# Mental Health in Prison – Justice Committee

1.1 This evidence submission is based on Dr Karen Slade’s professional and academic expertise in prisons, suicide and self harm. It responds to three of the questions asked of the inquiry covering how mental health issues are identified in prisons or when serving custodial sentences, the role of clinical and non-clinical support for mental health needs of prisoners/those serving sentences and the effect of the prison environment on mental health.

1.2 This submission makes eight recommendations to the inquiry which are listed at the end of this submission which reflect the content of this submission.

1.3 **Dr Karen Slade** is Associate Professor of applied forensic psychology and Forensic Psychologist at NTU. She is currently on secondment with HMPPS with this submission written in a personal capacity based on her academic research.

1.4 **Rich Pickford** runs Nottingham Civic Exchange, a civic think tank that supports NTU colleagues to do more with their research and civic activity by developing programmes of work, hosting debates and maximising the impact of research and practical knowledge and skills across NTU.

## How mental health issues are identified on arrival at prison and/or while a prisoner is serving a custodial sentence.

### 2. Improvements in integrated suicide risk assessment and prevention

2.1 There are ways to improve the current approach to the identification of potential suicide and self harm risk on arrival to prison through greater integration and a move away from prediction to broader prevention.

2.2 Two-thirds of people who are classed as a self-inflicted death in prison are not identified as being at imminent risk or managed under the Assessment, Care in Custody and Teamwork (ACCT) self-harm and suicide monitoring system at the time of their death1. There are no routine suicide risk assessments during a prison sentence and risk management relies on staff to identify life events or distress. Although prison entry is a high-risk time, over 70% occur more than a month after prison entry2.

2.3 However, attempts have been made in many settings, including prisons, there is no evidence for the effectiveness of screening tools to predict suicidality3 and it is unlikely, due to the complex interlink of factors that this prediction-based approach will be effective.

2.4 To achieve effective identification and prevention, it is necessary for joined-up approaches which draw together the knowledge from across services, professional groups, the person in prison and, as shown in the evidence review 4, informed by family and friends. At its simplest this should include access to information from services across the criminal justice service (CJS) pathway and health services. As reported in research exploring health information flow from police station to prison5 there remain practical issues in detailed information flow through the CJS. For example, Prison Escort Records may indicate that a significant risk was identified but lack the details necessary for full and individualised assessment and prevention action planning.

2.5 There are dual streams for the health and justice information flow which have limited interconnection, thereby limiting the identification of the inter-connected and cumulative factors for suicide or self-harm. For example, suicide risk assessment relies on the interlink between a complex set of factors but information sharing is frequently limited to previous self harm behaviour or current expression of suicidality. Good practice in risk management cannot rely only on two factors and the research evidence strongly suggests the list of ‘warning signs’ is far broader e.g., feeling trapped or a burden on others 6. Many of these factors are not routinely shared within or between services.

## Support (clinical and non-clinical) available to those with mental health needs, whether it meets the needs of those in prison and if there are any gaps in provision.

### 3. Beyond the individual to integrating environmental and social factors.

3.1 Prison-based operational and health services would benefit from integrating greater biopsychosocial understanding of self-harm and suicide into their approach. At present, available interventions over-emphasise treatment of the symptoms of a mental disorder and at the individual level, without sufficient appreciation of environmental and social factors. The significant reduction in male and increase in female self harm rates in 2020, whilst the Covid-19 Exceptional Delivery Model operated in prisons, supports that changing environments can affect behaviour 2.

3.2 There are no currently identified effective psychological interventions for suicide or self-harm within prison nor most community settings. The research evidence is consistent that we have not yet developed a suitable intervention and effects achieved through current approaches are small7. This, in part, is due to their narrow focus, either of population or of approach (e.g. problem-solving), which do not take account of the broader context and interlinking biopsychosocial elements of self-harm and suicidal behaviour. There needs to be investment in innovative approaches grounded in an evidenced theoretical basis relevant for prison, which reflects the inter-connected needs of this population. Scowcroft et al.,8 undertook an in-depth and broad study of suicidality in 10 prisons in the UK confirming the relevance of a theoretical -informed approach in understanding and responding to suicidality.

