Prison Reform Trust response to the Consultation on Preventing Suicide in England

Prison Reform Trust

The Prison Reform Trust, established in 1981, is a registered charity that works to create a just, humane and effective penal system. The Prison Reform Trust aims to improve prison regimes and conditions, defend and promote prisoners' human rights, address the needs of prisoners' families, and promote alternatives to custody. Its activities include applied research, advice and information, education, parliamentary lobbying and the provision of the secretariat to the All Party Parliamentary Penal Affairs Group. The Prison Reform Trust also serves on the Ministerial Board on Deaths in Custody, the National Advisory Group, and the Northern Ireland Ministerial Roundtable on Safer Custody.

Introduction

The Prison Reform Trust is pleased to have the opportunity to respond to the consultation on preventing suicide in England. The consultation marks an important commitment to cross-government work to prevent suicide, and draws on a wealth of accumulated evidence. The Prison Reform Trust also affirms the commitment to a broad, system-wide approach, bringing in a range of partner agencies and people who have been directly affected by the suicide of a family member. Our contribution is based on our experience, over 30 years, of advocating for improved prison conditions, running an advice and information service and help line for offenders and their families, applied research in prisons and influencing reform in policy and practice. We have restricted our response to areas of the consultation in which we are engaged.

Area 1: Reduce the risk of suicide in key high risk groups

Q1 In your view, are there any additional measures or approaches to reduce suicide in the high-risk groups that should be considered for inclusion? What evidence can you offer for their effectiveness?

> 'The evidence we have gathered suggests that prison actually leads to an acute worsening of mental health problems. By sending people with a history of attempted suicide and mental health problems to prison for minor offences the state is placing them in an environment that is proven to be dangerous to their health and well-being.' Parliamentary Joint Committee on Human Rights, 2004: p. 32
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> Thus, the first principle to be established in protecting vulnerable people from a heightened risk of suicide is that alternatives to custody (such as community

sentences) and diversion to mental health care (from courts or earlier in the criminal justice process) should be expanded for offenders who are at risk of suicide. Plans announced by the Secretaries of State for Health and Justice at the WI and Prison Reform Trust reception in March 2011 for diversion and liaison schemes to be established in police stations and courts by 2014 will undoubtedly help to reduce the risk of suicide and self harm in custody.

The engagement of the WI, a respected civic society group, and its Care not Custody campaign inspired by the tragic death by suicide of the son of a WI member, evidences public concern and preparedness to become involved.[i] The Care not Custody coalition to support and monitor government's drive for diversion has now attracted the membership of professional associations and charities representing over one million people.[ii]

People who are mentally ill are not always assessed or moved into secure mental health units quickly enough. They can therefore end up in segregation or health care units in prison, inappropriately located where staff are unable to meet their needs. The Prison Service Order on segregation (1700) which permits the use of segregation for people at risk of self-harm 'in exceptional circumstances' should be tightened to eliminate the current over-use of segregation units for prisoners with serious mental health problems. The particular vulnerability of women and children in prison are set out respectively in the Corston and Prison Reform Trust *Punishing Disadvantage* reviews.[iii]

The Prisons and Probation Ombudsman review of 200 deaths in custody found a number of concerns around the reception process. Two of these are the responsibility of the Department of Health: poor health screening and failures in requesting medical records from community practices. High levels of uncertainty and increased stress of indeterminate sentences place many people in prison at risk. Government proposals to curb the unnecessary use of custodial remand and consideration of the Kafkaesque indeterminate sentence for public protection, IPP, in the Legal Aid, Sentencing and Punishment of Offenders Bill should, if passed, go some way to reducing this risk.

The Care Quality Commission should monitor the extent to which equivalence in mental health care is being achieved in prisons. This could be conducted jointly with HM Inspectorate of Prisons.

According to Independent Monitoring Boards, given the importance of family support in preventing suicide, considerably more could be done to support and engage prisoners' families.[iv]

Q2 In your view, are there any other specific occupational groups that should be included in this section? If so, what are the reasons for inclusion?

For the reasons given in this consultation response we should like to see 'people in custody' identified as a group within the department's strategy to prevent suicide in England.

The Prison Reform Trust's *No One Knows* programme gathered evidence on the particular needs of prisoners who have learning disabilities or learning difficulties[v]. A common problem was that their disability barred them from full participation in the prison regime. Enforced idleness left them at greater psychological risk; many experienced high levels of depression and anxiety. They were found to be far more likely than other prisoners to be bullied by their peers and to be subject to disciplinary procedures by staff. Every prison should have learning disability specialists, providing a better assessment service, improved conditions and treatment, and follow-up support.

