Mental Health and Wellbeing of Young People in Custody: Evidence Review

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Executive Summary

Introduction

This document presents a review of evidence on mental health and wellbeing of young people in custody, focusing on suicide risk and prevention in custody.

It organises evidence into different frames and factors, separating the diverse perspectives through which mental health issues are analysed. These can shape alternative and sometimes contradictory understandings of problems and what to do about them.

Comparative context of prison Suicide

- Suicide is the leading cause of death of young people in prison in Scotland as well as internationally.
- Scotland consistently has a higher prison suicide rate than England and Wales though comparisons are complicated.
- Most prison suicide of young people takes place within three months of being detained.

Individual/clinical frames and factors

- Individual characteristics of suicide risk are well known and include: history of mental health issues including diagnosed disorders, prior suicide attempts and self-harming.
- High levels of ‘vulnerability’ are found among those who have died from self-inflicted causes in prison, but ‘vulnerability’ is a contested concept on the grounds of being both over and under inclusive and over individualising.
- Individual level and clinical frames recognise the contribution of non-individual factors to prison suicide, but often employ simplistic or limited understandings of other forces, especially institutional factors.

Operational, situational and management frames and factors

- Situational factors consistently observed in self-inflicted prison deaths include:
  - being in the early days or weeks of a sentence
  - being isolated, having recently been in segregated housing
  - being on remand
  - having had recent contact with health services
  - a recent triggering event in one’s life or institutional conditions
- Screening, identification and risk assessment tools have been subject to criticism both in their design and use.
- Information helpful to identifying a person’s risk is often available, but sharing and acting on this can be faulty.
- Frontline prison and health staff are crucial to managing suicide risk but their own risk of stress and workload is rarely considered.
- Translating known situational and operational factors of risk into prevention is not straightforward.

Social isolation and relationships frames and factors

- Isolation encompasses physical segregation, absence of stimulating activities, and lack of meaningful human contact.
- Isolation has profoundly damaging effects on a person’s ability to cope in prison with particularly intense and enduring effects on young people.
Even short periods of isolation in cell entail negative effects for young people; however, frequent very short periods (an hour or less) was less damaging than less frequent periods (of a day or more), according to one source.

This damage occurs regardless of whether isolation is for disciplinary, protective or regime reasons.

Interactions with staff must be meaningful in order to break down a culture of mistrust and miscommunication.

Family contact and relationships were identified most consistently by young people as helping them cope with the distress of institutionalisation.

Time out of cell for its own sake is not enough, this time needs to be meaningfully occupied with activities which support and allow social development.

**Institutional & environmental frames and factors**

Institutions have particular qualities that put people under pressure to cope and not to disclose difficulties.

They exacerbate, but also cause and are the site of, trauma.

The climate or ‘feel’ of a prison carries significant impact for all, especially prisoners, but also staff and visitors.

Physical environment and design of prison plays an important role in, but may not be able to entirely transform the culture or overcome the harmful effects of fundamentally disciplinary/security-focused institutions.

**Rights-based and person-centred frames and factors**

Dignity, respect, a sense of care and ‘being treated like a person not a number’ emerged as dominant concerns of those in custody.

Specific rights to life, freedom from torture, family, privacy, expression and thought create both limits and duties for the state, which have been legally ruled to have been violated in cases of a young person committing suicide in prison.

An untested ground in the UK is the potential for suicide in prison to be declared homicide, where the state seriously fails in its duties of care.

Rights frameworks are unequivocal about prohibiting the use of solitary confinement for juveniles and segregation for those at risk of self-harm or suicide.

Rights frames see vulnerabilities of those in prison as a grounds of limiting, rather than increasing, state involvement, and they frame vulnerabilities in prison as an inequalities issue.

It is important to guard against rights becoming operationalised in overly technical ways focused on narrow ideas of compliance.

**Conclusions**

The conclusion distils key findings from the evidence on: distress, wellbeing, suicide prevention risk, and challenges. It identifies some areas of best/better practice. It presents the authors’ own synthesis of the strongest messages from the evidence:

- Do not isolate young people.
- Do not deny access to family, belongings and support, ever.
- Maximise time out of cell and availability of stimulating activities and meaningful social relationships.
- Empower and support staff in understanding mental health issues, and address and minimise increasing demands placed on them.
1. Introduction

Background and terms of reference

Deaths of children and young people in custody are rare, but are of deep concern not least because nearly all such deaths are self-inflicted. In Scotland, between 2009-2015, more than 90% (14 out of 16) of deaths of young people (aged 24 or under) in custody were due to suicide; one was due to overdose, and one was a homicide (SPS, 2019). Each death constitutes a profound individual tragedy that also pervades the settings and lives of many others: the prisoners and staff who were present in the face and aftermath of another’s despair, the families, friends and communities of the person who has died. With each death, questions are asked about what might have been or could in future be done differently.

This review emerges as part of the response to the recent deaths in 2018 of two young people, Katie Allan and William (Brown) Lindsay, though it does not investigate or focus on individual cases. It was commissioned by the HM Inspectorate of Prisons for Scotland as part of the Government-appointed Expert Group Review of Mental Health and Wellbeing Support for Young People in Custody, and carried out by a two-person team based at the Scottish Centre for Crime and Justice Research.

The specific terms of reference for the evidence review presented here was to conduct: ‘An evidence review of mental health and wellbeing support for young people in custody including any areas of best practice’. However, literature on these topics is scant and less detailed compared with that which focuses on vulnerability, mental health problems, and especially on suicide in prison. Indeed, a forthcoming article notes (Tweed et al., under review: 5): ‘Most studies purporting to measure mental wellbeing among prison populations have in fact used instruments which measure distress or symptoms of mental illness’.

A frames and factors approach

Our initial plan to prepare a conventional literature review evolved and expanded, as we observed that issues of mental health risk and wellbeing, self-harm and suicide for young people in custody were framed in particular ways dependent on different disciplinary perspectives and methods. Traditional searching techniques supplied an extensive psychological/psychiatric and forensic mental health body of research, but one which was lacking contextualisation and critical engagement particularly in attending to and accounting for the dynamics of penal environments. In seeking a way to incorporate disciplines including sociology, criminology, law, public health and anthropology we also began to realise that different disciplinary frames not only offered a particular perspective on a given issue, but also fundamentally altered understanding of what the problems, and therefore possible solutions, are.

In order to approach this review in a way that is systematic but which avoids defaulting to an isolated disciplinary focus, we adopted a ‘frames and factors’ approach. That is, we have organised the literature we reviewed according to different analytical lenses (frames). Each of

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1 The year 2015 is the last year in which the majority of deaths in custody have had a cause determined through a Fatal Accident Inquiry.
these frames makes visible particular issues (factors) identified as making some evidenced contribution to mental health and wellbeing as well as suicide risk of people in prison. The frames we divided the evidence into are:

- individual/clinical
- operational and situational
- isolation and relationships
- institutional and environmental
- rights-based and person-centred
- concluding with a summary of distress, wellbeing, suicide prevention risk, and challenges

These frames are loosely, but not entirely, a function of different disciplinary perspectives (such as psychiatry, forensic medicine, sociology/criminology, law, anthropology, public health); they also come out of thematic analysis of the literature. For example, relationships (in particular family relationships and contact) were raised as an important factor across psychological, criminological, legal, and prisoner views literatures. Is family contact to be understood as a ‘protective factor’ (clinical frame), a human right (rights frame), a basic human need (isolation and relationships, prisoner voice frames), something inherently shaped and obstructed by being confined (institutional frame), or all of these?

The different frames of analysis presented in the report flag up the challenges of informing action. They do not provide neat, self-contained areas for improvement. Rather, we ultimately conclude that different frames may offer competing priorities and also contradictory paths of action. An example of this is assessment and diagnosis; much research indicates these could be developed further and play a role in identifying and thereby supporting better management of risk (Chapter 4). However, other frames, suggest assessment and risk management processes are part of a problem of: staff burnout and reactive working (Chapter 5); ‘tick box’ compliance rather than care in the eyes of prisoners (Chapter 5); turned to as a result of rather than addressing lack of family contact (Chapter 6); a tool of population management and discipline (Chapter 7); undermining person-centred approaches (Chapter 8).

**Structure of this evidence review**

The review is organised by these different frames. Before we set these out, we explain in the next chapter our methodology and approach to analysis. Following this we contextualise the issue of suicide in prison primarily through descriptive statistics. For each of the main chapters, we begin with a list of ‘key messages’ that highlight the main takeaway points, followed by a more detailed discussion of the issues. Most chapters weave in voices of those in custody and also add a concluding set of quotes. This is not anecdotal illustration of ‘real’ research, but constitutes an important source of evidence itself.

The objective of this structure is to allow the reader to have a self-contained account of each main theme of analysis, allowing one to consult chapters in any order. In the final part of this review, we have attempted to inform the Expert Group’s work by distilling key messages from the evidence about distress, wellbeing, suicide prevention, challenges in all of these, and examples of model practice.
2. Methodology

Key Messages

- While the terms of reference for this review was to identify evidence on ‘mental health and wellbeing support for young people in custody’, most of the research and investigation in this area is on mental health and wellbeing problems and challenges, and particularly focused on suicide and self-harm.

- We rejected a systematic review methodology, on the grounds this produced a patchy, under inclusive and overly medicalised understanding of young people’s mental health issues and coping in institutions.

- We employed a range of search approaches and assessed evidence quality in holistic terms that allowed us to gather high quality information from diverse sources including published academic research, organisational research, government websites, inquiries, commissioned reviews and more.

- We organised material according to different frames of analysis (medical, sociological, organisational, rights-based, prisoner views, and so on) emerging through our thematic assessment of literature. The different frames also make visible (or invisible) particular factors that contribute to risk or wellbeing of people in detention.

Search Approach

Literature search

We adopted standard literature review techniques, initially informed by systematic review methodology. We conducted literature searches through the main databases in social and medical sciences (cross-checked and expanded through Google and Google Scholar searches) using various combinations (of Boolean and natural language) search terms related to:

- mental health / wellbeing
- young people / juvenile / child
- custody / detention / imprisonment / confinement

Searches using combinations of these terms produced over a thousand results from international literature, some of which was clearly not relevant to the Expert Group’s work. Much of the mental health support and wellbeing results were either overly general (lacking in specific evidence) addressing principles of best practice or narrowly focused on evaluations of quite small scale interventions and programmes (often not related to custody). To produce more relevant search results, we subsequently added search terms to the original parameters as follows:

- suicide / self-harm / self-inflicted death / self-inflicted harm

This narrowed and focused results considerably though produced many more references. This included research specifically addressing health and wellbeing risks and outcomes as well as occasional evidence of best, or better, practices in managing custody for young people.
However, the work specifically on young people is limited, and so we also conducted searches of all terms above but excluding “young people / children / child”.

These searches collectively produced over two hundred results appearing to be relevant based on titles. Abstracts were then reviewed for relevance to the Expert Review terms of reference. The most relevant papers were read more closely and further references identified through snowballing from bibliographies in these. We divided the literature between the team, after a quick scan scoring items on a 0 (little/no relevance), 1 (some relevance) and 2 (highly relevant) basis. We focused on reading all top scoring items thoroughly, scanned medium relevant items (mainly useful in flagging up in reference lists more relevant research).

Other information sources

In addition to standard literature review searching we also received a list of key documents from the Expert Group which we scanned and selectively downloaded. These included policy reports, inquiry reports, academic work not turned up in our literature searches. We also drew on prior knowledge of prisons and health and on prisons death to generate relevant sources, and this included, as all research does, coincidental awareness of relevant work. This was how we came to include the Ashley Smith inquiry (see below), a Canadian case of a young woman’s experience and death in custody which triggered extensive review, recommendations and policy change.

We scoured references lists of search results for further research, continuing to snowball, asking colleagues for work they knew of, and also looked at key organisational websites (INQUEST, IAP, Harris Review, SPS) for further relevant items. We did not formally conduct numerical scoring but through the initial ranking exercise had a strong and calibrated sense of this to assess work as we became aware of it.

Literature types

The main types of literature we include in this review can be categorised as follows:

- Health and medical sciences research published in peer review journals
- Social sciences research and writing published in peer review journals, books and other academic outlets
- Organisational reports, websites and consultations (e.g. from professional bodies like the British Medical Association, NICE consultation on preventing suicide in detention, MOJ and SPS sources) that offer some further references to research and set out principles of best practice, or evaluations (e.g. of SPS policies)
- Inquiries and reviews (e.g. Ombudsman thematic reviews, coroner investigation reports) and the range of documents associated with these.

(Which) Evidence

We rejected a strict systematic review approach in determining what material to include in this review. The rejection was for two reasons:

- this would have limited results to a body of work that is overly narrow and patchy, focused on individual/clinical accounts of mental health risk, specific interventions and screening tools to the neglect of other known issues, particularly those that are non-individual and institutionally embedded; and, as a result, we felt
this methodology would have the tendency of continuing to privilege particular studies and study designs that risks amplifying a disproportionate focus on individual/clinical factors, reproducing an imbalanced research evidence base and subsequent policy debate.

