Preventing prison suicide:
Staff perspectives

Howard League for Penal Reform

Key points

- Suicide in prison has risen dramatically over the past three years and 119 people took their lives in 2016
- Incidents of self-harm have risen by 26 per cent and violent incidents have risen by 40 per cent
- Our review found that staffing shortages impacted on the safety of the prison
- Prisoners are spending longer in their cells and less time meaningfully occupied
- Substance misuse, specifically 'legal highs' like New Psychoactive Substances (NPS), is reported to be of increasing concern
- Prison culture, where distress, self-harm and suicide attempts are seen as manipulative, rather than indicators of need and vulnerability, contributes to an unsafe environment
- Prison staff are frequently exposed to distressing and traumatising events. Staff described working and living in prisons as being potentially 'toxic'
- Although prisoners can have multiple needs, often they do not meet the threshold for a mental health referral and therefore receive little support in prison
- We need a profound culture shift in prisons from a primarily punitive approach, to one centred around recovery, wellbeing and rehabilitation
- We will only see a significant improvement in prisoner wellbeing and decreased suicide rates when we recognise the traumatising and re-traumatising impact prison can have for both prisoners and staff.

Centre for Mental Health

Introduction

Centre for Mental Health and the Howard League for Penal Reform are working together to investigate suicide prevention in prisons. The work explores how police, the judiciary, prisons and health care providers can collaborate to prevent people from losing their lives through suicide in prison.

This is the fourth in a series of briefings. Centre for Mental Health's earlier briefing presented perspectives of people in or with previous experience of prison (Centre for Mental Health and Howard League, 2016). This briefing discusses the perspectives of staff working in prison as well as those reviewing clinical care post suicide. It focuses on staff views on what contributes to vulnerability and suicide risk, and makes recommendations based on staff members' views and their examples of promising practice. To protect identity no specific establishments are named. Interviews and focus groups were held with staff who worked in eight prisons, ranging from Category A to C and six health care providers including NHS Trusts. Participants came from health care backgrounds such as managers, nurses, psychologists and psychiatrists, as well as safer custody officers and independent clinical reviewers.

Background

The prison population of England and Wales was 85,898 on October 21st 2016 (MoJ, 2016). Since 2014 there has been a marked increase in suicides in English and Welsh prisons, with 89 prisoners taking their own lives that year (the highest number since 2007) and another 89 taking their lives in 2015 (MoJ, 2016). In 2016, 119 people in prison took their own lives, an unprecedented rise of 34 per cent (MoJ, 2017). The number of suicides in prison has nearly doubled since 2011-12 when there were 57. Additionally, rates of both self-harm and assaults have risen (MoJ, 2015). Self-injury has risen by 26 per cent in the previous year, with 36,440 recorded incidences of self-injury in the 12 months up to June 2016 (MoJ 2016).

Challenges

Staffing shortages

Cuts to staffing and problems with recruitment and retention have resulted in widespread staffing shortages, perceived to be contributing to all challenges faced by prisons:

> *"80 per cent of problems would be alleviated if there were more prison staff in place".*
> Health Care Manager

Research by Ludlow et al (2015) showed benchmarking (where prisons from similar categories must adhere to maximum budgets), new ways of working (changes to the ways in which prisons are staffed and the core day is delivered) and voluntary early redundancy had all reduced the prison workforce. Recent figures cited by the Howard League revealed that by 2015 there had been a 30 per cent reduction in prison staff (13,730 fewer staff) and that the ratio of staff to prisoner had reduced from 1 to 2.9, to 1 to 5.3. (PRT, 2015). The impact of these changes has been compounded by problems in recruiting and retaining staff. One prison we visited was experiencing 40 per cent staff vacancies across the estate. This resulted in relying on more costly agency staff who were generally deemed less able to provide "effective care…rarely going beyond fire-fighting". Additionally, sickness leave days have increased and are higher than the average in the nation's workforce (10.4 days compared to 4.4 days; MoJ, 2016a & PRT, 2015).

