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To cite this article: Naomi Humber , Adrian Hayes , Jane Senior , Tom Fahy & Jenny Shaw (2011) Identifying, monitoring and managing prisoners at risk of self-harm/suicide in England and Wales, The Journal of Forensic Psychiatry & Psychology, 22:1, 22-51, DOI: [10.1080/14789949.2010.518245](https://doi.org/10.1080/14789949.2010.518245)

To link to this article: <https://doi.org/10.1080/14789949.2010.518245>



Published online: 05 Nov 2010.



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Identifying, monitoring and managing prisoners at risk of self-harm/suicide in England and Wales

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(Received 18 January 2010; final version received 18 August 2010)

Rates of self-harm/suicide in prisons are high and procedures for the management of risk are important in reducing such rates. The aim of this study was to evaluate a pilot initiative developed to improve the management of those at risk of self-harm/suicide (Assessment, Care in Custody and Teamwork [ACCT]). The method involved reception screening, clinical presentations of prisoners, care planning and mental health provision for prisoners at risk being compared before and after the pilot. The results were as follows: At reception, there was no change in the proportion of prisoners with suicidal ideation who were placed on an at risk document. While in prison, ACCTs being more likely to be opened following factors indicative of risk rather than actual self-harm and were more likely to contain 'quality' entries suggesting improved care of and engagement with vulnerable prisoners. While under the care of an at risk system, a higher proportion of prisoners were likely to be receiving primary mental health care input prior to ACCT implementation and prisoners on ACCT were more likely to be depressed but to be receiving no mental health care. Post-closure reviews were significantly less likely after the introduction of ACCT. The ACCT was piloted followed by phased implementation across the prison estate and findings are discussed in relation to further policy developments.

Keywords: risk assessment; prison; prisoners; risk; forensic setting; forensic

Introduction

Prison populations are growing at a rate which exceeds general population growth (Kinner, 2008). Prisoners have various health and social inequalities (Social Exclusion Unit, 2002) and an increased prevalence of mental health problems (Fazel & Danesh, 2002). Mental health problems are the most

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significant cause of morbidity (Fazel & Danesh, 2002) and suicide is the leading cause of death in prisoner populations in most Western countries (Konrad et al., 2007). Increasing attention is being paid to the prevention of suicide in prison (Daigle et al., 2007; Konrad et al., 2007).

Studies of suicide in prison have demonstrated that rates are consistently higher than the general population and this is a historically consistent phenomenon across Western countries including the UK (Fazel, Cartright, Norman-Nott, & Hawton, 2008; Shaw, Baker, Hunt, Moloney, & Appleby, 2004), the USA (DuRand, Burtka, Federman, Haycox, & Smith, 1995), Australia (Dalton, 1998), Finland (Joukamaa, 1997), Austria (Fruehwald, Frottier, Matschnig, König, & Bauer, 2004), Italy (Tatarelli, Mancinelli, Taggi, & Polidori, 1999) and Canada (Wobeser, Datema, Bechard, & Ford, 2002).

Over the last few decades, national and international studies have reported that the characteristics associated with increased risk of suicide in jails, prisons and other penal institutions include being on remand, being charged with or convicted of a violent offence, being located in single cell accommodation, having a history of self-harm, having a history of drug and/or alcohol misuse and having a psychiatric diagnosis (Dalton, 1999; Fazel et al., 2008; Fruehwald et al., 2004; Hayes & Rowan, 1988; Humber, unpublished thesis; Shaw et al., 2004; Wobeser, Datema, Bechard, & Ford, 2002).

The provision of adequate and effective suicide prevention strategies is of paramount importance to reduce rates of self-harm/suicide in custodial settings and significant reductions in rates can be achieved once comprehensive prevention programmes have been implemented (Gallagher & Dobrin, 2005; White & Schimmel, 1995). The evaluation of such service-level factors is crucial to inform policy and practice and improve the care of this vulnerable population. For those prisoners identified as being at risk of self-harm/suicide, England and Wales, Scotland and Australia have developed multi-disciplinary care planning systems to plan, supervise and care for prisoners in crisis (Power, Swanson, Luke, Jackson, & Biggam, 2003; Senior et al., 2002; Western Australia Department of Justice Suicide Prevention Taskforce, 2002). Such care planning systems can include increased supervision and observation, increased social support, counselling and special accommodation. Studies which have evaluated risk management and care planning systems have found that both multi-disciplinary working and comprehensive staff training emerged as of key importance in providing effective care and support for at risk prisoners (Power et al., 2003; Senior et al., 2002; Western Australia Department of Justice Suicide Prevention Taskforce, 2002).