Systematic reviews can under include or exclude relevant work sourced from: non-academic authored research and other work (policy reviews, think tank and third sector work, i.e. ‘grey’ literature); books of any kind; websites (an increasingly important form of publication itself, e.g. NICE’s guidelines on prison health); Government publications; research in disciplines where terminology differs and thus will not appear using set search terms. The Harris Review Panel commissioned a literature review (no author, 2015) dominated by clinical research, that in our view, displays and suffers from these issues. That review appeared barely to inform the main review report and none of its findings were reflected in key points of the Harris Panel’s findings or recommendations (2015: 244), being summarised in a third appendix in terms of banal or overly specific conclusions that: (1) it is important to address the mental health of those identified as at risk of self-harm or suicide, (2) CBT and DBT hold potential for working with young people and (3) skilled and motivated staff are crucial.

Our inclusion (and definition) of evidence is based on a quality assessment using the following criteria:

- **Relevance**: relating to mental health and wellbeing in custodial environments; we sought a focus on literature about young people but also included research on all adults where appropriate.
- **Transparency**: it was clear how and what data was gathered so that this can be considered by the reader in assessment of its rigour.
- **Specificity, contextualisation and evidenced**: Excluding speculative and general claims; including findings where these were supported by a clear investigative activity; being clear about particular relevant contexts (such as age, gender, national contexts of evidence).
- **Significance, validity and reliability**: these are important standards of evidence quality, that we assessed in non-statistical terms to mean evidence that is ample/non-anecdotal, and continuously supported or repeated across different sources. A key example of this latter issue (as we discuss below about the use of prior inquiries to inform this evidence review) are numerous staff and prisoner views collectively captured in previous reviews; there is strong consistency of themes identified in these. This includes the Harris Review’s (2015) analysis of 48 surveys and 38 recorded phone calls from young people in prison and the commissioned study it also solicited that included 47 staff interviews, six focus groups and intensive participant observation in five prisons. The Independent Advisory Panel on Deaths in Custody (2017) received and analysed information from 100 detailed letters and 50 transcribed phone calls received in response to its own call for information about preventing suicide and self-harm in custody. Other non-academic reviews contain equally significant bodies of evidence produced through non-academic investigation including the Prison and Probation Ombudsman’s (2014) review of all 361 self-inflicted deaths in custody and the Prison Reform Trust and INQUEST (2012) analysis of 98 deaths of children and young people in custody.

Our selection of evidence to include in the review reflects a:

- **Focus**, but not exclusively so, on young people: definitions vary, but roughly we defined this in line with other work (Harris Review, 2015; PRT/INQUEST, 2012) as up
to age 24 (and refer to children as those aged 18 or under). We include research on adults where this is applicable. Work on young people consistently finds that similar issues and histories apply as with adults but often in more intense ways.

- Focus on the UK: most of the evidence included here is from the UK, often England and Wales where there has been recent significant work on self-inflicted deaths of young people. There are important differences between countries that can restrict comparisons. For example, US prison suicide research has extensively investigated crowding as a predictor; the scale of US prisons (individually and in system terms) and issues of crowding in many parts of the US are of a magnitude that is substantively distinct from anywhere else in the world. This limits and requires careful methodological attention to comparison.

Prior inquiries and investigations

An important source of evidence and guidance on the issues comes from previous investigations and inquiries. Significantly, investigations have approached the issue of suicide risk and self-inflicted death in more wide ranging ways than individual pieces of research, capturing how entangled both the factors associated with risk and the issues needing addressed to support wellbeing are. They also crucially fill a continuing neglect of the perspectives of prisoners and their families as well as frontline prison staff in published research.

The extensive number of documents associated with these reviews are striking in how closely they resonate with each other in their findings and conclusions relating to: the deep and often known issues of mental health difficulties of many if not most young people in custody; failures to share or act on this knowledge to reduce harm; the reliance on front line custodial staff to manage the complexity and challenges of these young people; the observed consequence that behaviour often is managed in disciplinary, damaging and punitive ways.

Ashley Smith inquiries and investigations (2012-13)

The Ashley Smith case in Canada involved the self-inflicted death in 2007 of a 19 year old woman, whose initial 30-day jail sentence at age 15 turned into four years of custody at the time of her suicide. Her detention was continuously extended for disciplinary infractions that largely consisted of self-harming (at least 150 times were recorded) as well as spitting on and verbally abusing staff. She was regularly placed in isolation – described as ‘therapeutic quiet time’ (Bromwich and Kilty, 2017: 158); her death occurred while prison staff were stationed outside her door observing and recording her in her cell. The case entailed two coroner’s investigations, inquiries and extensive academic research. Significantly, the second coroner’s investigation ruled the Ashley Smith’s death a homicide, an issue that has been raised as a possibility in the UK context (see Chapter 8), despite the fact that staff were found to have followed procedures. The findings, recommendations and outcomes produced by this case parallel those for various inquiries in the UK, including that:

- Personal distress and complexity were managed in punitive ways (‘mental health care and decision making throughout Ashley’s time in detention was subordinated to or became primarily accountable to security interests’, Carlisle, 2013: 6);
- Excessive use was made of isolation for disciplinary, protective and management reasons;
• The state should avoid use of detention and particularly isolation for young people, people with mental health needs and women;
• Staff burnout was an issue affecting management of Ashley Smith and an area of recommended change.


The Harris Review (2014-2015) had the remit of exploring whether lessons had been learned about self-inflicted deaths of young people (aged 18-24 years) after the 2007 rollout of a new system used to support prisoners at risk of suicide or self-harm in England and Wales, the Assessment, Care in Custody & Teamwork (ACCT). The Review involved a monumental effort of public and private hearings, commissioning of research, gathering evidence from experts, families, and young people, review of thousands of papers of policies, procedures and statistics, visits to prisons and YOIs and more. Its analysis included information about over 2,000 self-inflicted deaths of children and young adults between 1978 and 2014, and detailed consideration of the 87 deaths occurring between 2007 and 2013. We draw on the many documents of this review throughout this review.

PRT/INQUEST Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison? (2012)

INQUEST and the Prison Reform Trust collaborated to analyse the cases of 98 children and young people (up to age 24) of all 169 who had died in custody in England and Wales between 2003-2011. The vast majority of deaths during 2003-2011 were due to suicide – 85% of all deaths among 18-24 year olds were self-inflicted (for 18-20 year olds, the rate was 92%). Of the six children (aged under 18) who died in this period, five (83%) were by suicide (all hanging). The review offers compelling evidence in support of its findings that the children and young people who died in custody (p.1):

• were some of the most disadvantaged in society and had experienced problems with mental health, self-harm, alcohol and/or drugs;
• had had significant interaction with community agencies before entering prison yet in many cases there were failures in communication and information exchange between prisons and those agencies;
• despite their vulnerability, they had not been diverted out of the criminal justice system at an early stage and had ended up remanded or sentenced to prison;
• were placed in prisons with unsafe environments and cells;
• experienced poor medical care and limited access to therapeutic services in prison;
• had been exposed to bullying and treatment such as segregation and restraint;
• were failed by the systems set up to safeguard them from harm

PPO Ombudsman Review (2014)

This review by the Prisons and Probation Ombudsman involved thematic analysis of all 361 self-inflicted deaths of adults in prisons in England and Wales between 2007-2013, with a focus on the 72 hours leading up to a person’s death. It found a number of patterns among self-inflicted deaths during this period. Its key findings were (p. 6):
risk changes over time and in response to context and events;
contact with health services was common in the final 72 hours and represents a key opportunity for suicide prevention;
prisoners often withhold their distress from staff and fellow prisoners, and processes must be in place to respond effectively when family, friends or other contacts in the community raise concerns;
reception screening needs to take fully into account concerns raised by police, escort services or the courts.

In addition to these major efforts, we also draw heavily on supplementary reports and investigations including a collection of prisoner views gathered by the Independent Advisory Panel on Deaths in Custody (IAP, 2017) comprising 150 letters and phone calls about keeping safe from self-harm in prison; and the investigation conducted by the Children’s Commissioner for England in 2015 which produced a number of documents and young people’s and their families experience of isolation in detention.

**Approach to analysis**

We conducted a thematic analysis of our reading, noting themes that emerged repeatedly relating to factors associated with increased risk of distress, self-harm and suicide as well as factors associated with reducing risk, preventing suicide and supporting wellbeing of people in custody. Through this process we adopted the frames and factors approach discussed in the introduction.
3. Suicide in comparative context

Key Messages

- Suicide in prison occurs at much higher rates than in the general population; it is the leading cause of death for young people in custody.
- Scotland consistently has a higher prison suicide rate than England and Wales, though comparing jurisdictions of such different size and prison population composition is problematic.
- Prison suicide appears to be on the rise in Scotland, though estimating trends is particularly fraught.
- Younger people’s rate of suicide in prison internationally and in Scotland is much higher compared to older age groups in prison, and the disproportion between the suicide rate for people in prison and in the general population is greatest for younger age cohorts.
- Most suicides of young people take place within three months of being detained.

Discussion

This chapter uses statistical information to contextualise prison suicide in Scotland by comparing its rates to other countries, its own rates over time, and consideration of specific issues related to younger people (aged 24 or less). Well-established findings are:

- Suicide in prison is a leading cause of death in detention; in some countries it is the main cause of death in prison (Favril, et al., 2019)
- Suicide levels in prison overall and for younger people and women, is significantly higher than the same levels outside of prison for these groups (Ludlow et al., 2015)

Two particular challenges exist in comparative analysis of prison suicide: first, there are differing definitions of suicide; and second, the quality of data on suicide varies greatly. Both issues significantly affect understanding and interpreting Scottish data. Scotland uniquely uses a cause of death category called ‘event of undetermined intent’ (EUI), explained thus (McDowall, 2019: 2): ‘Where there is no known underlying medical condition and where there is no evidence that the death may be self-inflicted, these deaths are categorised as events of undetermined intent. Deaths which may be suspected as drug related will also be classed as events of undetermined intent until the FAI is concluded.’ Hence, in Scottish prisons drug overdoses, a form of self-inflicted death, are not categorised as suicide, even though Scotland is listed in research (Fazel et al., 2017, Table 1, p. 13) as being a country that does not require proof of intent in self-inflicted death to be counted as suicide. This raises questions about how and whether to exclude drug overdoses from counts of self-inflicted death, and lack of clarity about how this has been counted in other (and especially historical) research. This is a particular issue for reflection in Scotland, evidenced by the fact that EUI deaths increased 333% in the three-year period 2016-18 compared to the previous one, 2013-15 (McDowall, 2019: 4).

Second, there are data quality, availability and accuracy issues of all datasets on prison suicide throughout the world, with specific dimensions to be found in the Scottish data. The SPS
publishes deaths in custody tables on its website but many deaths over the past few years are ‘awaiting determination’ of cause. This reflects the requirement to complete a Fatal Accident Inquiry for all deaths in custody. There is an extraordinarily long time frame in which FAIs are completed. Of the 29 deaths in custody in 2018, the SPS published data lists a formally determined cause for only two (at the time of writing). The year 2013 is the last year of SPS published data for which all causes of death have been determined. This has consequences for the accuracy of research making use of SPS published data: Fazel et al. (2017) ranks Scotland as having a prison suicide rate of 69 (per 100,000 prisoners), well below that of England (at 83 per 100,000 prisoners), but this was based on a count (as published on the SPS website) of 22 suicides between 2011-2014 inclusive. The SPS’s own internal analysis (McDowall, 2019) identifies a total of 31 suicides taking place 2011-14, for a Scottish prison suicide rate of 97 per 100,000. The suicide rate for 2015-2018 (using McDowall, 2019) is 125 per 100,000, which is substantially higher than that observed in England and Wales, and around ten times the rate of suicide for the Scottish population as a whole (it was 13 per 100,000 during 2013-17, Scottish Public Health Observatory, 2018). Figure 3.1 shows these rates, and includes both Fazel, et al.’s (2017) classification and the revised rate based on SPS data. (This review accessed SPS data on deaths in custody published on its website and thus reflecting any updates made, between January and March 2019.)

Faulty data underlie inaccurate findings that can fuel misleading claims. Fazel et al. (2017: 5) notes that ‘prison suicide rates significantly decreased in Scotland’ between 2003 and 2014, on the basis of his team’s apparent undercount of suicide. The authors go on, referencing an un-tested and un-evidenced claim in Bird (2008), that this may be due to ‘changes in drug treatment within custody’ (Id.: 7). Not only is it impossible for a study published in 2008 to explain trends through 2014, but the trend noted appears to be overstated. This claim of significant decline and its attribution to drug treatment changes was repeated in a recent evaluation of the SPS suicide prevention strategy (Nugent, 2018). All of this is to underline the importance of exercising caution in both analysing and interpreting prison suicide data.