Staff discussed how officer shortages meant that prisoners spent much more time in "lock down" in their cells. Health care staff described how patients frequently missed their health care appointments because there was nobody to escort them. Prison staff, particularly officers, were seen as having less time to "observe", "interact" and build relationships with prisoners, and therefore less likely to pick up on subtle changes in mood. Previous research had indicated that prisoner-officer relationships are key protective factors against suicide (Ludlow et al 2015), but our participants discussed how there was no time available to foster good relationships.

Skills and experience

Staffing shortages were even more damaging because the depleted prison workforce was described as increasingly less experienced and skilled, with minimal training for supporting people experiencing mental health problems:

> *"…given what's known about the mental health of this population it's astonishing that mental health is not a core element of basic officer training..."*
> Mental Health Nurse

Additionally, staff reported poor take-up of mental health first aid training amongst officers due to availability.

Participants reported how health care staff were less prepared for working in the prison setting, for example:

> *…there is a significant problem in the training of mental health nurses now. It's community based training and they're not seeing people in an acute environment like a hospital which is more akin to a prison environment…"*
> Clinical Reviewer

"It was really surprising to me that nurses don't get properly trained in suicidal ideation. They didn't know how to tease out a narrative, i.e. when do you feel suicidal, what might be going on in your life, has anything happened recently to trigger this, are there certain times that are worse, like a significant anniversary, what coping strategies help…"
Clinical Psychologist

Staff wellbeing
The majority of staff interviewed highlighted poor mental health in the prison workforce. Research has demonstrated high levels of poor mental health amongst prison staff, which largely goes undetected and unsupported (Kinman et al, 2015). Not only important in its own right, this is also key to our understanding of prisoner vulnerability because of the impact of long-term sick on staffing numbers and how well "a stressed out" workforce can deliver care:

"If we're not functioning then the people we look after don't stand a chance…"
Prison Officer

Staff discussed the *"mental toll"* of working in a prison, *"an already demanding and stressful job"*, exacerbated by inadequate training and chronic staffing shortages. They spoke of the impact that suicide had on prison staff, for example a staff member presenting with PTSD symptoms such as flashbacks, after finding someone who had died. Participants discussed how prison staff were witness to and heard about many traumatising situations, but that they received little or inadequate support:

"…for example, you might hear about someone getting assaulted as you come onto shift. Or you might have been doing constant obs [observation] with a prisoner on ACCT, gone home and then come back to find out they're dead. These are all traumas…"
Clinical Psychologist

Officers discussed the impact of the work in "grinding them down slowly", but also the challenges in accessing support because of a culture of "not showing weakness", not recognising the toll the work was taking and not feeling able to trust how information is used.

Prison culture

Research has indicated that the prison's *"culture"* has a significant impact on the way in which suicide risk is interpreted and managed (Liebling 2005). Seeing a prisoner's distress, self-harming or suicide attempts as *"manipulative"* rather than *"vulnerable"* can affect the way in which staff intervene (Liebling 2005). Staff highlighted this, describing a process of *"hardening"* and *"distancing"* themselves from those in their care:

"It's a normal reaction to distance yourself from the individuals you work with else it'd be too much"
Psychiatrist

"You still need to treat each act of self-harm as serious and that's hard to maintain…"
Mental Health Nurse

Staff described *"underlying prison cultures"* where *"prisoners were seen as the scum of the Earth"*, and *"self-harming was seen as manipulative"*. Several participants discussed how mental health care teams became enmeshed in the prison culture:

"…the brutalisation of the system affects the clinicians carrying out that assessment…you forget that this is a human being…somebody's' son"
Clinical Reviewer

Although some staff described members of the workforce as holding *"callous"* views about prisoners, others described this *"desensitising… hardening"* process amongst staff who set out *"with the best intentions"*:

"…it's a brutal system and you become brutalised…"
Mental Health Nurse

The impact of working in demanding circumstances – with limited training, a depleted workforce and with a vulnerable population, who may be presenting very "disturbing behaviour", such as violent self-harming – was described as having a "profound and toxic effect on staff".

