



**The British
Psychological Society**
Promoting excellence in psychology

British Psychological Society response to the Scottish Government the Health and Social Care Committee

Prison Health

About the Society

The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries

We are content for our response, as well as our name and address, to be made public. We are also content for the Committee to contact us in the future in relation to this inquiry.

Please direct all queries to:-

Joe Liardet, Policy Advice Administrator (Consultations)
The British Psychological Society, 48 Princess Road East, Leicester, LE1 7DR
Email: consult@bps.org.uk Tel: 0116 252 9936

About this Response

The response was jointly led on behalf of the Society by:

Nigel Atter, British Psychological Society Policy Advisor

With contributions from:

Karen Slade CPsychol AFBPsS, Division of Forensic Psychology

We hope you find our comments useful.

Alison Clarke

Chair, BPS Professional Practice Board

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	<p>The Society believes the underlying principles for prison mental health care should include:</p> <ul style="list-style-type: none"> • The promotion of good mental health by improving mental wellbeing and preventing mental health problems developing; intervening early when prisoners have mental health problems; • Reducing the impact of mental illness and diagnoses such as dementia, severe personality disorder and co-existing conditions such as misuse of substances; • Provision of age-inclusive services, recognising the need for age-appropriate approaches and that through the life course, transfers between services must be based on individual clinical need rather than artificial age boundaries; • For children and young people, services will focus on early detection of risk and the development of resilience and life skills; • For prisoners of working age and post-retirement, services will focus on ensuring that they can live an independent a life as possible, with an emphasis on prevention and enablement, ensuring dignity in care.
	<p>There should be a focus on recovery and enablement by:</p> <ul style="list-style-type: none"> • Putting the individual prisoner at the centre of care and treatment; maximising their potential, the control they have over their own lives both within and outside prison, building resilience and restoring hope and ambition; • Supporting the optimum state of wellbeing through, in some cases, to the end of their life; • Promoting sustainable evidence-based approaches, looking at outcomes from a service user perspective by driving up quality and safety based on national guidance, best practice and service improvement techniques; measuring services from the perspective of the individual; service delivery is based on a human rights approach for people of all ages; • Ensuring that equality and diversity issues are addressed; tackling stigma and discrimination, and in particular fostering greater understanding of the needs of prisoners within mainstream service provision; • The right of prisoners to independent, informed decision-making about their care should be upheld.
	<p>Safety in Prisons: Strategic position</p> <p>Across all aspects of care, there is a need for greater joint strategic positioning across both health and justice on a national and local level on the prioritisation of services and consistent outcomes. This work should be evidence based, underpinned by theory and include a clear awareness of the psychological contributions to all harmful behaviours.</p>
4.	<p>Suicide and Self-Harm</p>

Self-harm is strongly related to violence in prison

Recent research has confirmed that self-harm and suicidal behaviour is integrated with the risk of violence within prisons. This has been shown in both male (Slade, 2017) and female prisons (Kottler, 2018). Within male prisoners, dual harm is prevalent at around 11-15% of the population (Slade, 2017; Slade, 2018) with around 40 and 60% of those who self-harm in prison also being violent (for both males and females). It is also clear from both practitioners and inquest that an escalation of violent behaviour may be an indicator of rising suicide risk but this is not routinely considered.

Health services need to prepare services to respond more effectively to integrated risk plus move towards a greater inclusion of harm to others within their remit. Forensic Psychological Services in HMPPS provide limited support for those at risk of harm whilst in custody with a planned development of greater consultancy but limited specialist individual or group work likely to be provided. Greater integration of psychologists from across health and forensic services may help address this shortfall. It is important that health services move towards an integrated risk approach where multiple risks are considered holistically, where health staff work in a more structured way with prison management and staff to manage areas of need. There is however limited evidence on the reasons for the relationship between self-harm and violence which might support the development of single intervention approaches and good quality research is required.

Complex needs in a non-health setting

Many of those in prison have the highly complex mental, physical and psychological needs as would be present within a mental health hospital setting e.g. 1 in 5 with dual diagnosis of substance use and serious mental health (OHRN, 2010) and a notable proportion having had recent mental health hospital discharges (Forrester et al, 2014). However, prison is not a health setting and prison health services must reflect elements more akin to a community setting in terms of prisoners' need to self-manage within an environment focussed on non-health priorities and by non-health trained staff.

In many services, the reality is that the assessment and management of mental health is undertaken in isolation from those leading with the daily care of those individuals with limited two-way information sharing and joint decision making. There remains some lack of clarity on the confidentiality requirements within this hybrid system where risks are high but where integrated care and full disclosure is not a requirement. This has multiple impacts with most prison staff largely unaware of the mental (or physical) health needs of those with whom they are expected to work. There is currently limited use of psychological formulation to understand the drivers and protectors of harmful behaviour and psychologists could provide effective support to staff to understand and work with these complex and multiple behaviours.