Scottish prison suicide over time

By combining a number of studies, it was possible to compile a continuous chronology of prison suicide rates in Scotland between 1980 and 2014. The studies all used four or five year periods (Figure 3.1). If we bracket issues about data quality and definitions mentioned above, there appears to be a trend of suicide increase between 1980 through the late 1990s, followed by a decline from the late 1990s to 2014, and now a rising trend through 2018. This is a crude and un-validated table, and one particular issue would be to clarify whether suicides counted in the 1994-98 and 1999-2003 periods included drug deaths (as this was the focus of the interest of the study reporting suicides in this period, Bird, 2008).

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2 Also note the category ‘event of undetermined intent’ came into use in 2006 (McDowall, 2019).
Figure 3.1 Suicide Rates (per 100,000) in Scottish Prisons 1980-2018

**Sources:**
* 1994-2003 data from Bird (2008); NOTE data is for male suicides only, but given the higher proportion among this gender, the overall rate is not likely to be significantly different by excluding women.
§ 2003-2007 data from Fazel et al. (2011)
§§ 2011-2014 data from Fazel et al. (2017)
(SPS) 2011-14, 2015-2018 data from McDowall (2019) and SPS website reported annual populations.

International comparisons

As noted, the adjusted suicide rate for Scottish prison suicide between 2014-2018 is 125 (per 100,000 prisoners). This is higher than for the same time period in England and Wales (Fazel et al., 2017). And, in fact, Scotland’s prison suicide rate is consistently higher than that of England and Wales; the differing size of these countries and the nature of their prison populations, and other factors of comparison, however, prevents any straightforward interpretation of this fact. Compared to all 24 high income countries in Fazel et al.’s (2017) research, Scotland was ranked 14th highest for suicide based on an uncorrected suicide rate of 69 (per 100,000); at the corrected rate, it would rank as 10th highest suicide rate among 24 high income countries; its current rate (over 2015-18) would place it as 4th highest (if the other countries’ rates have held steady).

Figure 3.2 plots prison suicide rates against national imprisonment rates, showing an unusual association: countries with lower imprisonment rates tend to have higher suicide rates.

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3 Prison suicide rates are calculated by using ‘average daily population’, a measure of prison stock. Scotland’s prison system is notable for having one of the highest rates of turnover (the highest in Europe), a measure of flow, meaning that many thousands of people move through the prison in a given year. Controlling for this factor would improve comparisons across prison systems.
Interestingly, the figure shows that **countries considered to have some of the best reputations for humane prison systems** and approaches to managing them (Norway, Denmark, Finland and Sweden) **also have among the highest prison suicide rates**. However, because the absolute numbers of suicides in any prison system is small while the prison populations of different countries varies massively. For example, Iceland had a single prison suicide between 2011-2014 but given its national prison population of just 130 prisoners means its prison suicide rate would place it at the top quartile of all prisons systems for suicide (Fazel et al., 2017); in addition, many of the Nordic prison systems as well as Scotland have high turnover rates (suggesting denominator problems in calculation of suicide rates). Due to these issues it is difficult to draw strong conclusions; investigation of these relationships would be worthwhile.

**Age, vulnerability and suicide in prison**

The death of a young person in prison remains a relatively rare phenomenon in Scotland, although there has been **at least one and up to four deaths due to suicide in each year between 2005 and 2018 among young people (aged 24 or less)**. By contrast, deaths among older prisoners (30 years or more) for all causes is on the rise (Figure 3.3); this is not surprising given the increasing average age of prisoners and the increasing average length of time prisoners serve in Scotland. Figure 3.4 shows the percentage of deaths in older and younger age groups due to suicide (compared to all deaths within a given age group), making clear how dominant suicide is as a cause of death for younger prisoners compared to older ones (too many causes of death are still awaiting determination for older prisoners for 2016-18 to include this data in the figure). Again, this may be unsurprising given that the older age of prisoners would increase probability of dying by natural causes; however, **the figures underline the fact that when a young person dies in custody, it is typically due to suicide**. International research consistently finds adolescents have even higher rates of suicide compared to adults in prison (e.g. Radeloff et al., 2015 in a German study).
Figure 3.3 Number of deaths in Scottish prisons among older and younger prisoners, 2005-2018

SOURCE: Authors’ analysis of SPS web published data on deaths in custody

Figure 3.4 Proportion of deaths within an age group due to suicide in Scotland, 2005-2018

SOURCE: Authors’ analysis of SPS web published data on deaths in custody.

Bird (2008) presents the data in a slightly different way (Figure 3.5) showing the suicide levels of different age groups (males only) as a proportion of all suicides in prison between 1994 and 2003. This shows that suicide was strongly skewed towards much higher rates among younger people.
Finally, the data from Scotland are consistent with international research, showing that the vast majority (79% or 19 of 24 total suicides 2005-2018) of young people who commit suicide in prison, do so within three months of being detained. In the following chapters of the report (see especially Chapter 5), we note that suicide often occurs in the early days and weeks of custody, as well as refer to various research that suggests young people who are detained have particularly complex and intense backgrounds which means they are at greater risk for distress, vulnerability and self-harm in custodial environments (see also, Jacobson et al, 2010 and PRT/INQUEST, 2012, Robinson et al., 2017).

In Scotland, SPS analysis of suicides in prison over 2016-18 show disproportionately higher levels among younger age groups (McDowall, 2019). For example, while those aged 21 or younger did not account for a large portion of all suicides in prison during 2016-2018 (12% of
all suicides, with those aged between 30-49 accounting for over 60%), their rate relative to suicide among similar age groups in the general population is striking. While younger people (21 years and under) accounted for 12% of prison suicides, the same age group accounted for only 4% of suicides in the overall population, a difference by a factor of three. No other age group in prison had anywhere near such a large disproportion with groups outside prison.  

Emerging research on wellbeing in Scottish prisons

A forthcoming paper (Tweed et al., under review) draws data from three sweeps of the Scottish Prisoner Survey specifically to explore wellbeing. This is a rare example of research using data measuring wellbeing, rather than distress. Its findings offer interesting insights that largely echo findings in literature on distress and its disproportionate levels among younger people and those on remand:

- Across the three survey years (2013, 2015, 2017), there is a decline overall in wellbeing scores.  
- Women had lower wellbeing scores than men in 2013, but there was no observable difference with later years.  
- Older people had higher wellbeing scores than younger people.  
- Those on remand had lower wellbeing scores than sentenced respondents in all three years.  
- Those with multiple previous experiences of prison had lower wellbeing scores.

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4 This is admittedly a crude calculation, and further investigation would control for the age profile of prison compared to that outside prison.
4. Individual and clinical frames and factors

Key Messages

- The individual level characteristics associated with suicide and self-harm in prison, include having a mental disorder, history of prior suicide attempts and suicidal ideation, history of abuse and trauma, having a substance use issue.

- Vulnerability and trauma are common terms of classifying individual risks but are contested concepts that also refer to social structural and criminal justice experiences. This may conflate different issues, and complicate understanding of the mechanisms by which vulnerability translates into risk or need, as well as the best ways of responding to this.

- Research in the health and medical disciplines (psychology/psychiatry, medicine, public health) dominates not only the literature but also guidelines on suicide, self-harm and mental health issues in prison.

- There is increasing recognition of the need to account for institutional and other factors in addition to individual characteristics in understanding risk of suicide and self-harm in prison.

Discussion

Much of the research on the topic of suicide, self-harm, mental health and wellbeing in prison is published in health and related discipline journals, which tends to adopt individual level frames of analysis (emphasising psychological, psychiatric characteristics of the individual and modes of diagnosis and treatment as the response). This literature has provided evidence of a number of individual characteristics associated with higher risk of suicide and self-harm. Kenny et al. (2008: 358) sum up these factors noting in their Australian research that suicidal and self-harming (SSH) young people in custody ‘reported more severe psychopathology, childhood trauma, and psychological distress than non-SSH young offenders. Past emotional abuse, current psychological distress, and depersonalization disorder were significant risk factors for suicidal ideation’. Similarly, a leading UK and international researcher of suicide in prison, Seena Fazel and colleagues produced a systematic review that ‘evidence for major depression and psychotic illnesses in suicide prevalence among prisoners ‘is the strongest.... Another consistent theme is the high rate of substance misuse’ (Fazel et al., 2016: 4).

It is important to keep in mind that mental health problems generally are overrepresented in prison populations: ‘Most prisoners with mental health problems have common conditions such as anxiety and depression’ (Harris Review, 2015: 137; Ludlow et al., 2015: 2, summing up research in this area). The Harris Review also quoted an academic who cites statistics that ‘40% of male and 55% of female prisoners experience suicidal thoughts in their lifetime, compared respectively with 14% and 4% of men and women in the wider community’ (Id.: 140).

The strong association between a history of mental health issues and self-inflicted death is confirmed in UK data via the PPO thematic review of all deaths in in prison in England and
Wales between 2007-2013 which found that ‘three quarters (76%) of the prisoners [who had died] were identified as having mental health issues’ and ‘over a third were already known to have self-harmed or attempted suicide in prison’ (PPO, 2014: 16). ‘Poor mental health has been reported to be even more prevalent among young people in prison’ in England and Wales, with 95 per cent having at least one mental health problem and 80 per cent having more than one’ Ludlow et al., 2015: 2). One literature review found prevalence levels of mental health problems of young people in contact with criminal justice as between 25-81%, with the highest levels found among those in custody (PRT/INQUEST, 2012, citing Hagel, 2002). These issues apply in Scotland; Robinson et al. (2017: 4) summarise findings from a large, longitudinal study of young people in Edinburgh noting: ‘that 15 year olds involved in violent offending were significantly more likely than their non-violent peers to be victims of crime and adult harassment, be involved in self-harming and para-suicidal behaviour’ among other issues including higher rates of ‘social deprivation and family turbulence’.

A common term used in medical/psychological literature on prison suicide is ‘importation risk’, refers to the risk factors people have prior to being imprisoned. WHO guidance (2007) on preventing suicide in jails and prisons, for example, refers to the ‘importation’ model of suicide risk: ‘people who break the law inherently have a lot of risk factors for suicidal behaviour (they “import” risk), and the suicide rate is higher within the offender group even after their release from prison’ (p. 4), adding:

‘Jails and prisons are repositories for vulnerable groups that are traditionally among the highest risk for suicide, such as young males, persons with mental disorders, socially disenfranchised, socially isolated, people with substance use problems, and those who have previously enacted suicidal behaviours.’ (p. 5)

The medical literature increasingly recognises the need for more attention to institutional and wider social or structural factors that contribute to risk of suicide and mental health generally (Dye, 2010, and see Chapter X7). Fazel, et al. (2016: 10), for example conclude that research ‘should move beyond simple prevalence [of mental health disorders] studies and examine the contribution of prison to these excess rates’. Kenny et al. (2008: 359) add with reference specifically to young people in custody:

‘The high rates of self-harm in detention suggest that the detention environment and management practices should be reviewed to identify structural elements that contribute to distress in some young offenders that for a significant minority is associated with SSH ideation and behaviour.’

In a medical/ health frame factors that are treated in other literatures as social structural or institutional environmental can be articulated in terms of the individual (e.g. Fazel et al., 2011: 191, citing the work of Liebling, among others). Fundamentally, the research evidence is clear that ‘there is more [self-inflicted death] risk in the prison system than can be accounted for by imported vulnerabilities alone’ (Ludlow, 2015: vii; and see Stoliker, 2018 in a US study).

Notions of trauma and vulnerability increasingly appear in research and guidance on mental health of young people involved in criminal justice (e.g. Robinson, et al., 2017; BMA, 2014; Saunders, 2014; Wright and Liddle, 2014). Framed at the individual level, these issues are interpreted as limitations and disabilities as qualities of the young person: inability to process rational thought, a tendency towards impulsivity, displays of aggression, inappropriate sexual behaviour. It is important to recognise that vulnerability is a contested concept with critics claiming the term blurs or conflates medical, psychological, social, structural and environmental factors of a person’s situation, and may over medicalise or pathologise young
people from particular backgrounds or involved in typical adolescent behaviour (e.g. smoking marijuana and drinking). It may encourage interventions that undermine or discount the agency and capabilities of people given these labels. Women, and especially younger women, often are considered to have greater or more complex/intense backgrounds of trauma, abuse and vulnerability (e.g. Women in Prison, 2014). However, a study of near lethal self-harm among women prisoners found that situational factors (see Chapter 5) common to all prison suicide was more predictive of self-harm: ‘While socio-demographic factors were only modestly associated with near-lethal self-harm, being on remand, in single cell accommodation, and reporting negative experiences of imprisonment were strong correlates’ (Marzano et al., 2011: 874).