Over half of all elderly prisoners suffer from a mental illness, the most common being depression which can emerge as a result of imprisonment. Some older prisoners will have a physical health status of ten years older than their contemporaries on the outside. A University of Oxford study found that more than 80% of sentenced male prisoners aged 60 and over suffered from a chronic illness or disability. Mental health in-reach teams should have training on the specific mental health needs of older people.

Improved drug treatment and detoxification in prison and better first night in custody procedures are both thought to have contributed to stabilising the upward trend in deaths in custody. More could be drawn from analysing and applying the success of these methods. Insufficient attention has been paid to those with a dual diagnosis and people in prison withdrawing from a dependence on alcohol. Particular concerns have been raised about the well-respected first night work of groups such as pact, the Prisoners Advice and Care Trust[vi] which are now under threat or lost due to cutbacks and new commissioning arrangements. This is worrying at a time when rising prison numbers have created a greater 'churn' in the system and more prisoner movements mean more first nights in unknown establishments.

Area 2: Tailor approaches to improve mental health

Q3 In your view, are the most appropriate groups considered, including any groups where there are issues relating to equality?

Every prison should expand its links to voluntary organisations outside, in particular, with black and minority ethnic groups. Mental health in-reach teams should also ensure that they maintain links with the PCT's community development workers. There are disproportionate numbers of people from black and minority ethnic groups held in custody and, for many, this then acts as an inappropriate gateway to the mental health care that should have been available at an earlier stage in the community.

Q4 In your view, are there any additional measures or approaches to reduce suicide in the identified groups that should be considered for inclusion? What evidence can you offer for their effectiveness?

The consultation does not cite the work of Listeners. Listeners are prisoners in every establishment, trained and supported by the local Samaritans and on call 24/7 to other prisoners in distress and considering suicide. The Listeners should be described as a peer support system which could be a model for suicide prevention in other contexts. In prisons, the confidential support from a peer is key to its power to help people in crisis. The consultation should show that more can be done to ensure that Listener schemes are sustainable, for example by consulting Samaritans about what they need to work with prisons more efficiently.

The low predictive powers of the ACCT strategy (between one-quarter and one-third of people whose deaths are deemed self-inflicted are on an open ACCT at time of death) underlines the importance of staff treating all prisoners respectfully and keeping them safe. The Prison Service cannot reduce suicide solely by focusing special treatment on the few who are identified by staff. (This is a finding of Professor Alison Liebling's Safer Locals evaluation).

Information sharing systems, within prisons, and between health services in the community and prisons, are still inadequate. Health care staff do not always support prison staff with the information they need to care for someone properly, particularly in regard to mental health needs.

Each prison should have a full complement of staff in mental health teams, equivalent to the norms that would apply in the community for the prevalence and caseload of psychiatric morbidity.

Area 4: Provide better information and support to those bereaved or affected by a suicide

Q7 What additional measures would you like to see to support those bereaved or affected by suicide? Please comment on how this help could be provided effectively, and appropriately funded.

Delayed inquests are particularly stressful for families bereaved by a death in custody. Following a self inflicted death in prison custody, a clinical review is commissioned from the local Primary Care Trust (PCT) or, in the case of deaths in Wales, Healthcare Inspectorate Wales. In turn, they appoint a clinical reviewer (or reviewers) to assess the health care provided to the deceased and provide a report for the Prison and Probations Ombudsman Office. We are concerned about the length of time that elapses before these investigations are carried out and also that the investigations are not independent. There is a clear conflict with a PCT investigating the care of a death of a patient the same PCT was caring for.

Evidence provided to the All Party Parliamentary Group on Penal Affairs by bereaved families[vii] showed the stress they experience. It also exposed the unacceptable

practice of means testing bereaved families so that those with resources could find themselves having to re-mortgage a property in order to pay for representation to find out how their loved one took their own lives whilst in the care of the state.

Q8 What additional information or approaches would you like to see provided to support families, friends and colleagues who are concerned about someone who may be at risk of suicide? Please comment on how this help could be provided effectively, and appropriately funded.

Those working in prison visitor centres, prison chaplains and members of Independent Monitoring Boards could offer support and pass relevant information to prison staff from concerned relatives. In Scotland the system of family contact development officers works well in the prison system and could be replicated in England and Wales.[viii]

Area 6: Support research, data collection and monitoring

Q11 Is there additional information available that could be collected at a national and local level to support the suicide prevention strategy?