"It would take quite an individual to stand up in this macho, intimidating culture and advocate for a prisoner".
Health Care Manager

Unlike health care teams, where reflective practice and clinical supervision have been built into the routine, officers were described as having no *"safe space"* to *"be honest about the impact of their work"* or to reflect:

"As the mental health team we can go in and then afterwards come back and talk about how that interaction made us feel. It would be normal to say I'm worried about X, and what I've tried isn't working…"
Mental Health Nurse

Prison staff pointed out that officers regularly provide first-hand care, often informally acting as *"counsellors"* but without the support or recognition:

"It's often not recognised but we act as counsellors… I have sat down and spoke to a prisoner through their problems for hours on end"
Prison Officer

Safety in prison

In 2015, there were eight homicides in prison (MoJ, 2016). In the 12 months up to March 2016, there were 23,775 serious assaults recorded and 5,423 assaults on prison staff, a 40% increase on the previous year (MoJ 2016, MoJ 2016b). Participants discussed growing concerns relating to prisoner safety through the use of New Psychoactive Substances (NPS), which were having *"serious and unpredictable"* psychological and physical health implications. Between 2013 and 2016, 58 deaths were of prisoners using (or suspected of using) NPS. Of the 58, 39 were self-inflicted including some involving psychotic episodes (PPO, 2016).

Staff discussed increasing challenges in ensuring safety in prison, exacerbated by staffing shortages. Living in such a threatening environment where prisoners were not physically safe exacerbated distress as well as reducing their ability to express vulnerability. Several staff members feared that prisoners experiencing bullying and abuse (seen as linked with self-harm and suicide) would not ask for help, and risk would go undetected.

The Prison Population

Staff described the increasing complexity and diversity of the prison population. In one prison ages ranged from 18 – 70. One health care manager discussed:

"prisons are trying to do too much…you've got prisoners on remand, prisoners facing deportation, prisoners serving life, prisoners as young as 18 and older than 70…you have this complex system with very different populations of prisoners in terms of their sentences and the needs they present…"
Health Care Manager

Although some populations have been identified at greater risk of suicide in prison (such as individuals with learning difficulties), the majority of staff discussed how targeted interventions could result in many vulnerable individuals *"falling through the gaps"*. Nonetheless, staff did feel that there needed to be better screening in place to detect well-known vulnerabilities and risk factors.

People or procedures?

Aspects of the prison regime such as arrival and assessment procedures and services were highlighted as either failing to address, or adding to, suicide risk. Every participant expressed the view that no tool can replace the need for *"competent and caring staff"*. A major challenge described by staff was how the essential human element of their work was being replaced or *"stripped away"* by a preference for *"tick-box"* tools. Procedures like Assessment, Care in Custody and Teamwork (ACCT) were unanimously welcomed by all participants in providing a systematic and collaborative response to risk *("I'm amazed at the ACCT and how the prison system responds to a need and risk…you wouldn't get that support in the community…")*, but the *"tick-box"* nature of assessment tools risked replacing *"clinical judgement"* and curbed authentic interactions:

"I as a person can have those conversations, but you have to have them in a way that you can record on ACCT. It becomes unnatural…"
Prison Officer

Across the establishments, we witnessed staff and prisoners making positive differences. For example, letters from service users outlining the significant impact of therapy on their lives, officers sitting on *"cell mates' beds for hours chatting"* and *"buddy"* schemes where peers trained in mental health first aid provided *"fantastic"* support. Staff described the degree of care that goes *"unnoticed"* because of its *"soft"* and *"unmeasurable nature"*. Several participants felt that there needed to be a better way of recording this *"relationship-based"* work, seen as *"the mechanism of change"* underlying improved wellbeing in prison and a key *"protective factor"* against suicide.

The First Night Centre

Arrival in prison was seen as a particularly risky time as staff struggled to complete inductions for the influx of new prisoners arriving from court. Participants discussed how staff had no knowledge regarding the incoming prisoners and Prison Escort Records from the courts rarely accompanied them:

"…people enter prison mostly in the evenings after court. You don't know who is coming, when they are coming or how many…"
Health care Manager

"Quite often, because of the pressure of numbers coming through the system, the prison escort record, a crucial piece of information doesn't get to the nurse doing the assessment…"
Clinical Reviewer

There were huge time constraints on nurses to complete assessments before the end of the evening, contributing to a *"template driven"* system over the use of *"clinical judgement"*. Staff were

concerned that it meant that unless somebody had an *"obvious"* mental health or substance misuse need, vulnerabilities were vastly undetected.