Harm prevention would benefit from a psychological perspective.

Prison health services would benefit from integrating a biopsychosocial understanding of mental distress and of self-harm and suicide into their approach. At present, available interventions over-emphasise treatment of the symptoms of a mental disorder. Psychologists, from across forensic, clinical and counselling could play an important role in identification and intervention. Those who die by suicide in prison are in mental distress but two-thirds are not identified as at imminent risk and are not placed under the Assessment, Care in Custody Team (ACCT) self-harm and suicide monitoring system before their death (PPO, 2014). In addition, most have

	<p>primary care needs and do not meet the criteria for secondary mental health services (PPO, 2016). Therefore, the health services need to account for highly complex primary care needs in a differing format to that provided with community settings (Forrester et al, 2014).</p> <p>Research has also demonstrated that self-harm behaviour is often accompanied by a wide range of other refractory behaviours, which can lead to extensive punishments for a highly vulnerable group (Slade, 2017; Kottler, 2018). There are currently no mental health safeguards in place around some of these punishments e.g. Basic regime, even for those who are already noted as vulnerable. The use of punishment for vulnerable and at-risk individuals is not usual practice within community or hospital settings and for equivalence to be realised, there needs to be development of bespoke health responses to these. At present, there is no published research on the impact of the use of constant supervision or basic regimes and very little high-quality research on the impact of segregation on risk of later harm, although there is clearly concerns about the risk of suicide under a segregation regime as highlighted in prison policy (PSI 64/2011) . One piece of research, as yet unpublished, has however shown a close and relevant link between the use of the restrictive regimes of both segregation and 'Basic' regime on the likelihood of the use of highly lethal methods of self-harm (ligature and self-strangulation) (Slade, 2018). The development of a stronger research base on any impacts of prison procedures on increasing and decreasing later risk of harmful behaviour would support evidence-based policy and practice.</p>
5.	<p>Assessment and identification</p> <p>Theory-driven approaches to understanding self-harm and suicide are required</p> <p>There remains an overemphasis on 'risk factors' as individual elements and considering harmful behaviours within a mental health framework. There are strong and well-evidenced biopsychosocial models which could support research and practice more effectively, if they were utilised within prison healthcare and mental health approaches. Suicide research is very clear on the complexity of the relationship between psychological factors and suicide ideation and the utility of theory-driven approaches to understanding suicide risk. As outlined in the recent BPS (2017) publication 'Understanding and preventing suicide: A psychological perspective' our practice can be enhanced by utilising well-evidenced understanding of why and how someone moves towards suicide with clear possibilities of intervention. The key dynamic elements of the integrated motivational-volitional (IMV) model of suicidal behaviour outlined in this BPS paper has been tested within prison settings and shown to be highly predictive of self-harm and suicide ideation (Slade et al, 2014a, 2014b). There is also evidence of useful models for self-harm (Power et al, 2014) and this is currently being tested within a UK prison setting and emerging results are positive.</p> <p>Actuarial (screening) tools are ineffective for individual risk identification.</p> <p>There is a persistent focus on the development and use of screening instruments to attempt to identify persons at risk of suicide, attempts which are unlikely to be fruitful. The benefits of actuarial tools are well established when predicting health risks and some criminal behaviours. However, even the very best actuarial assessment on criminal behaviour cannot identify individuals at imminent risk but only high-risk groups over a long period of time (e.g. 2 years) with known dynamic factors missing from the assessment (Large & Neilsson, 2017; Dahle, 2006). In</p>