Information could be gathered, and used more effectively, from Coroner's offices in particular where a narrative verdict has been given. The proposal not to proceed with the Office of the Chief Coroner in the current Public Bodies Bill will be a retrograde step in this regard.

Q12 In your view, where are the gaps in current knowledge of the most effective ways of preventing suicide?

There is a heightened risk of suicide immediately post-release: this should be subject to applied research to determine how the transition from custody to community increases the risk of suicide. Further, the high rates of post-release suicide highlight the need for local health care to give greater priority to the health needs of recently released prisoners.

[Note: The Prison Reform Trust response does not comment on Area 3: Reduce access to means of suicide; or Area 5: Support the media in delivering sensible approaches to suicide and suicidal behaviour.]

Annex: Key facts of suicide and self harm in prison[ix]

- **There were 58 apparent self-inflicted deaths in custody in England and Wales in 2010.** This is down from 61 in 2009.
- **This figure includes the death of one woman, four young people aged 18-20 and no children.**
- **The three-year rolling average to the end of 2009 was 71 self-inflicted deaths per 100,000 of the population.** This is down from 130 per 100,000 in 2004. Safer custody programmes, improved drug detoxification and first night in custody schemes are all thought to have contributed to this reduction.
- **The suicide rate for men in prison is five times greater than that for men in the community.** Boys aged 15-17 are 18 times more likely to take their own lives in prison than in the community**.**
- **Men recently released from prison were eight times more likely, than the general population, to take their own life.** Women were 36 times more likely to take their own life.
- **Twelve self-inflicted deaths in 2009 occurred within the first seven days in prison.**
- **Remand prisoners, 16% of the prison population, accounted for 38% of self-inflicted**
- **deaths in 2009.**
- **Twenty four of the 65 prisoners who took their own lives in the 12 months to 31 August 2009 had reported a history of attempted suicide prior to reception into their final establishment.** Seventeen of these reported having attempted suicide in the previous 12 months: 10 whilst in custody and 7 whilst in the community. Eight of the 65 had a documented history of attempted suicide in their final establishment.
- **Over 100 prisoners were resuscitated during 2007 after serious self-harm incidents.**
- **Approximately 30% of prisoners who take their own lives had no family contact prior to their deaths.**
- **According to the government's Social Exclusion Unit, more than 50 prisoners take their own lives shortly after release each year**

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[i] Action Pack: What the WI has achieved and what you can do next in your community
http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth/CarenotCustody

[ii] http://www.guardian.co.uk/society/2011/mar/30/keep-care-not-custody-promise

[iii] Jacobson, J. (2010), Punishing Disadvantage – a profile of children in custody, London: Prison Reform Trust.
http://www.prisonreformtrust.org.uk/Portals/0/Documents/PunishingDisadvantage.pdf

[iv] Edgar, K. and Rickford, D. (2009), Chapter 12, Family support - Too Little Too Late: An Independent Review of Unmet Mental Health Need in Prison, London: Prison Reform Trust.
http://www.prisonreformtrust.org.uk/Portals/0/Documents/Too%20Little%20Too%20Late%20-%20a%20review%20of%20unmet%20mental%20health%20need%20in%20prison%20.pdf

[v] Talbot, J (2008), No One Knows: Prisoners' Voices: No One Knows Report and Final Recommendations, London: Prison Reform Trust.
http://www.prisonreformtrust.org.uk/Portals/0/Documents/No%20One%20Knows%20report-2.pdf

[vi] Jacobson, J. et al (2007), There When You Need Them Most: *pact's* First Night in Custody Services, London: Prison Reform Trust
http://www.prisonreformtrust.org.uk/Portals/0/Documents/there%20when%20you%20need%20them%20most%20a%20review%20of%20pact's%20first%20night%20in%20custody%20services.pdf

[vii] Prison Reform Trust (2010), p.23, Too Many Prisoner: The All-Party Parliamentary Penal Affairs Group January 2008 - March 2010
http://www.prisonreformtrust.org.uk/Portals/0/Documents/APPPAG2010.pdf

[viii] Loucks, N. (2005), Keeping in Touch: The case for family support work in prison, London: Prison Reform Trust
http://www.prisonreformtrust.org.uk/Portals/0/Documents/KEEPING_IN_TOUCH.pdf

[ix] Prison Reform Trust (2011), Bromley Briefings Prison Factfile
http://www.prisonreformtrust.org.uk/Portals/0/Documents/Fact%20File%20June%202011%20web.pdf