3.3 There is currently limited professional support for suicidal or self harm with few specialist services available in prison. There is evidence from our review9 of a service provided by Psychologists which provides an individualised formulation (evaluation) of the person’s suicidality or self harm which was grounded in theory and supervised by specialists in suicide prevention. The research confirmed this approach as being both feasible and considered beneficial.

3.4 Prison-wide approaches, developed with a strong emphasis on multi-disciplinary working, individualisation, environmental development, and a focus on prevention over process were shown by our research10 to be effective in reducing suicide rates.

### 4. Dual Harm: A highly relevant but under-considered population & Single Case Management

4.1 There is a growing awareness of the relevance and importance of recognising those who engage in both self harm and violence in prison, known as *Dual Harm*. My research emphasised the scale of the overlap between self harm and violence in English prisons, with 60% of men and women who self-harm in prison also engaging in violence11, 12, 13.

4.2 As an overlapping group dual harm represents a significant safety and health improvement opportunity. In 2020, 39% of self-inflicted deaths were prisoners charged or sentenced to offences of violence against the person2. My research showed that the Dual Harm population, 11% of the prison population, accounted for 56% of all misconduct incidents (including damage, disorder and firesetting)12. The exaggerated impact on prison stability of this complex group emphasises the need to focus on early identification, joined-up single case management and intervention.

4.3 Currently, the ACCT process is used to manage self harm or suicide risk and the Challenge, Support, Intervention (CSIP) approach utilised for violence. Health services operate additional separate case management systems to the prison. There is a significant complexity in working with and managing those who dual harm. Our research14 interviewing men who dual harm suggested that the interlinking effects of extreme psychological distress, early trauma and unmet mental health needs on behaviours in this group may be better met through integrating a single case management approach with early intervention which crosses behavioural and professional boundaries. No review of the mental health needs for this population has yet been completed.

### 5. Evidence of effective treatment for depression and anxiety

5.1 Our recent systematic review15 considered Randomised Controlled Trials (RCT) of psychological therapies with mental health outcomes in prisoners (37 studies). The review found evidence that psychological therapies overall can be effective, with most evidence for Cognitive-Behavioural Therapy and mindfulness-based trials for depression and anxiety. However, effects were not sustained on follow-up at 3 and 6 months which may be due to the aftercare.

## The effect of physical prison environment on mental health.

6.1 Our research on dual harm has demonstrated that self-harm behaviour in prison is often accompanied by a wide range of other refractory behaviours, including violence, can lead to extensive punishments for a highly vulnerable group11, 12,13. There are safeguards in policy about the risk of suicide under a segregation regime (PSI 64/2011) indicating segregation to be used only in exceptional circumstances. Currently no mental health safeguards are in place around other restrictive regimes e.g. Basic regime. There is highly limited published research on the impact of the use of basic regimes or constant supervision to inform best practice in prison or to consider their effects on the risk of harmful behaviours, health or wellbeing.

## 7. RECOMMENDATIONS

7.1 This submission sets out eight recommendations based on the evidence and professional expertise of the author. These recommendations cover three of the questions posed by the inquiry and are listed below.

* Adopt a broader preventative approach to tackle potential suicide and self harm incidents across the prison and probation service.
* Explore the opportunities to integrate key data between systems.
* Enhanced reporting and sharing of broader ‘warning signs’ across the system to support enhanced monitoring of at-risk people.
* There needs to be investment in innovative approaches grounded in an evidenced theoretical basis relevant for prison, which reflects the inter-connected needs of this population, with professional support by specialists.
* Further development of the links and differentials between self harm and violence (dual harm) should be explored, with methods of single case management engaged across health and justice.
* Undertake a review of the mental health needs of Dual Harm cohort to further understand and mitigate the risks they pose to themselves and the wider prison system.
* Psychological therapies such as CBT must be maintained over the medium term or additional aftercare set up to ensure positive effects are sustained.
* The risk of all restricted regimes needs to be considered for people identified as at-risk from suicide and self harm and further research and policy development must be explored.

7.2 Dr Karen Slade is available to provide further detail or oral evidence if called.

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