There is also a concern that particular vulnerabilities and trauma concepts medicalise social and inequalities problems, targeting attention on an individual’s behaviour and choices rather than on the state’s duties and limits, as well as fail to recognise professional and institutional responses themselves as traumatic (sometimes called sanctuary trauma, see, Freuh et al., 2005, and see Chapters 7 and 8, and BMA, 2014). This is not to ignore the profound and multiple sources of damage and disadvantage disproportionately found among those in criminal justice settings, but to draw attention to how different frames support alternative ideas about the nature of problems, causes and solutions. Some research on trauma and vulnerabilities is now being deployed to evidence the damage of and the need to avoid detention and isolation of young people (e.g. PRT/INQUEST, 2012; American Psychological Association, nd). The Harris Review was unstinting in its finding that: ‘All young adults in custody are vulnerable’ (2015: 9).

There are a number of other issues raised in the medical and health sciences literature: one issue is the relationship between self-harm and suicide risk. The PPO (2014) investigation of 361 self-inflicted deaths found high levels of self higher among those who died but the cause of death generally differed from the method of self harm (p. 18). The same investigation also found that women had higher numbers of self-harm incidents but lower levels of death (Id.). Other research has found repetitious self-harm behaviour more common among women in prison than men, and stronger associations between suicide and increasing incidents of self-harm (Hawton et al., 2014). McDowall (2019) also notes the overrepresentation of self-harm among women in the Scottish prison system. Fazel et al. (2008) found those ‘with a history of self-harm were over eight times more likely to die from a self-inflicted death than those with no history of it’ (quoted in Harris Review, 2015: 139). However, while there is strong association between self-harm and suicide, it is unclear if self-harm is a predictor of suicide.

A second issue relates to a possible clustering or contagion effect of suicides, particularly in prison settings. Scotland has seen periods where there have been multiple suicides within the same institutions and time periods (e.g. Glenochil in the 1980s, Cornton Vale in the 1990s, Polmont, more recently), but which have never been researched for a contagion effect. Niedzwiedz et al. (2014) identified prisons as an important site of suicide cluster research in their systematic review on the topic and noted most clusters involved young people (see also Cox and Skegg, 1993 on New Zealand).
5. Operational, Situational and Management frames and factors

Key Messages

− There are a strongly consistent set of situational factors regularly observed in prison suicides: being on remand or in the early days/weeks of a sentence; recent contact with health services; recent experience of isolation; a change in circumstances (bereavement, sentence status, relationship breakdown); hanging as the dominant method.

− Screening, intake, assessment and risk management tools have been subject to criticism not only for their design and quality but especially as they are used in practice: available tools often are used inconsistently, the responsibility of otherwise overworked/undertrained staff to implement or facilitate practices that are not experienced as helpful by those in custody.

− Often, information about people’s histories of or changes in risk is readily available but there are problems in sharing this information at the right time, with the right people to support preventive actions.

− Frontline prison and health staff are widely acknowledged as having a powerful influence, both good and bad, on a person’s distress and wellbeing levels. They also are themselves at risk of being overwhelmed, and pulled in different directions between increasing personal engagement with prisoners while also managing heavy paperwork loads and otherwise monitoring prisoners’ risk.

− Translating these factors into prevention for a given individual is not straightforward.

Discussion

The situational factors commonly found among those who have died by their own hand are well-established: being on remand or early in a sentence; hanging as the most common method of death; recent contact with or request for health services; recent experience of isolation (for any reason), or being in isolation or a single cell at the time of death (PPO, 2104; Favril et al., 2019; Humber et al., 2013). In England and Wales, one-quarter of all self-inflicted deaths occurred within a month of entering custody, and 10% occurred within three days (PPO, 2014: 12). These factors are even more pronounced among young people in Scottish prisons: More than half of all 35 young people who died in prison between 2005-2018 did so within their first month of custody (54% or 19 people), and 43% (15) died within their first week. In Scotland, as elsewhere, remand is associated with higher rates of suicide than those serving sentences. The PPO (2014) review of self-inflicted prison deaths emphasised the changing, dynamic quality of people’s disposition to engage in self-harm, identifying a non-exhaustive list of changes in circumstances, or triggers, they observed in the situations of those who had died, including bereavements, anniversaries, changes in sentence status, parole recall, prison transfers, social withdrawal. Induction and reception processes, therefore

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5 Analysis by authors of SPS website data on all deaths in custody of young people up to age 24.
are both crucial opportunities of learning but also in easing the transition into the institutional environment.

Operational and management factors refer to the policies, procedures, tools and practices in use within prisons, that address suicide risk and distress. This includes induction/reception processes; screening and assessment tools and practices for self-harm risk and mental health issues; wellbeing and suicide prevention policies; organisation and deployment of staff to implement policies. This frame also encompasses information gathering and sharing practices, within prisons, between prisons and between prisons and other locations and groups. Areas where concerns have been raised, typically relate to:

- **Timing**: how quickly processes were done, or how quickly requests for help were acted on;
- **Completeness and consistency**: patterns of inconsistent practices of assessment/management or missing data and incomplete information provided;
- **Individualisation**: tools and processes have been criticised as not designed for prisons (Fazel et al., 2016), in being a one size fits all approach, with particular issues noted such as the lack of assessment and screening tools tailored for young adults and reliance on screening delivered to all adults entering prison (PRT/INQUEST, 2012).

**Assessment and screening tools is an area that is particularly problematic in the search for improved outcomes.** Much of the research on screening and assessment isolates and focuses on the qualities of tools themselves, without consideration of contextual factors that affect how such tools are used, how their use impacts on staff time available for other activities, how their use affects prisoners, or how dynamics of penal environments affect their reliability and value. A basic issue affecting accuracy in identification of risk is the underreporting by prisoners of their histories or current feelings of distress (e.g. Borschmann et al., 2017 found fewer than 40% of those with medically validated history of self-harm disclosed this during screening); not disclosing vulnerability and the pressure to be seen to be coping are familiar and embedded dynamics of carceral environments (see Chapter 7).

Concerns also have been raised about accuracy, validity and over determining risk: ‘many diagnostic instruments currently used have not been validated in prisons, and include items that may not be specific’ as well as ‘criteria (disregarding norms and rules, low threshold for aggression or violence, and inability to profit from experience) [that] are together highly correlated with criminogenic factors’ (Fazel et al., 2016: 3). This may explain excessive rates of false positives, and general unreliability of tools (Ibid.).

Gould et al’s. (2018: 356) systematic review of prison suicide risk screening tools recognises some concerns, including ‘overrepresentation of actuarial tools’ in their review and the fact that screening tools generally ‘rely on a restricted range of static risk factors’, but argue ‘suicide screening in the prison environment will fulfil its purpose if it enables the limited number of professional staff available to focus more precisely on “at risk” individuals’ (Id.: 347). This prioritises crisis management over everyday strategies of supporting wellbeing generally in institutional environments. A prisoner view offers a useful insight of the issue:

“The Mental Health Team sent out a questionnaire about how they could do their job better. I replied that they are like an A+E trauma team. Once somebody’s behaviour has got really really really bad, mental health will swoop in and deal with it. But there’s no provision for all the hundreds of low level mental illness/distress/sadness/low IQ stuff going on on the wing. It’s like the NHS that is
only A+E, fabulous at trauma and car smash-ups but no GPs, no cancer care, no school nurses, no ENT clinics.’ (IAP, 2014: 37)

Identification of a person being at risk of self-harm can trigger responses that undermine one’s ability to cope or general wellbeing. For example isolating of the person in a safer cell (see Chapter 6), removing materials which can facilitate self-harm, or instituting through the night checks that are stressful and intrusive. A prisoner perspective (which captures the unclear relationship established in research between suicide and self-harm, see Chapter 4):

‘In prison when someone is seen to be self-harming one of the first things the authorities do is to take away everything the individual could use to harm themselves. This is a dangerous, unconsidered act. The only thing that could be stopping a self-harmer from a suicide attempt is the ability to be able to harm themselves.’ (IAP, 2017: 29)

This is not to say that screening and assessment are not or cannot be part of reducing risk or increasing wellbeing of those in prison. However, how screening tools and prevention plans are used in practice, and what decisions are made based on them, was a major source of criticism and concern in much of the evidence we found.

Moreover, criminological research has identified the pain of psychological assessment itself where ‘one’s experiences and identity are “formalized and institutionalized”... often given an enduring master-label, for example, as someone with “impulsivity problems” or an “anti-social personality”’ (Crewe, 2011: 515). Multiple screenings and assessments also require a person to repeat distressing and confidential details of themselves that may in itself be a stressful experience.

The Harris Review and PRT/INQUEST’s Fatally Flawed (2012) investigation both identified issues in how risk management plans (primarily the ACCT system used in England and Wales) affected overall engagement with people in distress. The Harris Review (2015: 146) found that staff adopted a ‘mechanistic dependency’ on ACCT, partly out of a fear of being blamed if a person died, and which discouraged them from using their discretion. Resonating with this, Ludlow et al. (2015: 34) found in their research on staff that, ‘with some notable exceptions [self-inflicted death] risk was generally managed reactively more than proactively. ACCT dominated and non-ACCT vulnerability management options were generally underdeveloped.’ Prisoner perspectives echoed this finding: ‘on the whole prisoners felt that prisons were less good at the prevention of self-harm and suicide than they were at providing care to those who were subject to ACCT’ (Harris Review, 2015: 146).

The evidence offers potentially mixed messages for staff: on the one hand, overreliance, or mechanistic dependence on tools and plans was seen to undermine more meaningful and proactive engagement with prisoners at risk of self harm. On the other hand, the PPO (2014) investigation concluded prison staff can over rely on a personal assessment of how well a prisoner seems to be coping, disregarding risk factors in their history or situation. Such personal assessments could be flawed due to prison staff lacking understanding of mental health ‘fundamentals’ (Correctional Investigator of Canada, 2017). There is also the problem that ‘distress and vulnerability can often be mistaken for someone simply being “difficult”, “un-cooperative” and “aggressive”’ (Harris Review, 2015: 70, citing evidence of the Royal College of Nurses; see also, BMA, 2014). A regularly observed feature in prison environments is the interpretation of symptoms of distress or mental illness as ‘acting out’ or manipulative behaviour (Galanek, 2013: 209; see also, Rhodes, 2004).
Information that would support enhanced efforts of support and intervention often was available, however. The same PPO (2014: 16) investigation found that more than a third (34%) of people dying from self-inflicted causes between 2007-2013 ‘had seen a healthcare professional within their final 72 hours, compared to just 6% of the prisoners who were not identified as having a history’ of mental health issues. Recent contact with health services may flag a crucial sign of, as well as opportunity to intervene with, those heading towards suicide.

One of the strongest messages from the literature about the need for an assessment of suicide or self-harm risk to be translated in practice as an individualised, engaged plan of intervention and care. This picks up observations that ‘assessment alone is not sufficient if a pre-agreed uniform pathway for managing a child who has been identified as vulnerable is not in place’ (PRT/INQUEST, 2012: 44). This builds on concerns about a one size fits all approach found by researchers and reinforced in staff views that management plans ‘could be more individually tailored’ (Harris Review, 2015: 146). Overall, many reviews underline the ‘[h]uge gulf’ between policies and procedures and actual delivery of care (Harris Review, 2015: 60).

Often staff are the focus of addressing breakdowns between policy and practice, assessment and management. Frontline prison and health staff are in a crucial position to observe, advise and act on people’s changing risk (Wright et al., 2014). ‘Officers working on the residential wings often have the most frequent contact with prisoners. This gives them a particular opportunity to be aware of prisoners who may be becoming more withdrawn or when changes in behaviour may indicate a prisoner at risk’ (PPO 2014: 15). Ludlow et al. (2015: 34) note that among staff: ‘There was widespread underestimation of the potential for early intervention’. Recognition of the importance of the staff role regularly leads to recommendations for staff training and more staff responsibility, for example with the Harris Review’s recommendation in creating a new personal officer role. However, staff are under immense pressures of time and workload, and can feel insufficiently qualified and supported to deal with mental health issues. Staff consulted in the Harris Review felt ACCT required trained (health) professional input and that there were too many for them to manage effectively (2015: 146). Prison staff themselves felt training they received was ‘too focused on procedure at the expense of mental health awareness’ (Harris Review, 2015: 70).

Information recording and sharing have been highlighted as faulty in two ways, in missing opportunities to pass on relevant knowledge (PRT/INQUEST, 2012; Harris Review, 2015), and as an accountability problem where important information that would help clarify practices (such as time out of cell, access to visits, contact with health services and time frames of this) and other key information may not be recorded or available (ADS, 2015; Harris Review, 2015). Information sharing failures have been identified has happening within the prison (between departments and different establishments) and between the prison and those outside of it including services, agencies, families and friends (PRT/INQUEST, 2012). In particular, opportunities have been missed in prisons communicating with those in the community – including professionals but also families – who can fill in the picture of a person’s situation and also identify subtle but important signs indicating deterioration of mental health (Harris Review, 2015).

While recommendations for better, wider, more integrated multi-agency working is a frequent response to information sharing problems, this does not address time, staffing and workload issues required to make this work: the Harris Review (2015: 143) quoted an evidence submission from the Health Inspectorate criticising ‘the limited number of trained and qualified healthcare staff and poor communication processes, [and that] there is not always a
multi-disciplinary/agency, or clinical presence at ACCT or other meetings where prison staff have to determine crucial decisions in further care or risk management’ (see also, PPO, 2016).