	<p>addition, systematic reviews have repeatedly demonstrated very clearly that there are no tools which are better than chance when screening large numbers of people, unless they have already expressed at-risk behaviours (e.g. attended hospital following a self-harm) either in the community or in prison (Gould, McGeorge and Slade, 2017; Zalsman et al., 2016). There must be caution applied with the use of screening instruments since anecdotal evidence has shown that in practice, those undertaking the screen place more emphasis on the results than is appropriate, screening out individuals who are in fact at high risk. Moving from a less statistically-derived to a more psychologically and theoretically-derived position may be more fruitful since research has demonstrated that assessing a combination of these factors as a far greater predictive capacity than actuarial 'group' based methods (Slade et al, 2013).</p>
6.	<p>Interventions</p> <p>Individual formulation-driven psychological interventions There are currently no effective psychological interventions for suicide or self-harm within prison or most community settings. The research evidence is clear that we have not yet developed a suitable intervention and effects achieved through current approaches are small (York et al., 2013; Zalsman et al, 2016). This, in part, is due to their narrow focus, either of population or of approach, which do not take account of the clear biopsychosocial elements of self-harm and suicidal behaviour. There needs to be investment in innovative approaches with a clear theoretical basis with strong awareness of the needs of this complex population.</p> <p>Organisational interventions Self-harm, violence and suicidal behaviours do not occur in isolation nor are solely located in the individual due to the highly important role of human relationships and personal experiences on the development of these behaviour.</p> <p>There is evidence that organisationally-based approaches to suicide prevention can be very effective in reducing suicide rates, even in the absence of specific interventions for the behaviours. As outlined in Slade & Forrester (2014) a true integration of services across health and justice is the single most important factor to achieving suicide prevention. The process of commissioning for health services and the changing of providers in some prisons has contributed to a mismatch of priorities and outcome measures between services and a lack of joined-up strategic and practice approaches across health and justice. An example includes the recent HMIP inspection of HMP Nottingham, which resulted in the lowest rating on Safety due to extremely high suicide, violence and self-harm rates at the prison, leading to the first Urgent Notification. However, the reported health inspection the same week rated the health and mental health service as 'good'.</p> <p>There are examples of organisational approaches to suicide prevention which could act as a starting point for a bespoke system suitable for a criminal justice population. For example, the Zero Tolerance Approach to Suicide adopted by Merseyside NHS trust http://www.mersecare.nhs.uk/media/3190/sd38-v2-zero-suicide-uploaded-29-nov-16-review-oct-19.pdf . This work was detailed, evidence-based, underpinned by theory and applicable when piloted and developed in Detroit by Dr Ed Coffey.</p> <p>Method restriction Where possible restricting access to means involves implementation of measures to reduce availability of and access to frequently used means of suicide.</p>

Internationally, there is consistent evidence that restricting access to lethal means is associated with a decrease in suicide and that in the community, substitution to other methods is limited (Zalsman et al, 2016).

However, there is some evidence that prison self-harm may not consistently follow the trend, since there is an already restricted choice of means, potentially leading to greater use of more lethal means e.g. ligature during their prison stay, than would be expected in the community. This is reflected in prison self-inflicted deaths with 97% resulting from ligature and over 10,000 incidents/year (24.5%) of self-harm in prison being undertaken with the highly lethal methods of hanging, self-strangulation or overdose (Ministry of Justice, 2018).

There is a need for a specific large scale epidemiological study on suicides in all custodial, detention and secure mental-health settings, which focusses on 18-25 year old males. This research should fully account for variables such as maturation (physical and psychological / emotional), bullying (by other inmates and staff), punishments, over-crowding, environmental distress, lack of evidence-based interventions, drug-use and drug availability.

Postvention after suicide

There has been increased recognition of the importance of supporting vulnerable populations, such as bereaved families and friends, following suicides (WHO, 2014). The research demonstrates that people who are exposed to suicide deaths are at increased risk of complicated grief, traumatic grief and PTSD (Melhelm et al., 2004). Furthermore, the relatives and friends of the deceased may be particularly vulnerable to suicidal thoughts and behaviour (Joiner, 2005). Psychologists have a key role in providing support and interventions to those affected by the death and psychological models may be applied to understand how individuals manage grief and adjustment following a death by suicide.

Suicide deaths are often incredibly traumatic, the method of death is frequently violent and survivors are often plagued with the “re-experiencing” symptoms of trauma, such as flashbacks, nightmares and intrusive thoughts. These can occur even if the survivor did not witness the death scene and with suicide rates in some prison settings at high levels, the likelihood of exposure to suicidal behaviours in others are very high. Re-experiencing, when accompanied with avoidance and hypervigilance symptoms, is characteristic of PTSD, and therefore counsellors need to be equipped to recognise and manage these symptoms or refer the person for trauma-focused cognitive therapy or another recognised PTSD treatment (NICE, 2005).

There is emerging evidence supporting beneficial effects of a number of interventions, including counselling postvention for survivors and outreach at the scene of suicide (Szumilas & Kutcher, 2011). In addition, evidence-based guidelines for responding to suicide in a secondary school setting have been published recently (Cox et al, 2016). However, further research is required into the effectiveness of postvention services and interventions on reducing future suicide and attempted suicide/self-harm within a criminal justice context where exposure is high and access to some protective factors are limited.

There are a number of services and initiatives which may support postvention work across service users, staff and bereaved family and friends. These include:

- Listeners Scheme run by Samaritans provide peer support to prisoners. They currently run established postvention services for schools and for