Custodial settings differ internationally with respect to prisoner populations and local conditions to identify, monitor and manage self-harm/suicidal behaviour. Suicide prevention strategies are underpinned by prison or correctional policies and procedures, with organisational leadership for the accountability of the management of at risk prisoners. These

arrangements can vary and in terms of their specific suicide prevention strategies and these factors may influence suicide rates in different ways (Konrad et al., 2007). Although the specifics of the programmes may differ in response to local resources and prisoner need, the *International Association for Suicide Prevention Task Force on Suicide in Prisons* highlighted a number of important service-level strategies which could be regarded as a general basis for best practice in suicide prevention in prisons in Western societies, including reception screening, comprehensive identification, monitoring and management of those at risk of self-harm/suicide, staff training, inter-/multi-disciplinary liaison and communication, mental health intervention and treatment (Konrad et al., 2007).

An important part of suicide prevention and effective risk management in prison are care pathways from reception screening and the referral for any clinical need or problem identified while the prisoner is at reception. Many suicides in prison occur within the initial stages of custody (Towl & Crighton, 1998) and suicide screening must occur immediately at reception into prison to ensure risk is assessed and identified (Fruehwald et al., 2004). Once risk of self-harm/suicide has been identified or self-harm/suicidal ideation expressed (Kekka, Argyiou, & Beratis, 2006), adequate measures, such as being placed under observation or a multi-disciplinary care planning system of risk management needs to be implemented. A mental health professional should assess the prisoner as soon as possible to identify clinical need and make any appropriate specialist mental health referrals (Dahle, Lohner, & Konrad, 2005; Daigle et al., 2007).

When self-harm/suicide risk has been identified, adequate and appropriate monitoring and management are necessary (Konrad et al., 2007). A management process must be established with clearly articulated policies and procedures outlining responsibilities for staff, such as care planning, continued supervision/monitoring and mental health intervention for prisoners who have been identified as at risk of self-harm/suicide. Staff should ensure that appropriate prison, healthcare and specialist staff are informed of the individual dynamic status of each prisoner placed on self-harm/suicide procedural care. Multi-disciplinary team meetings and case reviews including prison, healthcare and specialist mental health staff should occur on a regular basis to discuss the status and needs of a prisoner at risk of self-harm/suicide. The authorisation of self-harm/suicide risk monitoring and management should be documented on designated forms and distributed to appropriate staff involved in the care of the prisoner. This documentation should be comprehensive, accurate and up-to-date to ensure effective care and management. Follow-up management and care, which includes contingency plans should there be a risk re-lapse, is required so that the prisoner can be effectively managed in the future.

In targeting the prevention of suicide in prison, most Western prison or correctional systems should evolve around the availability of mental health services (Daigle et al., 2007). Prisoners have a high rate of mental illness and a significant concern in the care of those with mental disorder is the risk of self-harm/suicide (Fazel & Danesh, 2002). All prisoners who present a risk of self-harm/suicide should be provided with adequate mental health referral, assessment and treatment to address any clinical needs.

A key element in many suicide prevention strategies in European countries, the USA, Canada and Australia is staff training in mental health and suicide awareness (Aardema, Blaauw, Gatherer, & Kerkhof, 1999; Camilleri, McArthur, & Webb, 1999; Cox & Morschauser, 1997; Hayes, 1995). Most prison suicides occur on wings or housing units (Shaw et al., 2004) and training should be given to discipline or correctional staff for awareness of mental health problems and risk factors indicative of potential self-harm/suicide to protect prisoners in their care. All prison or correctional staff should receive initial suicide prevention training followed by refresher training each year to ensure the efficient identification of factors associated with mental illness and self-harm/suicide risk (Konrad et al., 2007). Factors indicative of risk for self-harm/suicide, such as mental illness and drug/alcohol withdrawal (Fruehwald et al., 2004; Shaw et al., 2004) should form part of mental health awareness training for prison or correctional staff so it is identified as early as possible in the custodial process to protect vulnerable prisoners and aid prevention strategies.

This study sought to evaluate a pilot initiative for identifying, monitoring and managing prisoners at risk of self-harm/suicide in England and Wales. The pilot was conducted in five prisons and formed one part of a wider programme of work to reduce rates of self-harm/suicide. The procedures referred to in this article relate to a UK context but have implications for international systems of care for at risk prisoner populations. As a recent case-control study of suicide by prisoners in England and Wales reported that suicides were nearly nine times more likely than controls to have been monitored by a self-harm/suicide at risk system during the prison term (Humber unpublished thesis), it was deemed important to consider and reflect upon the findings from the pilot evaluation study in light of more recent policy developments. The pilot initiative evaluated in this study was followed by a full implementation of the system, which has now been operating for some years, and the findings presented in this article were discussed internally at that time (Senior et al., 2005). However, during this later stage the findings can be discussed with regard to what has worked well and what needs improvement in the strategies implemented to prevent suicide in prison.