Staff felt the initial reception assessment consistently failed to detect and address vulnerability. Although seen as helpful, participants highlighted the following limitations: firstly, that the scale is completed by staff with varying skills:

> *"The staff completing the assessment is not really alert to anything more than the immediate task of completing the tool. The assessor isn't using their clinical skills – thinking about 'how does this look and feel? What is this saying to me?'"*
> Mental Health Nurse

> *"The assessment is done by luck of draw… I've seen it done by health care assistants to incredibly experienced nurses with no rhyme or reason… more of a taxi rank principle – 'first up, I'll take you'…"*
> Clinical Reviewer

Secondly, indicators such as *"good eye contact"* were given too much weight:

> *"…in one case of suicide a nurse said to me that the man was really happy and bubbly and had good eye contact…this is a man in a prison reception and his 'really good mood' didn't raise any alarm bells or merit further investigation…"*
> Clinical Reviewer

The second part of the assessment comprises a follow-up interview, which is intended to provide an overall general health assessment. Staff highlighted that if the follow-up interview happened it was varied, with some prisons using it as an opportunity to complete a more thorough mental health assessment. Several participants perceived that the second assessment did not place enough focus on the mental state of the prisoner:

> *"…generally the second assessment is about things like whether you're interested in giving up smoking etc. That could be pushed further down the line. It should actually focus on how the prisoner is? You have been in prison overnight now, how are you feeling?"*
> Clinical Reviewer

Given the high proportion of suicides that happen during the first month of prison (PPO, 2016), staff stressed the importance of improving the initial assessment process.

Mental health provision

Thresholds for mental health service referrals appeared to vary across prisons. Often cited were challenges where a referral had been made by an officer but had not been accepted by the mental health team. Participants were concerned that this resulted in the *"reason for referral"* not being *"attended to"*.

Individuals often did not *"fit the criteria"* for a specific service, e.g. if they had *"multiple, complex but subthreshold needs"*. One participant discussed challenges with how services like IAPT (Increasing Access to Psychological Therapy) operated:

> *"I have IAPT saying that's not what I'm being paid for… and if someone's self-harming they're not suitable for IAPT either… they don't work with people who are too low or high risk. IAPT will work with people who'll engage and concentrate. I'm not sure that's what prisoners need…"*
> Health care Manager

Mental health teams were described as increasingly working from a forensic *"risk management"* perspective, as opposed to a *"clinical mental health"* one, the latter with a greater focus on trauma and vulnerability. Jones (2015), a clinical and forensic psychologist at Rampton hospital, outlined the distinction between therapy in prison settings compared with clinical hospital settings. He discussed the greater risk of being exposed to re-traumatising experiences in prison. Jones (2015) postulates that prison's focus on *"punishment"* and construction of its inhabitants as *"offenders"* limits its potential for *"recovery"* and rehabilitation.

Prison risk management: ACCT

Assessment, Care in Custody and Teamwork (ACCT) is a prison intervention for managing risk and preventing suicide. Several participants perceived the ACCT training to be inadequate, raising concerns about how qualified officers were to assess vulnerability. Staff argued that it was therefore crucial for health care to be regularly involved in the management of individuals on ACCT. Participants were concerned that health care were not present at enough of the ACCT reviews, resulting in poorly informed decision making:

> *"I've done a case where health care was not present and the ACCT was closed and nor I or the PPO thought it should have been closed. The prison officer managing the ACCT reported that the man was fine and had no suicidal ideation but within 12 hours later he had killed himself and in the nine hours before the review he had self-harmed three times…"*
> Clinical Reviewer

Suggestion for improvements

Staff made recommendations for improvement based on examples of positive approaches in their workplaces. The four key steps in this section are drawn from our interviews and the wider evidence base, including from our three previous briefings.

1. Engage the whole prison estate in collaborative working towards stepped care that attempts to support people with the lowest appropriate service in the first instance, only 'stepping up' to intensive/specialist services as clinically required. The stepped care model features in the commissioning service specifications for prison mental health services; however, the degree to which non-health care staff are engaged in or are aware of the stepped care model in many prisons is questionable. To achieve stepped care, the whole estate must be responsible for wellbeing. This requires better collaboration and a psychologically informed workforce, such as implemented in Psychologically Informed Planned Environments (PIPEs) (Turley et al 2015).