Ultimately, there is a challenge in translating situational and operational factors associated with risk of self-harm and suicide into practices that can achieve reductions in these. Academic evidence quoted at length in the Harris Review (2015: 140, quoting Dr David Scott) points out that ‘even if a person who takes their life has mental health problems, this cannot tell us why they took their life at that specific time or provide any insight into the distinct set of interpersonal dynamics leading up to the act’. The risk factors for self-harm are evidence at high levels and in many parts and situations of the prison – how can this be addressed?

A key opportunity appears to be actually enabling, above and beyond creating such roles on paper, frontline staff to have time and disposition to get to know prisoners well. ‘Knowing your prisoner is the heart of everything; the heart of being an officer […]. You have to get to know what the real issues are – what matters most for that person. And the only way to achieve that is through talking and spending time with them. You can manage their risk by working together – ask the prisoner what would help him to cope better and go from there’ (Ludlow et al., 2015: 35).

Another lesson from the evidence is about understanding and harnessing the value of informal and simple measures compared to more technical, expert and formal modes of intervention. ‘I try to get them out [of their cell] whenever I can and give them something to do – even if it’s basic, like sweeping, or mopping, or painting. It keeps them busy. It’s when they’re locked behind their door alone for long stretches that they often get stuck in their own head and it just magnifies everything’ (Prison Officer, Ludlow et al., 2015: 36).

At the same time that frontline staff are crucial, evidence makes clear that management and leadership drive this, and influence wider cultural change in a prison (Harris Review, 2015). Slade and Forester (2015) retrospectively studied a London prison (adult males) that had not experienced a single suicide in three years. It found evidence for the effect of two factors in particular: senior management support for cultural change and cross-professional collaborative working. Senior management support elements included: ‘clear messages that suicide was not inevitable; physical presence on the wings encouraging personal communication; offering hope and support to front-line staff; supporting innovative approaches with clear expectations; and holding staff to account … Crucially, staff reported that the development of an optimistic approach towards suicide prevention was central to this renewed emphasis and its associated outcomes’ (Slade and Forester, 2015: 752-53). Also, ‘the utilisation of a senior-level forensic psychologist to project lead, with experience of working across disciplines, knowledge of prisons, risk management and prison suicide, was considered to provide an effective mix to develop practical and effective strategies. It indicates that project leads within high-risk prisons should be equipped with the skills to manage complex interdisciplinary negotiations, along with sufficient professional knowledge to guide services.’ (Id.: 753)

**What do prisoners say?**

‘In fairness, upon arrival, it was a breath of fresh air. The reception was warm, clean, comfortable and the staff were friendly. I was given a cup of tea by a Listener and he explained the scheme. I then moved to the Induction Wing which was clean, airy and welcoming. The first week was structured and my mood improved significantly.’ (IAP, 2017: 24)

‘the current induction process is inadequate - I speak to many people who have been unable to talk to anyone on the outside even after a week unless they can
remember parents/friends addresses and phone numbers........ They cannot write to or phone loved ones for support at their most vulnerable hopeless moment’ (Harris Review, 2015: 122)

‘My son was fine when he got there but then he had problems with his girlfriend etc. and he became really depressed but no one noticed. If someone just phoned me and told me that they were concerned as he was giving all his clothes away, I would have gone there; I would have told them to watch him carefully. I knew how important his clothes were for him.’ (Harris Review, 2015: 123)

‘I find talking to a member of staff is helpful only if you can see they are listening to wot you say and give you 5 minutes of there time it goes a long way’ (Harris Review Young Adult Strategy, 2015: 8)

‘staffs general attitude has a big impact on prisoners mood.’ (Harris Review Young Adult Strategy, 2015: 8)

‘Officers are not qualified but seem to like to psychoanalyse prisoners that self-harm. They say things like you're manipulating the system, your paranoid etc. When a prisoner presses the call bell first thing staff ask is what's the emergency. That in itself is provoking.’ (IAP, 2017: 19)

‘I wanted to talk to a Listener late in the evening during lock-up. I rang the cell bell and was asked ‘What’s the emergency?’ in an aggressive way. The officer showed no empathy or compassion for me and made what was, for me, a bad situation far worse.’ (IAP, 2017: 16)

Everyday, I think about [suicide] but I made a promise to a very good officer that I would not while I was in prison and would ask for help when I need it. That officer has now gone and now officers don’t care.’ (IAP, 2017: 26)

‘[ACCT] can become a paper exercise of ticking boxes and just deciding how frequent observations should be.’ (IAP, 2017: 38)

‘ACCT needs to address the reasons behind mental health, not just monitor those on suicide watch.’ (IAP, 2017: 38)

‘Instead of saying that you're a pain in the arse and you're going on an ACCT. Give us some support. Try and help us through the hard times that we’re going through.’ (IAP, 2017: 38)

‘Basically [what’s needed is] less paperwork for the staff to do and a bit more time for them to give to people with issues’ (IAP, 2017: 38)

‘You’re put straight on the ACCT, you’re observed. To me that’s OK but it’s not working. Sort of like putting anti-grappling bars on the windows or things to hold ropes up with – they find other ways. So I think it’s worth talking .... All recovery begins with talking rather than just observing. (IAP, 2017: 39)

‘... all too often [ACCT] documents are closed by assessors who have done little to seek the views of the prisoner.’ (IAP, 2017: 39)

‘Having a torch shone in his face every hour at night prevents sleep...This led to massively increased sleep deprivation, which only makes your desperation worse.’ (IAP, 2017: 39)

‘inmates avoid saying how low they are feeling in an attempt NOT to be put on one, in short, you’re encouraged via the ACTT (sic) system to bottle your troubles up, something we all know is one of the worst things you need to do.’ (IAP, 2017: 39)
6. Social and relational frames and factors

Key messages

− Isolation includes a range of physical and social forms of separation including extensive periods locked in cell; lack of meaningful, stimulating activities; lack of supportive and caring social contacts.

− Isolation is identified as profoundly damaging, with extensive evidence specific damage for young people.

− Even short periods of isolation in cell entail negative effects for young people; however, frequent very short periods (an hour or less) was found to be less damaging than less frequent but longer periods (of a day or more).

− This damage occurs regardless of whether isolation is for disciplinary, protective or regime reasons.

− The importance of meaningful and plentiful family contact and peer support in both preventing suicidal and self-harming behaviours and supporting mental wellbeing is a strong theme.

− Interactions with staff must be meaningful in order to break down a culture of mistrust and miscommunication. There is a widespread perception of those in custody that seeking help for mental health issues will lead to negative consequences including intrusive, punitive and distressing responses.

− Time out of cell for its own sake is not enough, this time needs to be meaningful with activities which support and allow social development.

Discussion

A dominant theme across the literature is the major role that social isolation plays in suicide and self-harm, and in issues of coping generally in custody. Social isolation can arise through: disciplinary (segregation) or protective (safer cell) removal to a separate wing and cell; limited regime in which individuals are locked up for substantial periods of the day; lack of opportunities and activities that facilitate meaningful contact with others (including peers, professionals, staff, family and friends); staff shortages or work patterns (as on weekends) leading to longer time locked in cells. On the other hand, reducing isolation and supporting meaningful relationships and activities is a crucial part of a person’s successful coping with institutional environments.
**Solitary confinement or segregation** is the most extreme form of social isolation which sees a person being totally removed from their peers with minimum human contact available. It is defined by the UN (Mandela Rules, 2015, Rule 44) as confinement ‘for 22 or more hours a day without meaningful human contact’ and has been described alongside strip-searching as ‘degrading’ (PRT/INQUEST: 51). While feelings of isolation and hopelessness are inherent to being in prison (Harris Review, 2015, and see Chapter 7), isolation within the prison worsens and deepens this. It is important to note that the damaging effects of isolation do not arise only from the point that one’s segregation reaches the UN definition for solitary confinement:

‘Children interviewed for the purposes of our research described how the experience of isolation generated feelings of boredom, stress, apathy, anxiety, anger, depression and hopelessness. Staff confirmed that even short periods of isolation could trigger self-harm, exacerbate the impact of trauma experienced in the past and cause psychotic episodes.’

(OCCE, 2015: 2)

Isolation also can be exacerbated by the regime within each establishment depending on numerous factors such as family contact arrangements, peer-support schemes and prisoner-staff relationships. The negative feelings from being physically isolated from family and friends outside of prison can also be exacerbated when a person experiences isolation and blocked support networks within prison. This was identified as a key factor in Slade and Forrester (2015: 12) where management led cultural change in a prison supported their conclusion that suicide prevention strategies should not be punitive, but focused more on a culture of integration.

Feelings of isolation which accompany loss of freedom and thoughts of hopelessness within prison contributes to prison suicide (Dye 2010: 797; and see Brown and Day, 2008). Dye studied the combined effects of personal and institutional conditions on suicides in American prisons finding that greater levels of deprivation were associated with higher suicide rates. Various forms of prison deprivation such as how cut off the prison was from society, higher levels of security, less provision of educational and other programs, higher levels of violence were associated with higher suicide rates compared to prisons with lower levels of these forms of deprivation (Id.: 797). This study found that family contact was important, and prisons which helped maintain family contact showed lower rates of suicide (Id.: 797). Family contact is ‘one of the most important areas where actions can be taken to moderate vulnerability and help manage the risk of self-inflicted death’ according to Harris (2015: 120).

Isolation of children in custody is a current focus of research and reform in England and Wales and the US. The **profoundly damaging effects on mental and physical health and on the development of young people** is now well established (Human Rights Watch/ACLU, 2012; Haney, American Psychological Association, nd; Haney, 2018). Research conducted for the Children’s Commissioner of England’s review of isolation of children in secure care and YOIs found that: ‘Several children with histories of mental health problems said that their symptoms worsened during isolation, and the staff agreed that a child’s personal risk of self-harm and suicide is heightened’ (ADS, 2015: 63). The Children’s Commissioner also exposed the use of isolation for varying reasons, sometimes having nothing to do with discipline or protection, and for varying lengths in different kinds of secure accommodation for children. It was observed that YOIs tended to use isolation at lower rates but for much longer periods than secure training centres and other secure accommodation (Id.). A great deal of isolation goes unrecorded and unregulated (Id.). ‘Cellular confinement in YOIs, being a largely unregulated form of isolation, brings its own challenges for children’ (ADS, 2015: 47). Indeed, figures for various kinds of isolation in prison are not routinely reported. Harris and Stanley (2017) listed the diverse and seemingly haphazard reasons for the use of segregation in New Zealand including:

‘Having a history, or indicating thoughts or actions, about self-harm or suicide attempts; behavioural issues, such as violence or not complying with staff; being distressed,
emotional or anxious; exhibiting symptoms of mental health problems, being a forensic patient, or having had previous mental health issues; not coping in the main prison environment or fearing for safety; being a first-time prisoner; having physical health issues, such as injuries, disease or illness; having withdrawals from alcohol or drugs; being a short-stay prisoner or placed as no other space in the prison; coping with death in family; not being an English speaker; processing issue’ (2017: 520)

The reasons for isolating children can be as haphazard and diverse, as found in the UK:

‘YOIs typically do not record when children remain on the residential unit ... all day, for example due to bad behaviour (fighting), not having an a vocational activity to attend or refusal to leave the unit, which can result in remaining locked up for several hours. On the other hand, secure training centres and secure children homes record isolation as single separation even when a child requests to be in their room whether that be for a period of 30 minutes to a couple of hours.’ (ADS, 2015: 50)

Supporting the large body of evidence on the damage of isolation the research on children in England found damage through a loss of control over their lives and absence of meaningful activities (OCCE, 2015). ‘The isolation tends to build up anger and anxiety in children who are likely to already struggle with emotional regulation, thereby often leading to exacerbation rather than alleviation of symptoms’ (ADS, 2015: 63).

Whilst prisons often have it as part of their mission statement to support family contact, **prisons are often too far geographically for families to realistically manage regular visits**. ‘The physical distance and lack of contact with family and friends can fuel a young person’s feeling of isolation, and further undermine their emotional well-being’ (BMA 2014: 38). As well as making it more difficult to visit their loved one in prison, **distance also made it harder for family and friends to be involved with sentence management making the young person feel like they are facing their sentence alone**, compounding their feelings of isolation and vulnerability (Prison Reform Trust and INQUEST 2012: 47-48). The importance of **family support** was expressed in more than one in five letters and telephone calls to the IAP (2017: 33) where **developing and maintaining relationships both for their own sake and to ‘stave off feelings of isolation and depression’** were highlighted. The importance of family contact to reduce reoffending is well established, however there is an argument that family contact for its own sake should also be valued.

