition of this,

conventional clinical care sets out to match the level of perceived risk with graded intensity of staff supervision. Such supervision should not be set up as a form of impersonal surveillance; the person at risk would inevitably perceive this as intrusive, even punitive. Its real aim is to establish a supportive alliance against suicide and thereby render the situation safe. Severe risk may mean that one or more members of staff will remain at all times with the individual at risk, sometimes in close proximity. Ensuring the safety of staff is important when aggressive as well as suicidal behaviour is judged possible. In such circumstances provision of physical security also assumes very great importance. Physical seclusion and isolation is not a feature of this approach. There is no one way of establishing intermediate levels of supportive observation. Most schemes involve, as one component of the overall approach, establishing and documenting direct one-to-one contact with the patient at intervals, say, of 15–20 minutes. All staff members should be clear about what is involved; there should be no ambiguity concerning this, especially when a patient is transferred to another clinical situation. In assessing and managing risk the widest possible perspective should be taken, from that revealed through face-to-face interview, to other reported events, such as change in behaviour, environmental hazards and supervening stresses arising out of problems in relation to others.

Suicide risk is a symptom, not a condition in itself. It follows that apart from measures aimed at rendering the situation safe, the underlying causes of the suicidal state need to be treated vigorously. In some this may mean treatment of underlying psychiatric disorder. Attention to risk posed by environmental hazards, particularly to potential suspension points, is important at all times: regular review of the hospital environment from this point of view is imperative.

## Appendix 2. The prison suicide situation in the Republic of Ireland

Table A2.1 outlines the relationship between the number of suicides, prison population (average daily population; ADP) and turnover during the past decade for prisons in the Republic of Ireland. The ADP has risen steadily, particularly during the latter half of the 1990s. The turnover figure consists of committals to prisons, both on remand and on sentence. The figures indicate that a relatively small number of prison places are occupied by a large number of people over the course of a year; the average prison stay is about 3 months. Suicide figures for the 1990s do not indicate a gross disproportion of remand suicides. Given the small number of events per year, no attempt has been made to relate this to a 'rate per 100 000', as even a small increase or decrease would have a disproportionate effect on such a rate calculation.

These figures do not include deaths from overdose, which have amounted to 1–2/year. There has been little evidence in these cases of self-injury intent. Although the figures indicate some increase, this has been inconsistent and, to some degree, reflects the overall rise in the ADP. Unlike the situation in England and Wales and in Scotland (during the latter half of the 1990s), there has been no dramatic and sustained increase in the number of prison suicides during the last decade.

**Table A2.1. Prison suicides in the Republic of Ireland, 1990–2000**

Year	Average daily population	Total admissions turnover	Number of self-inflicted deaths	
			Sentenced	Remanded
1990	2108	6406	3	
1991	2141	7054	4	2
1992	2185	8511	3	1
1993	2171	10 457	1	1
1994	2141	10 153	3	1
1995	2109	9928	1	1
1996	2197	10 367	5	3
1997	2424	11 429	3	1
1998	2567	11 307	2	2
1999	2763	(c 11 000)	6	2
2000	2875	–	3	0

Factors which are, to a certain degree, relevant to the prison situation are: (a) the fact that there has been a significant increase in the suicide rate for men in the general community aged 15–44 years; and (b) the high proportion of prisoners with substance misuse problems (30–40% of Irish prisoners have a recent or current opiate misuse problem). The Steering Group Report (Department of Justice, 1999) summarises the situation and makes a variety of recommendations in four broad areas:

- Data-gathering and local review – this applies in particular to the need to gather accurate information concerning incidents of self-harm involving prisoners and also for the need to undertake regular and systematic review of all such incidents
- Staff training – both in relation to the recognition of prisoners at risk and also in relation to the provision of support to prisoners either before or after incidents
- Provision of support services – medical, therapeutic, support (e.g. Samaritans)
- Structural issues – minimising structural deficits that might facilitate self-injury, particularly suspension points within cells.

There is no obvious explanation for the steady state of the suicide rate in the Irish prisons compared with British prisons. It could be a statistical artefact. It could be that the Irish system had its rise earlier (suicide numbers never rose above 2 before 1987 and in the years 1977, 1978, 1979 and 1984 there were no suicides). It could be that the prison ambience is a protective factor, staff/prisoner ratios are better, there is a more relaxed atmosphere and prison populations are lower so that both prisoners and staff know one another better. It could not be said that medical, psychiatric, psychological or other therapeutic services are adequate in the Irish prison system either in general terms or, more specifically, to address the problems afflicting prisoners and which may predispose them to self-injury or suicide. Also, it is likely that the population entering the Irish prison system has a similar number of psychiatric problems, including drug abuse, to the population entering the English or Scottish systems.

## Appendix 3. An audit of suicides in prisons in England and Wales, January 1992–October 1993 (summary)<sup>1</sup>

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### Self-inflicted deaths

75 deaths, 69 of these reviewed by staff questionnaire

66 men (17–56 years, mean 29 years)

3 women (20–44 years, mean 31 years)

### Charges or convictions

Murder 14

Other violence 10

Sex offence 7

Theft (including burglary) 22

### Type of prisoner

Sentenced 27

Pre-trial 37

Convicted, pre-sentence 5

### Length of time in prison at time of death

Between 1 day and 17 years: 27 sentenced prisoners (17 for less than 1 year)

Between 1 day and 15 months: 37 pre-trial prisoners (18 for less than 1 month)

### Psychiatric history

#### *Previous*

34 individuals (psychotic disorder: 8; neurotic disorder: 9, substance misuse: 6; personality disorder: 7; not known: 4)

#### *Current*

23 individuals (psychotic disorder: 7)

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1. Further details available from Mary Piper, Prison Health Policy Unit, Department of Health, Wellington House, 133–155 Waterloo Road, London SE1 8UG

### *Previous deliberate self-harm*

1 or more previous attempts	36
In prison	13
In community	21
In police custody	2

### **Number of deceased previously thought to be at risk of suicide**

44 individuals thought to be at risk
20 suspected by health care centre staff in prison
22 by wing staff in prison
7 by police
8 by family
4 by other inmates

### **Situation immediately before death**

14 were on formal suicide observation (F1997) (8 because of mental disorder)
24 were referred to a visiting psychiatrist
3 were recommended for NHS treatment immediately
2 were recommended for NHS treatment immediately if further deterioration (all died before NHS care was accessed)

### **Diagnosis**

37 were considered to have a disturbance of mood (27 died within 1 month of this assessment, 7 within 24 hours)
9 were described as paranoid
8 were described as agitated
7 were described as depressed
7 were described as violent

### **Time and place of suicide**

23 of the deaths occurred between 04.00 h and 08.00 h
42 of the deaths occurred on normal location
14 of the deaths occurred in the health care centre
12 of the deaths occurred in segregation or seclusion
16 of the deaths occurred in shared accommodation
53 were alone at the time of death
34 of the prisoners had just received bad news (9 ending a relationship, 7 a sentence of punishment, 5 a divorce pending)

### **Cause of death**

64 died by asphyxiation
5 died by overdose (4 of these at home)
7 had a pathological level of a prohibited drug at autopsy (toxicology undertaken in only 14 cases)

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