Participants reflected on the need for collaborative working between all relevant agencies, e.g. health care, the chaplaincy and the prison service:

> *"We certainly see people who might present as clinically depressed who may benefit from medication or a talking therapy. But we mustn't compartmentalise things: there may be a mental health issue but it's an individual at the centre of it. For example, their faith may be a really significant part of their life and to be able to practice it and have contact with others from that faith may be really important for them…"*
> Psychiatrist

Additionally, participants highlighted the role of family and friends as a huge resource in the individual's support system. For example, one prison discussed how families made mental health referrals (for example if they noticed a change in mood during a visit or phone call) and were involved in a multi-system approach to care provision.

2. Key partners such as peer mentors, education and gym staff, chaplaincy and officers were described as delivering essential and often informal *"counselling"*, deemed to *"prevent problems from escalating"*. Recognising these essential partners as forming the lower tiers of a stepped care model was described by participants as key to improving wellbeing in prison. For successful implementation, key stakeholders such as prisoners with current and past experience of poor mental health in prison, health care, and prison governors need to be involved in the organisation of the stepped care model.

As part of stepped care, mental health experts discussed specific psychological interventions, which were perceived to be effective in engaging patients, reducing risk of suicide and improving wellbeing. Staff listed a range of evidence-based practices in psychological intervention.

An example included flexible patient-centred approaches which focused on building a trusting relationship. In one prison, mental health staff spent time on the wings engaging clients. Several participants discussed using visual aids such as *"The Stress Bucket"* during therapy sessions, reported to be helpful in making sense of distress and behaviour. Trauma-focused psychological interventions which built *"grounding techniques"* into therapy sessions *"empowered"* individuals to use and develop their own coping strategies and protective factors in prison.

However, what was clear from this and other Centre for Mental Health reviews (Durcan, 2016) is that the psychological support varies greatly across the prison estate. The following would help to ensure greater access and quality in the psychological support offered in prisons:

- Evidence-based practices in psychological intervention should be included in the service specifications for prison mental health care.
- The mental health component of Prisons Health Care Needs Assessment (HNA) should specify the need within each prison establishment for each tier of the stepped care model and the need for each evidence based psychological intervention.

NHS England has a clear role in supporting the implementation of the above. The Royal College of Psychiatrists' Quality Network for Prison Mental Health Services has, through wide consultation, developed a set of standards for prison mental health care (Georgiou et al, 2016) and peer reviews standards, and runs shared learning events. Its membership includes many prison mental health services across the UK and Ireland and all such services should be encouraged to participate.

3. Investing in staff

To implement an effective stepped care model there needs to be enough well trained, supported, competent staff on the ground. If everyone in a prison has the responsibility for promoting wellbeing, then everyone needs the support and training appropriate to their role to do so. Investing in staff training and support was seen as crucial to making prison a safer environment:

> *"Thinking about reducing suicide, it's about creating positive relationships and environments and having a healthy positive workforce who can provide care, purposeful activities etc…but look to see if there is any investment in that…"*
> Psychiatrist

3.1. Training

Participants discussed the need for better training for all staff (not just health care) in mental health, describing a tiered approach to training to match the tiers of stepped care. Considering that as many as 90% of prisoners have a mental health need (Singleton et al, 1998), participants felt it imperative that staff were better equipped to address mental health. Participants recommended that mental health training with regular updates became a mandatory part of the officer training and a core competency for all staff.

Participants discussed how mental health training for officers needed to be less of an A-Z in psychiatric diagnosis and more focused on psychological ideas, such as trauma and fight or flight stress responses. For example, training needed to support prison officers to explore *"challenging or manipulative behaviour"* as a way of communicating distress. Prisoners perceived that often the only way individuals were listened to was through doing something extreme (Centre for Mental Health, 2016). Jones (2015) highlighted the risk in punishing individuals experiencing distress of retraumatising them. He discussed the need for a "trauma-aware workforce" who understand how trauma behaviourally and psychologically manifests.