By its very nature, prison Is isolating although this can be exacerbated depending on the prison regime and how much association with peers is allowed in order to alleviate these feelings of isolation. **Peer support schemes such as the Listeners have been deemed valuable support mechanisms where and when they are implemented properly with sufficient support from prison staff and management**, and a sense of trust exists in the prison. The reason for this is these schemes are run by fellow prisoners who are specially trained to support those in need rather than manage their risk. Whilst valuable for alleviating stress and feelings of isolation, peer support often is not formally linked to helping staff with suicide prevention (Prison and PPO, 2014: 10). Additionally, ‘Research has shown that having support from peers is valuable to prisoners, since they are able to fully understand problems that staff or other professionals may not’ (Harris Review, 2015: 128; Barker et al.: 235).

Peer-support workers in a position to develop meaningful relationships with vulnerable young people have more of an opportunity to develop further in more supportive regimes— for example establishments which **allow more time out of cell for association and a staff culture which is supportive of these schemes**. Findings by the Harris Review led to recommendations that Governors should place high priority on peer support systems, such as Buddy schemes, Peer Mentors and Prisoner Councils and should ensure that there is a guaranteed commitment from their staff towards these schemes (Harris 2015: 133).
Peer support groups have similarly been recommended in other places, for example in Canada. The various investigations and reviews following the death of Ashley Smith led to recommendations include a permanent peer-support scheme ensuring as much confidential access as necessary to peer-support workers, regardless of whether or not the prisoner is in segregation (Carlisle 2013: Recommendation 5; see also CIC, 2017). However, as has been highlighted in other chapters of this review, much depends on the culture within each prison and relationships between staff in those in their care. There can be scepticism among both prisoners and staff about formal peer support schemes, and there is a dearth generally of research on informal ways that prisoners support each other.

Front-line staff such as personal officers, hall staff and other staff who have daily interactions with prisoners play an important role not only in early intervention but negating feelings of isolation and hopelessness in the first place (see also Chapter 5). The importance of staff/prisoner relationships was evidenced throughout the Harris Review where ‘several young adults named the same officers as being the ones they wanted to talk to and spend time with (Harris, 2015: 65). However, ‘Young Offender Institutions were on average showing poorer scores for the quality of relationships with staff when compared with female prisons and male local prisons (Id.). Research also found pockets of prison staff culture where staff were felt to be distant and unapproachable, and at risk prisoners often are seen as manipulative and attention seeking rather than vulnerable and in need (Ludlow et al., 2015: 6). This means that prisoners will often go to the same member of staff when they are on shift leaving this member of staff with a heavier workload and possibly limiting the level of professional care he can attribute each case. Prisoner/staff relationships have been defined in the literature as key to identifying and managing risk (Ludlow et al 2015: 20; Slade and Forrester, 2015; Wright et al., 2014), and making the difference between inducing further stress or being a protective agent (Ludlow et al 2015: 3).

Frontline staff are well positioned to be helpful to those facing difficulties but only if they have sufficient training, experience and managerial support to recognise where support is needed and provide that help. This is valuable not only once they perceive a person to be at risk of self-harm but to step in long before. The ability to do so however is more through experience than training, according to research by Ludlow et al (2015: 20). Termed ‘jail craft’, this experience alongside ‘knowing your prisoner’ is what prison officers interviewed in Ludlow et al considered most important for self-harm and suicide risks (Id.). Where officers have built high quality relationships with those in their care, they can identify when a person is having issues with common problems such as maintaining family contact, accessing work and/or education or accessing healthcare needs. Developing relationships that the person in their care values will also see them more likely to approach them for help or advice.

Slade and Forrester (2015: 17) found that management must facilitate staff to nurture meaningful relationships by creating a supportive environment in which these relationships can flourish. Key elements identified by the authors in interviews with staff were ‘clear messages that suicide was not inevitable; physical presence on the wings; encouraging personal communication; offering hope and support to front-line staff; supporting innovative approaches with clear expectations; and holding staff to account’ (Id.: 17-18). Alongside other key factors, management supporting staff to feel empowered contributed towards a London adult prison being suicide free for three consecutive years. Staff having sufficient training to develop and maintain meaningful relationships with prisoners could break down feelings of mistrust that leave many feeling they cannot approach them with concerns for fear of being placed straight on ACCT or other reactionary measures aiming to stop suicide or self-harm (IAP, 2017: 39).
However, the literature describes a culture of mistrust when examining relationships between staff and prisoners. In the Bradley Report, children ‘spoke about individual staff who had been good to them’ which echoes the Harris report, but also describing a mistrust of staff as well as other inmates (Harris 2015: 65). Van Ganneken et al. (2017: 80) explain the reason is that ‘rather than trying to cultivate relationships on the basis of mutual trust, staff can be preoccupied with risk in their interactions with prisoners’. Punitive actions based on risk management due to a culture of mistrust towards prisoners was found by Harris and Stanley in their research of At-Risk Units (ARUs) in New Zealand where prisoners were considered to be trying to get easier time or were too afraid to be in the general population (2017: 525). Evidence gathered for the Harris Review (2015: 248) also highlighted the issue of trust towards prison officers, particularly in the early days of custody, when feelings of isolation and vulnerability were at their highest. Also noted in the literature was that building trust between prisoners and staff has become more difficult due to the lack of available staff on wings leaving the staff who are on shift with less time to deal with individual cases (IAP 2017: 15). In addition to this, it is believed that some staff ‘do not project a positive attitude’ which is ‘absorbed by prisoners’ leaving them unwilling to ask for help or taking part in treatments (Id.: 16)

The issue of trust was not restricted to prison staff, it was also noted that trust between prisoners and healthcare staff was of great importance. Where healthcare staff were involved, even if indirectly, with disciplinary measures such as strip searching, this led to damaging perceptions of healthcare and those who provide it. This was viewed as likely to impact the likelihood of someone requesting help (BMA 2014: 39, and see Wright et al., 2014).

Throughout the literature one of the most prominent protective factors against self-harm and suicide is meaningful activity (Lees, et al., 2006; Favril et al 2019: 1; 7; Dye 2010: 798, Van Ginneken 2017: 77, 81; Nugent 2018: 13, 22; Haney 2018: 286-287, 90, 294; Ludlow et al 2015: 65; IAP 2017: 23-24). Meaningful activity is not simply time out of cell but requires something that occupies and stimulates the mind and – this can be family contact, contact with friends outside of prison, education, sports, and association time within prison (Harris 2015: 35-37) as well as vocational training and counselling. Definitions of meaningful/purposeful activity in research do not necessarily coincide with HMPPS and SPS official definitions of purposeful activity, which can be any time a prisoner is out of their cell to complete prison assigned tasks such as cleaning the hall or working in prison work sheds.

The Harris Review investigating self-inflicted deaths of 18-24 year olds in English prisons describes the concept of being locked up all day a ‘disturbing one’. It also found that young people have ‘greater’ needs of both physical and mental stimulation (2015: 35). However, the review found that despite the importance of meaningful activity as a protective factor against suicide and self-harm, too few prisons had sufficient space to allow adequate access to activities such as education or vocational training (2015: 37). The importance of meaningful activity internationally is further highlighted in the Harris Review (2015) by outlining numerous internationally-agreed standards including the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) which states that prisons should aim to provide at least eight hours per day of activities of a varied nature (see also Chapter 8). The reason Harris places such emphasis on the importance of purposeful activity could be the finding that:

“purposeful activity remains highly significant as a protective effect ... the current study suggests that increasing purposeful activity may be particularly important for reducing one of the most pressing mental health problems in prison, namely self-inflicted death.” (IAP 2017: 23)

However, meaningful activity appeared throughout various reviews and studies of prison as something which was lacking in both quantity and quality – and especially for particular groups such as remand prisoners who were often left locked up for larger portions of the day compared to convicted
prisoners, and those on reduced regimes. This is surprising given the weight of the evidence that highlights being on remand as a key risk factor, as well as the early days of incarceration as being at the highest risk of suicide (Favril et al 2019: 42; Harris 2015: 101; Van Ginneken 2017: 80; Fazel et al 2011: 192; HMPPS 2018: 22; Liebling 1992: 5; Liebling 1999: 296, 298; McDowall, 2019; and see Chapter 5).

As well as being an important aim in itself for general mental wellbeing, the availability of purposeful activity can have major implications for family contact. The difficulty of maintaining contact with family when there are not enough access to paid activities is expressed by numerous respondents to ‘keeping safe’ – prisoners views in England and Wales which were collated by the Independent Advisory Panel in 2017 with the aim of preventing suicide and self-harm in custody. Respondents complained of the difficulties getting paid work within a particular prison as well as the high cost of phone calls across establishments. The Service Agreement for Public Sector Prisons outlines the expectation that each prison will ‘have pay and other support systems which reward all purposeful activity’ (2009: 14) as part of the Scottish Prison Service’s incentives and earned privileges scheme. Without the ability to take part in paid activity, many prisoners cannot afford to maintain family contact as these wages are required to purchase phone time and postage stamps, adding further to feelings of social isolation (IAP 2017: 44).

What do prisoners say?

‘As a young offender I felt really vulnerable and scared coming to prison. The main issue is loneliness. Prison breaks you away from your family.’ (Harris Review Young Adult Strategy, 2015: 7)

‘It was a lot of emotions going through my head at once really, I was upset, angry. I’ve gone from being out of my pad all day to being isolated, well locked up really for three days straight so there was a lot of emotions going through my head. I didn’t really know what was going on. I was up and down I was angry smashing up my pad and stuff like that. I ended up tying something round my neck and dropped to the ground.’ (Child in YOI, ADS, 2015: 63)

‘Once you’re in your cell for so long you’re over-thinking, you can stress out; some people get upset and then that can affect them. If there was more to keep us occupied like us coming out more, us doing more activities it would cause less problems as well as in arguments because when you’re in a cell for long and you come out for that hour, people are well stressed! That’s how it causes problems. Cause if they give us more to keep us occupied I think there’d be less problems like that.’ (Child in YOI, OCCE, 2015: 4)

‘[It’s fair] to a point yeah, but they should get you out for cleaning and stuff like that when you’re on bang up. Know what I mean, to keep you a bit sane, know what I mean – obviously if you’re sitting there with only four walls without any afternoon activity they should give you at least the opportunity to come out and clean’ (OCCE, 2015: 6)
7. Institutional and Environmental frames and factors

**Key Messages**

- Institutions have dynamics and effects that cannot be reduced to their respective individual, operational, situational, physical dimensions; prison institutions have particular qualities that put people under pressure to cope and not to disclose difficulties.

- Institutional trauma is the distress caused by imprisonment that is independent of but which can exacerbate an individual or group’s pre-existing vulnerability and ability to cope in custody. Institutional trauma has been described as a form of ‘slow violence’.

- The climate or ‘feel’ of a prison carries significant impact for all, especially prisoners, but also staff and visitors.

- The physical environment and design of prison plays an important role, but may not be able to entirely transform the culture or overcome the harmful effects of fundamentally disciplinary/security-focused institutions.

**Discussion**

Institutions, and specifically penal institutions, have implications for and an effect on wellbeing that is more than the sum of the individual, operational, situational, management, isolation, relational, physical environmental factors that are a part of them. Prisons share features of all large residential institutions in certain operational requirements – to undertake and organise all the tasks involved in managing groups who eat, sleep, work, and move within them, and to ensure the safety and security of all people within them. But they also have a particular culture and qualities as disciplinary and security focused institutions (Bartlett, 2016). These inform the ‘logic’ by which the institution is run and shape the pressures and codes of behaviour on those within them. One of the greatest weaknesses of much of the medical and health sciences work on mental health risk and wellbeing in prison is the neglect of or an unsophisticated account of the institutional factor in contributing to distress and risk. This discussion attempts to allow for a more considered integration of the institutional frame in thinking about an individual’s risk of self-harm in prison. In particular, showing vulnerability, disclosing confidential information about oneself or others, trusting others are crucial for assessment and management of mental health, but in the prison environment can trigger significant negative consequences such as bullying and segregation.

**Institutional trauma** refers to the profound distress that can be caused through the overlapping effects of the physical qualities, daily routines and typical events, organisational culture and prevailing (or constrained) social dynamics of institutions themselves. It can afflict prisoners, staff and visitors in a prison, though is mostly studied in relation to prisoners. It is well-established and well evidenced, but a form which is almost entirely absent in contemporary Scottish interest in trauma. This may be partly because of the different disciplinary perspectives where institutional trauma is documented – primarily in sociological, legal and criminological literatures – in which it is not always called by this name (but may be discussed as environmental, ecological, adaptation, coping, ‘institutional neurosis’ see Jewkes, 2019, or other kinds of strains of being in institutions) compared to the more medical and
health based approaches that measure trauma at the level of the individual and focus on pre-institutional causes (e.g. ACEs). Mills and Kendall employ the concept of ‘slow violence’ to:

(help us recognise the cumulative harmful and often catastrophic emotional and physical effects of everyday practices... such as “bang up” [locked in cells for extensive periods], the inability for prisoners simply to be heard by a compassionate listener, and the hostility expressed not only towards prisoners but also towards [mental health workers and programmes]’ (p. 123).