	<p>Network Rail. https://www.samaritans.org/your-community/samaritans-education/step-step</p> <ul style="list-style-type: none"> • Prison Chaplains have a key role in providing support to bereaved families. • Support After Suicide Partnership https://supportaftersuicide.org.uk/ • The Scottish Prison Service’s “Talk to Me” http://www.sps.gov.uk/Corporate/Publications/Publication-4678.aspx, The Welsh Government’s, Talk to me 2 Strategy http://gov.wales/docs/dhss/publications/150716strategyen.pdf,
	<p>References</p>
	<p>Dahle, K (2006) Strengths and limitations of actuarial prediction of criminal reoffence in a German prison sample: A comparative study of LSI-R, HCR-20 and PCL-R, <i>International Journal of Law and Psychiatry</i>, 29, 431 – 442.</p> <p>Forrester, A. Singh, J. Slade, K. Exworthy, T. and Sen, P. (2014), "Mental health in-reach in an urban UK remand prison", <i>International Journal of Prisoner Health</i>, 10(3), 155 – 163.</p> <p>Gould, C., McGeorge, T. and Slade, K., 2017. Suicide screening tools for use in adult offenders: a systematic review. <i>Archives of Suicide Research</i>.</p> <p>Humber, N., Hayes, A., Senior, J., Fahy, T., & Shaw, J. (2011). Identifying, monitoring and managing prisoners at risk of self-harm/suicide in England and Wales. <i>The Journal of Forensic Psychiatry & Psychology</i>, 22(1), 22-51).</p> <p>Kottler, C, Smith, J. and Bartlett, A. (2018) Patterns of violence and self-harm in women prisoners: characteristics, co-incidence and clinical significance, <i>The Journal of Forensic Psychiatry & Psychology</i> (online).</p> <p>Large, M., & Nielssen, O. (2017). The limitations and future of violence risk assessment. <i>World Psychiatry</i>, 16(1), 25–26.</p> <p>Offender Health Research Network (2010).</p> <p>The pathway of Ministry of Justice (2018) Safety in Custody Quarterly: update to December 2017 [accessed at https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2017].</p> <p>Power, J., Smith, H. and Beaudette, J. (2016) Examining Nock and Prinstein’s Four-Function Model With Offenders Who Self-Injure, <i>Personality Disorders: Theory, Research, and Treatment</i>, 7(3), , 309–31.</p> <p>Slade, K., 2017. Dual harm: an exploration of the presence and characteristics for dual violence and self-harm behaviour in prison. <i>Journal of Criminal Psychology</i>. ISSN 2009-3829 (Forthcoming).</p> <p>Slade, K. and Forrester, R., 2015. Change. <i>The Journal of Forensic Psychiatry & Psychology</i>, 26(6), pp. 737-758.</p>

	<p>Slade, K., Edelman, R., Worrall, M. and Bray, D., 2014a. Applying the Cry of Pain model as a predictor of deliberate self-harm in an early-stage adult male prison population. <i>Legal and Criminological Psychology</i>, 19(1), pp. 131-146.</p> <p>Slade, K. and Edelman, R., 2014b. Can theory predict the process of suicide on entry to prison? Predicting dynamic risk factors for suicide ideation in a high-risk prison population. <i>Crisis: The Journal of Crisis Intervention and Suicide Prevention</i>, 35(2), pp. 82-89.</p> <p>Yoon, I., Slade, K. and Fazel, S., 2017. Outcomes of psychological therapies for prisoners with mental health problems: a systematic review and meta-analysis. <i>Journal of Consulting and Clinical Psychology</i>.</p> <p>York, J. et al, (2013) A Systematic Review Process to Evaluate Suicide Prevention Programs: A Sample Case of Community-Based Programs, <i>Journal of Community Psychology</i>, 41(1), 35–51.</p> <p>Zalsman, G. et al. (2016) Suicide prevention strategies revisited: 10-year systematic review, <i>The Lancet Psychiatry</i>, 3(7), 646 – 659.</p>
	<p>Resources</p> <p>Prison Reform Trust Bromley Briefings Prison Factfile http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Autumn%202017%20factfile.pdf</p> <p>Howard League for Penal Reform - Preventing Suicide https://howardleague.org/wp-content/uploads/2016/05/Preventing-prison-suicide.pdf https://howardleague.org/wp-content/uploads/2016/03/The-cost-of-prison-suicide.pdf https://howardleague.org/wp-content/uploads/2016/11/Preventing-prison-suicide-report.pdf https://howardleague.org/wp-content/uploads/2017/02/Preventing-prison-suicide.-Staff-perspectives.pdf</p> <p>NICE Guidelines CG26: PTSD Management CG78: Borderline personality disorder: Treatment and management CG90: Depression in adults: The treatment and management of depression in adults CG113: Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care CG115: Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence CG120: Psychosis with coexisting substance misuse: Assessment and management in adults and young people CG123: Common mental health disorders: Identification and pathways to care CG133: Self-harm: longer-term management CG155: Psychosis and schizophrenia in children and young people: Recognition and management</p> <p>Ministry of Justice: Prison Service Instructions PSI 64/2011: Management of prisoners at risk of harm to self, to others and from others (Safer Custody) https://www.justice.gov.uk/downloads/.../psipso/psi.../psi-64-2011-safer-custody.doc</p>

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End.