Participants advocated continually upskilling mental health practitioners and discussed running on-going training with health care practitioners. For example, in developing clinical questioning skills relating to suicidal ideation, using clinical note-keeping as *"reflective and intervention planning time"* and doing clinical formulations with patients. Clinical formulations are the "process of making sense of a person's difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them" (Johnstone, 2012). The individual and therapist co-construct a narrative, drawing on psychological theory to understand the person's difficulties and develop a shared intervention plan which they revisit (Johnstone, 2012).

Participants discussed how mental health staff needed to be able to provide trauma-focused interventions:

> *"We've done trauma training as we've had difficulties of nurses not wanting to explore trauma with a patient, not feeling equipped and so not wanting to open a box … but that box has been opened and it's crucial that the patient experiences being valued and believed…"*
> Clinical Psychologist

3.2. Support

Participants stressed the need for better staff support across the estate. For officers, support needed to shift from being *"reactionary… post-incident…"* to being built into standard practice. This included a *"safe forum"* where staff could talk honestly about their work and the individuals in their care. This was seen as essential to maintaining a caring and non-judgemental approach. One participant described introducing Gibbs' reflective cycle (1988) with officers as a way of self-reflecting. Several participants commented on how they utilised the skills in the mental health teams in providing ad hoc support to staff across the estate, e.g. *"over a cuppa on the wings"*. One participant discussed *"connecting officers to their own mental health"* to introduce reflection into the work:

> *"… I ask them what they're like after a bad day, what their kids notice, what their wife notices… with the intention of bringing their humanity into the role, rather than this rigid mask…"*
> Clinical Psychologist

Participants stressed that governors needed to commit to prioritising training and support for all prison staff. Collaborating with prison staff in developing staff support and training would ensure that it is accessible and appropriate.

4. Robust assessments

Given the heightened risk of suicide during early custody, the initial assessment was seen by staff as a priority. All participants discussed amending the initial assessment tool to

include more questions relating to risk. Across several prisons, supplementary tools had been created to understand better a prisoner's risk and protective factors. Tools have also been developed to accompany ACCT. Kingston and Woodcock (2015) developed and implemented the "self-harm interview" and the "suicide thoughts and behaviour interview", designed to be completed by a mental health practitioner when an ACCT has been opened. The two tools comprise a set of questions, which seek to draw out a more in-depth narrative, understanding the level of risk and what circumstances exacerbate the risk as well as developing coping skills and an intervention plan with the patient. We recommend the use of these tools and standardising such practice is likely to lead to more effective systems nationally.

Future thinking

Having sufficient staffing on the wings is a essential. In a previous briefing in this series, people in or with previous experience of prison stressed the need for enough prison staff who *"care about the wellbeing of prisoners"* and who are well trained and well supported. The culture, stemming from the governor and managers, needs to encourage and facilitate reflective practice across the whole estate.

Professionals working in prison are exposed to multiple potentially traumatising experiences, which negatively impact their own wellbeing and the care they can provide, and in turn contribute to an unsafe and un-rehabilitative prison environment. Participants in our briefings and the wider literature (e.g. Enabling Environments, RCP 2013) have discussed the importance of relationships as key protective factors against suicide. Fostering good relationships will need the collaboration of partners across the prison estate. We need to recognise and support key partners such as peer mentors, chaplaincy and education staff in providing essential care. We need to join with current and former prisoners to learn from their expertise about what helps and involve them in service development. To tackle suicide in prison and improve wellbeing there needs to be a shift from a culture which has an emphasis on punishment, where individuals are *"seen as unworthy of care"* to one where the whole estate seeks to understand vulnerability and trauma and work towards recovery.

About the Howard League for Penal Reform

The Howard League is a national charity working for less crime, safer communities and fewer people in prison.

We campaign, research and take legal action on a wide range of issues. We work with parliament, the media, criminal justice professionals, students and members of the public, influencing debate and forcing through meaningful change.

About Centre for Mental Health

Centre for Mental Health is here until people with mental health problems have a fair chance in life.

We change the lives of people with mental health problems by using research to bring about better services and fairer policies.

www.centreformentalhealth.org.uk/

A full list of references is available at www.howardleague.org/publications/

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