Liebling (1999: 283) observed ‘discontinuities’ between different paradigms of research where ‘[p]sychological research has concluded the effects of imprisonment are largely minimal’ (p. 284) while sociological research has represented the power of institutions as “brutal”, “mortifying” and “damaging” (p. 285). Prison suicide, she argues, is the ground where these oppositional perspectives might be reconciled (p. 286), and where one can try and elicit the ‘additional strain’ of imprisonment.

De’Veaux (2018) provides a comprehensive list of references on the trauma of prison (rather than pre-existing trauma and its management in prison). Rather than any specific experience of victimisation within prison, it is the accumulation of qualities, effects and demands of being in institutions can combine to trigger both chronic and acute forms of trauma, including: the helplessness and dependence characteristic of institutionalisation, lack of privacy and regular scrutiny by staff (even that which is not objectively intrusive) and witnessing, hearing about or experiencing aggression and harm; routine but invasive practices such as body and cell searches (De’Veaux, 2018, and see Carlisle, 2013). In addition, there is a profound ‘degree of anguish experienced by many prisoners through their own efforts to keep anguish and distress under control’ (Liebling, 1999: 288); that is, the demands of the penal institution to appear to be coping constitutes an institutionally caused harm itself. It is not surprising that research has found “over 80 percent of inmates in all types of penal establishments reported feeling more irritable, more anxious, more depressed, and more apathetic in prison than they did outside” (Liebling, p. 315 citing a 1980s study).

Contemporary support comes from the Children Commissioner for England’s (2015: 4, see Chapter 6). The Harris Review (2015: 9) further articulates the combined effects of institutional qualities (including physical environment, regime, policy and practice):

‘prisons and YOIs are grim environments, bleak and demoralising to the spirit. ... [T]his harsh environment, the impoverished regimes (particularly with current staff shortages) and the restrictions placed on young adults because of their IEP status or because of local policies on the management of gangs, all combine to make the experience of being in prison particularly damaging to developing young adults.’

The damaging effects of custodial institutions are at their most intense in the case of isolation. This is especially thoroughly studied and documented for the most extreme forms of isolation such as long-term solitary confinement, and in terms of the disproportionately damaging effects for particular groups, such as children and young people. However, isolation, and its profoundly negative effects, is not limited to disciplinary or extended forms of segregation. As noted in Chapter 6, even non-disciplinary, and short term forms of being locked in one’s own cell or placed in a safer cell are experienced as, with potentially similar effects of, punitive forms of isolation (see also, Harris and Stanley, 2017). A national US study (Hayes, 2009) found that 62% of 110 juveniles committing suicide had experienced ‘room confinement’ (including for short periods as a ‘timeout’); half committed suicide during this confinement.
Increasing attention has turned within prison studies to the climate of institutional environments, and an influential frame for this was developed by Alison Liebling and colleagues at the Cambridge Institute of Prison Research. They developed a measurement tool for the ‘moral performance and quality of life’ of prisons that uses staff and prisoner surveys as well as ethnographic observation to operationalise concepts like humanity and dignity (e.g. Liebling, 2011, this tool was used in a recent SPS commissioned study of HMP Grampian). While not the only way to conceptualise or research the contribution of prison environment to wellbeing (or its opposite) its application has shown how significantly prisons differ in terms of levels of wellbeing and distress within them even when they have similar populations, policies and governance arrangements; in other words it evidences and isolates the impact of the prison itself. Their study of HMP Warren Hill in England showed it to be among the highest scoring prison ever in terms of respect, relationships, meaningful activities, and morale of both staff and prisoners but also found to their frustration that despite the exemplary work and pervasively positive feelings about this, nearly half prisoners also ‘felt stuck in the system’ and agreed with the statement ‘I need to be careful about everything I do in this prison, or it can be used against me’ (Liebling et al., 2019: 16). Liebling et al. (2019) explained this in terms of resettlement budgets and wider sentencing issues, but it also suggests that even in the most well run prisons, hopelessness, anxiety and lack of trust are not banished.

Rhodes (2004) studied maximum security prisons in the US with a remit for treating those with mental health issues; she points out the potential insoluble internal contradictions of a system mandated to both punish and treat. Prisoners, workers, and administrators all struggle to retain dignity and a sense of self within institutions, and she characterises prisons as settings that place in question the very humanity of those who live and work in them. Overall, work on the environment and climate of prisons makes clear that some practices can reduce the negative effects of detention, but not eliminate them. See also, Samele, et al. (2016), who found that the particular environment and often rapidly turning over populations of penal institutions can limit the work even of otherwise effective mental health interventions and workers.

Can negative institutional effects be ‘designed out’ of the prison? This was the subject of a recent ESRC project led by Prof Yvonne Jewkes. In previous work it was noted “new” [up to date prison design] does not always mean “better”’ (Hancock and Jewkes, 2011: 623), and even the well regarded Nordic prisons (specifically the internationally lauded Halden in Norway), continue to experience suicide and inmate disturbances (Ibid.). Penal institutions fundamentally employ a logic of control and an ethos of ‘surveillance and discipline’ (Jewkes, 2017: 320), and every rewarding or positive aspect of prison simultaneously also becomes an additional opportunity of punishment (Hancock and Jewkes, 2011). A well designed cell can be taken away and the prisoner moved to an austere one; similarly, extra family visits can be allowed and or denied for behaviour; time out of cell reduced, and so on. The question is whether more humane physical design can ameliorate or overcome the inherently damaging effects of custody. Jewkes’ review of prison planning and design in Scotland, England, Wales, Australia, New Zealand, Scandinavia and more explored this question. She found that cost efficiency perceptions and myths (like economies of scale to build as big as possible and centralise services) often overlapped with punitive ideologies (especially in England). She (2018, 2019a, 2019b) offers cautious, and so far speculative, hope that prison architectural design that incorporates humane, rehabilitative values might reduce the negative effects of institutional environments. Key features of prison design that may support less negative effects of institutions relate to building scale (small facilities over large ones), and also living scale (where units are organised around smaller groups than typical prison wings or flats) availability of natural light, access to outdoors, and spaces that support and are made available for engaging activities (Id.).
Jewkes (2018) gives the example of Macmillan Cancer Care centres as a model of institution whose design alters the way people with cancer and their families are engaged, shifting from a medicalised focus on prolonged life (in large hospitals full of the equipment and arranged according what is necessary for treatment and medics), reconstituting ‘patients’ into people whose voice and quality of life are at the centre of unobtrusive service provision. This does raise questions about whether, in adapting these insights, a prison would actually be prison at all, suggesting overcoming fundamental dynamics of carceral institutions means avoiding their use altogether.

The implications of prison’s institutional dynamics and culture for mental health and wellbeing are significant, though under analysed in health and medical literatures (with the exception of medical anthropologies, e.g., Rhodes, 2004; Bartlett, 2016; Galanek, 2013). Research has found that different spaces of the prison have different emotional qualities, with education and chaplaincy in particular being examples of spaces where prisoners felt less hemmed in by institutional pressures (Crawley, 2004; Crewe et al.; Harris Review, 2015: 67).

While research is beginning to explore how institutions might be designed and run to minimise negative effects, the evidence so far suggests harmful environmental effects and dynamics may be inherent in prisons. HMP Grampian was designed according to a more ‘Nordic’ style (Armstrong, 2014) with extensive use of natural light, plexiglass doors and walls in some units, and a college feel, but in a recent FOI reported the highest rates of self-harm compared to older prisons (SPS, 2019b). The issue of prison suicide focuses attention on the most shocking and extreme events of institutional life, but research makes clear that the daily life and routines of confinement, for both short and long staying prisoners are considerable. This frame of analysis suggests a focus on improving the overall environment and culture of an institution may be an essential ingredient of preventing the worst acts of harm. This largely sociological and anthropological literature finds support in medical and health research, such as Slade and Forester’s (2015) study finding that positive cultural change was the dominant factor in explaining an English prison’s ability not to be the site of any suicides over a three year period.

What do prisoners say?

‘In prison [rooms] are really dull which makes the environment worse. It’s like a rainy/dreary day – doesn’t do anything for the spirits.’ (Harris Review Young Adult Strategy, 2015: 5)

‘A wee boy tried to kill himself the other day [...] He [judge] sent him here for seven days when he should be in secure. He’s just a wee boy not cut out for prison’ (‘Oscar’, Nolan et al., 2018: 540)

‘When I was in a local Cat B prison whilst I was on remand on this sentence one of my room mates hung himself in the cell we were sharing ..... this was the first time I actually saw someone hanging when I came back for gym and I had to call for help which stays with you for a long time and I still can’t forget what I saw. I never got no support with dealing with what I saw and I did not know if any support was available I just had to get on with it.’ (IAP, 2017: 30).
8. Rights-based and person-centred frames and factors

Key Messages

- Dignity, respect, a sense of care and ‘being treated like a person not a number’ emerged as dominant concerns in literature focused on rights as well as in literature that presents the views of people in prison.

- Specific rights to life, freedom from torture, family, privacy, expression and thought create both limits and duties for the state, which have been legally ruled to have been violated in cases of a young person committing suicide in prison.

- An untested ground in the UK is the potential for suicide in prison to be declared homicide, where the state seriously fails in its duties of care. This has happened in Canada.

- Rights frameworks are unequivocal about prohibiting the use of solitary confinement for juveniles and segregation for those at risk of self-harm or suicide.

- Rights frames see vulnerabilities of those in prison as a grounds of limiting, rather than increasing, state involvement, and they are increasingly framing vulnerabilities in prison as an inequalities issue.

- It is important to guard against rights becoming operationalised in overly technical ways focused on narrow ideas of compliance.

Discussion

Rights-informed perspectives have become increasingly apparent and important in the literature on the wellbeing and safety of people in prison, specifically in the reports of various inquiries and reviews (e.g. PRT/INQUEST, 2012; INQUEST/T2A, 2015). The language and principles of rights also are dominant in the perspectives of prisoners themselves in their repeated mentions of words like being treated with ‘respect’ and ‘dignity’ and ensuring staff are ‘good, decent people who will treat prisoners with humanity, respect and common sense’ (IAP, 2017: 6). Many people in prison spoke in terms of getting the ‘basics’ right, of being treated in humane, and simply human, ways (Id.). These simple values are not simplistic but reflect the underlying values of fundamental principles of moral and humane treatment of those in detention (Liebling, 2011). We refer to this frame also in terms of being person-centred because prisoner voices, and much of the way rights frames have been developed for young people in particular focus on the right of the person to have a voice and knowledge about what is happening to them.

Of particular note, various authors have pointed out the potential for suicide in custody to amount to such a failure on the state’s duty of care that it constitutes homicide (Harris, 2015: 190; INQUEST/T2A, 2015: 30). This is precisely what happened in the case of Ashley Smith in Canada (see Chapter 2), which was ruled a homicide even though prison staff complied with all procedures. As yet a similar finding has not occurred in cases of a prison suicide in the UK.
Key conventions, rules and frameworks of rights relating to mental health support and suicide prevention in prison especially as this relates to young people are:

1. The European Convention of Human Rights (incorporated in Scotland through the Human Rights Act 1998), for example Article 2 protect the right to life, and Article 3 creates rights against torture and freedom from inhuman and degrading treatment. Additionally, people in prison, and in particular young people, have rights to privacy, family, expression, and thought (see BMA, 2014: 17-21, for a summary).

2. The European Convention on Prevention of Torture (CPT), which the Harris Review (2015: 202) stated required that ‘all young adults in custody must be able to spend a reasonable part of the day (8 hours or more) outside their cells, engaged in purposeful activity of a varied nature’.

3. The Mandela Rules (2012) are the UN’s Minimum Standards of Treatment for prisoners and includes specific rules including a prohibition of solitary confinement of juveniles (Rule 45.1).

4. The Beijing Rules (1985) are the UN’s standards for juvenile justice and emphasise institutionalisation of young people as a last resort (Rule 19.1: The placement of a juvenile in an institution shall always be a disposition of last resort and for the minimum necessary period).

5. The United Nations Rules for the Protection of Juveniles Deprived of their Liberty

6. These UN conventions have informed both the European Prison Rules and legally binding The Prisons and Young Offenders Institutions (Scotland) Rules (2011).

7. Getting It Right for Every Child (GIRFEC) in Scotland specifically places children’s rights and voices at its heart ‘to help them to grow up feeling loved, safe and respected’ and is informed by the UN Convention on the Rights of the Child (Scottish Government, 2019).

Rogan (2018) has conducted a legal review in Europe including the UK specifically relating to implications of human rights standards for prevention and response to prison suicide:

- Article 2 ECHR’s guarantee of the right to life has been ruled to include the state’s duty to prevent suicide in prison, and one specific ruling in a suicide case that ‘where the prison authorities know or ought to know of a threat to life and do not act, they will not have fulfilled their obligation under Article 2’ (Id.: 18). This line of reasoning supported finding a violation of Article 2 in the case of a 16-year old who killed himself in prison in Turkey, where prison authorities were aware of his previous suicide attempts and threats (Ibid.)

- Limited or denied access to health care also can constitute a violation of Article 2.

- Young people, women and people with ‘mental disabilities’ have special status in rules that further place limits on their treatment in detention.

- The Mandela Rules make clear accurate record keeping is a protective measure in rights compliance and the European Committee on Prevention of Torture (CPT) has recommended a central register for recording all suicides in prison (Id.: 20).

- Solitary confinement is a particular area of focus in rights frameworks and is defined as ‘being in confinement for 22 hours or more a day without meaningful human contact’ (Mandela
Rule 44). The CPT has stated that ‘the use of segregation for an inmate at serious risk of attempting self-harm or suicide is totally unsuitable and unacceptable’ (Rogan, 2018: 21).

- Article 2 of the ECHR also has been ruled to create a duty of investigation and accountability in cases of prison suicide that includes an ‘element of public scrutiny’ (Id.: 22).

In addition to Rogan (2018), the Mental Welfare Commissioner for Scotland (2014: 17) stated that GIRFEC creates a duty to involve children and young people in a way which places their views at the centre, but found in its visits to secure care accommodation that ‘young people were not as fully involved in their mental health care as they could be’ (Id.: 7). Other directions that rights debates are taking relate to a suggestion that the conditions of confinement – the quality of physical environment, the levels of bullying, the climate (see Chapter 7) could be grounds for both informing and making rights based challenges to prison sentences specifically of young people and/or vulnerable people (Kerr, 2017, analysing the Canadian context).

The rights of children and young people increasingly is understood in terms of inequality. The BMA described ‘multiple layers of disadvantage’ characteristic of young people in custody (BMA, 2014: 23, quoting a 2012 Prison Reform Trust report Punishing Disadvantage), arguing that ‘every child in the UK is born with an equal right to the conditions necessary for good physical, psychological and emotional health and wellbeing (Id.: 2). This positions imprisonment not simply as a space where young people’s interests should be monitored and protected, but as an exacerbating factor of reduced life chances and equality. The ‘BMA has also expressed growing concern about health inequalities and the social determinants of health in the UK’ and sees practices of youth detention as part of this issue (Id.: 62).

A rights frame of analysis places clear limits on state intrusion into an imprisoned young person’s life, and recognises their autonomy and voice. It draws on evidence of vulnerabilities similar to that in the individual/clinical frame (see Chapter 4) but articulates these in terms of enhanced state duties and right of the young person to be heard and listened to. Rights based views, expressed by lawyers, doctors and prisoners negate the idea that imprisonment provides an unconditionally positive opportunity of addressing unmet health needs. The ‘secure estate can be a less than ideal environment in which to provide that care: all too easily health comes a poor second to security’ (BMA, 2014: 62). And as we pointed out in Chapter 6, practices that isolate out of an interest in ensuring the safety of ‘at risk’ prisoners, more often ‘have served to diminish an undermine humane practices towards suicidal or ‘at-risk’ prisoners’ (Harris and Stanley, 2017: 516). Overall a rights frame draws attention to the importance of basic fair and decent treatment, limits and warns against the actions of the state even when delivered under the banner of helping, reinforcing frames that show the beneficial impact of supportive relationships and prison conditions and the damage of isolation and dull and dangerous prison conditions. However, rights frames can become operationalised in overly technical ways focused on narrow ideas of compliance thus drifting from deeper principles of respect and a basic standard of care (Armstrong, 2018).

**What do prisoners say?**

‘No-one tells you anything, you just need to find out yourself really’ (‘Ethan’, Nolan et al., 2018).

‘[I] am simply explaining how incredibly frustrating, inhumane and uncaring this environment is. I have been in so much pain at times, I have given serious consideration to attempting suicide. I have, at times, felt completely invisible.’ (IAP, 2017: 21)

‘let me work let me feel human again’ (IAP, 2017: 23)
‘...the loss or feelings of loss of ones own humanity can lead to despair that for some may lead to self harm and suicide’ (IAP, 2017: 30)

‘Overall I don’t think the staff are bad when you get to no [sic] them but there are a few I don’t like to be honest they talk to us like dirt but I haven’t had that 4 a while so things are looking up (sic)’ (Harris Review Report, 2015: 65)

‘staff speaking to prisoners with a decent attitude – not speaking to us like shit for no reason.” Harris Review Youth Engagement Report, 2015: 8)

‘Not to be treated like nothing treat them with dignity and respect they are son, father, brother or grandfather of a human being’ (IAP, 2017: 16)

‘I’ve been a self-harmer since the age of 13…I’ve tried stringing up numerous times but they don’t seem to care. They just do the paperwork in front of the governor and they don’t seem to care at all I am to them is another number.’ (IAP, 2017: 16)

[feeling suicidal after the death of a teenaged son] ‘This man [officer] took the time to sit and talk to me not as a prison officer and prisoner but as two human beings. This man turned the tide for me’ (IAP, 2017: 17)

[These views are echoed by young people, not in prison, who have experienced mental health distress:

‘It was important for me not to feel like an abstract or a ‘patient’, rather a human being that to some extent wanted to take control and be involved in my care. I wanted to understand why I was feeling the way I did and not be a figure on a waiting list.’ (NHS/NCCMH), 2018)]
9. Conclusion: Reducing risk, increasing wellbeing?

This final chapter distils content from the previous chapters to list the most frequently identified factors in associated with distress, supporting wellbeing and preventing suicide in custody.

As already noted, the extensive information that is available about self harm and self-inflicted death reveals clear patterns and associations, but this does not itself constitute evidence or always suggest a clear course of action to prevent future instances of harm. In addition, reducing risk is not necessarily the same thing as increasing or supporting wellbeing, though these issues often are conflated. In short, keeping someone alive is not the same thing as keeping someone well. Evidence specifically exploring and testing ways of increasing wellbeing is especially limited, but there are some promising ideas, and we have included these below.

The material is organised into what the evidence tells us about: causes of distress, facilitators of wellbeing and specific guidance in relation to suicide prevention and risk management. A section on challenges further underlines the barriers to addressing known causes of distress and known enablers of wellbeing, and makes clear that issues of distress and wellbeing are entangled and difficult to address individually or separately. The chapter concludes with excerpts from sources about models of practice.

If we were to conclude what in our opinion were the most important findings around supporting the mental health and wellbeing of young people in custody, it would be:

− Do not isolate young people at all: divert young people from custody wherever possible.
− Do not deny access to family, belongings and support even when being disciplined: if there is an unavoidable reason a young person requires temporary separation from others this should be on a justified and tightly limited basis and with continued access to personal belongings, family contact and supportive engagement with staff.
− Maximise time out of cell and availability of stimulating activities and meaningful social relationships.
− Support prison staff in learning about mental health issues, empowering caring relationships with those in custody, and able to develop positive informal modes of engagement.
### Distress: What does the evidence say about the context and causes of distress in custody?

**Context:** Custodial environments feature widespread levels of anxiety, depression, low mood, low self-esteem, vulnerability.

**Causes and contributors:**
- Isolation, segregation for any reason (disciplinary, protective, operational)
- Boredom, loneliness
- Bullying by staff or other prisoners
- Witnessing bullying or distress in staff or other prisoners
- Lack of or limited family contact or access
- Lack of action in response to requests for help and services
- Fearful, untrusting institutional culture
- Bleak, grim physical environment
- Limited/no activities that are stimulating, social and meaningful
- Lack of limited availability of professional support and services
- Lack of awareness and expertise in mental health basics, vulnerability/distress manifestations
- Intrusive forms of contact (body and cell searches, through the night suicide monitoring checks)
- Overly formal, impersonal forms of contact; a sense of paperwork and tickbox compliance driving action

### Wellbeing: What does the evidence say about the context and supports for wellbeing in custody?

**Context:** Generalised, establishment wide issue, best addressed continuously and over longer periods.

**Causes and contributors:**
- Supportive and enabled relationships with staff prisoners, family, friends
- Opportunities and encouragement of informal, supportive work with young people
- High quality, quantities and developmentally appropriate of leisure, educational, work
- Time out of cell
- Regular family contact in multiple ways (visits, phone, family activities)
- Feelings of being heard and listened to, having people (staff, prisoners, others) one can turn to for help
- Management, leadership actively engaged and effective
- Hope about one’s life, possibility of release
- Empowering, optimistic, hopeful staff culture
- Confidential, accessible, readily available health services
- Possibly attractive physical environment, smaller scale of establishments/units

**Suicide risk and prevention: What does the evidence say about the signs and prevention of suicide risk in custody?**

**Context:** Need arises due to particular, often urgent situations and intensive prevention/support efforts should be individualised, targeted, time limited

Factors that should trigger close monitoring and support:
- Recent, repetitious, increasing self-harm
- Recent change in circumstances
- Recent contact, request health services

Factors that facilitate higher chances of prevention:
- Fast and thorough info gathering from all sources
- Clinical assessment and management of risk
- Careful, caring, attentive management of the first night, week and month in custody
- Involving person at risk of harm in discussions and decisions

**Challenges**

Causes and contributors:
- Difficult complex backgrounds and behaviours of people in custody
- Consideration in isolation or prioritisation of factors associated with different frames, especially focusing on individual/clinical and situational factors
- Inherent and possibly insoluble tension in security and care roles of prison, institutional forms of trauma
- Pressures on staff and staffing
- Scale and condition of physical environments
- Management and leadership in particular establishments
- Distress, vulnerability and situational factors are widespread – cannot ‘target’ based on these
- Timely, accurate, public data on deaths in custody (in Scotland, the FAI system is a challenge)
- Lack of specific evidence on many issues to inform best practice
- Resources to implement good practice and support
- Need of tailored services and responses, that may or may not be available locally and depend on precarious sources of support (e.g. third sector, grassroots organisations)
- Rapid turnover in custodial populations (especially an issue in Scotland and in remand and youth/young person custodial settings)
Office of the Children’s Commissioner (2011) ‘I think I must have been born bad’: Emotional wellbeing and mental health of children and young people in the youth justice system:

HMYOI Hindley was established as a 440-bed young offender institution across seven accommodation blocks, making it the largest such facility in Western Europe. In a comparatively short time, Hindley has overcome challenges to establish itself as an exemplar of good practice in provision for the emotional and mental health needs of the children it houses. Key to this has been effective leadership.

All senior staff had knowledge of attachment theory and demonstrated a good degree of awareness of mental health and emotional wellbeing.

Key to this has been effective leadership.
• Good reception and first night induction
• Effective support for those at risk of self harm or suicide
• Good child protection procedures
• Access to equivalent community based health services
• Full range of therapeutic services have been commissioned

Ludlow, A. et al. (2015) Self-inflicted deaths in NOMS’ custody amongst 18-24 year olds, staff experience, knowledge and views (commissioned by the Harris Review):

Where prisons were described by interviewees as working ‘at their best’, services were highly integrated and communication channels between services within the prison, with relevant outside services and with other prisons were well established and regularly used. (pp. 65-66)


This research retrospectively studied a London prison (adult males) that had not experienced a single suicide in three years. It found evidence for the effect of two factors in particular: senior management support for cultural change and cross-professional collaborative working. Senior management support elements included: ‘clear messages that suicide was not inevitable; physical presence on the wings; encouraging personal communication; offering hope and support to front-line staff; supporting innovative approaches with clear expectations; and holding staff to account ... Crucially, staff reported that the development of an optimistic approach towards suicide prevention was central to this renewed emphasis and its associated outcomes.’ Also, ‘the utilisation of a senior-level forensic psychologist to project lead, with experience of working across disciplines, knowledge of prisons, risk management and prison suicide, was considered to provide an effective mix to develop practical and effective strategies. It indicates that project leads within high-risk prisons should be equipped with the skills to manage complex interdisciplinary negotiations, along with sufficient professional knowledge to guide services.’
Marzano et al. (2016) Prevention of Suicidal Behaviour in Prisons: An overview of initiatives based on a systematic review of research on near-lethal suicide attempts:

Ideally, preventative interventions should address both clinical and prison-related factors, and be sensitive to the needs and vulnerabilities of different groups of prisoners (p. 331)

Scottish Government action plan on suicide (2018):

‘people at risk of suicide feel able to ask for help, and have access to skilled staff and well-coordinated support’


We would like the framework to be a starting point to break down the fear of the unknown of how to speak with someone in a very fragile mental state. [...] I hope this framework encourages people to act with kindness, hope, compassion and humanity.
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Organised by primary focus and categorisation in evidence review. Sources below may be cited in multiple chapters.

**CHAPTER 2 METHODOLOGY (Prior Inquiries and Investigations)**


**CHAPTER 3 SUICIDE IN COMPARATIVE CONTEXT**


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**CHAPTER 4 INDIVIDUAL AND CLINICAL FRAMES & FACTORS**

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**CHAPTER 8 RIGHTS-BASED AND PERSON-CENTRED FRAMES AND FACTORS**

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