The UK has a long tradition of developing, maintaining and reviewing strategies for reducing the risk of self-harm/suicide in prisons. In 1994, the Prison Service launched a new strategy for prisoners at risk of suicide called *Caring for the Suicidal in Custody*. Key features of the strategy included a

multi-disciplinary approach, a local suicide awareness team in each prison establishment and case-conferences for at risk prisoners (HM Prison Service, 2001b). A self-harm/suicide at risk form, *Form 2052 for Suicide/Self-Harm (F2052SH)* was introduced to monitor and manage those deemed to be at risk (HM Prison Service, 1994a,b, 1995).

From 1994, prisoners at risk of suicide in England and Wales were identified, assessed and managed through procedures known as the F2052SH, named after the documentation completed in such circumstances. When an F2052SH was active, it was referred to as 'open'. The F2052SH procedure emphasised multi-disciplinary care, whereby any member of staff, either in prison or during court proceedings, could open a document, so identifying a prisoner as being at risk. The document specified who opened the document (e.g. court, prison, healthcare staff) and the date that it was opened. The reason/s for the opening of the document and deeming the prisoner to be at risk of self-harm/suicide were specified. A member of healthcare staff, such as a Doctor or Nurse was required to conduct a medical assessment of the prisoner within a specified time of the document being opened, including mental state and self-harm/suicide risk which would be recorded in both the F2052SH and the prisoner's clinical record. After an initial assessment, a care plan was drawn up which required a multi-disciplinary approach to care for the prisoner. The care plan was reviewed at multi-disciplinary case reviews, which were held at specific regular fixed intervals, with all contact with the prisoner detailed. The F2052SH was designed to ensure prison staff kept a concise record of the prisoner's care, needs and problems. Regular notes were required to be made by staff about the prisoner, such as periodic observations of and comments on their subjective/objective mood and behaviour which were documented in line with the specified level of observation and monitoring stated (e.g. random, every 15 min, every 30 min). In the document, entries related to elements of the care plan and documented evidence of engagement/communication with the prisoner were expected rather than merely surveillance.

If the prisoner moved to another wing or prison, the document accompanied them so that all prison staff were aware of the monitoring and management procedures in place for the prisoner. Prison staff were required to complete the F2052SH document as per policy and evidence of fulfilling the form at specified intervals were a procedural requirement. An F2052SH was referred to as 'closed' when risk was considered to be adequately reduced and the prisoner was no longer to be managed under the system. A post-closure review was held with staff involved in the care of the prisoner to discuss follow-up care and any risk indicators that could be identified for signs of mental health state deterioration and increased self-harm/suicide risk along with specified contingency plans.

The *Caring for the Suicidal in Custody* strategy was the subject of two subsequent reviews to determine whether its suicide prevention procedures

were effective. In 1990, Her Majesty's Chief Inspectorate of Prisons reviewed the strategy and reported it to be in general terms 'fundamentally sound', although certain faults were identified. In 1999, HMCIP criticised senior management for inconsistent adherence to the strategy, such as, the lack of case reviews, quality documentation or audits. There was a lack of any awareness training for staff on suicide and self-harming behaviour. As such, fundamental problems began to emerge, such as, the use of the at risk F2052SH document as an apparent paper exercise with little appropriate care given to suicidal prisoners (HMCIP, 1999). In response to the findings of HMCIP, HM Prison Service conducted an internal review which supported many of the criticisms documented, including the lack of suicide awareness training for prison staff, identification of prisoners at risk of suicide/self-harm, policy compliance and 'at risk' protocol adherence (HM Prison Service, 2001b). The F2052SH was generally criticised as having ineffectual care plans, a reactive procedure with inadequate identification of current risk, poor individualised care planning, a lack of professional accountability and inter-agency sharing of risk-pertinent information (HM Inspectorate of Prisons, 1999; Royal College of Psychiatrists, 2002; Senior et al., 2002).

At around this time, the Scottish Prison Service had commissioned Gunn (1996) to produce an internal report on their suicide prevention strategy and this along with Power's (1997) Evaluation of the Scottish Prison Service suicide prevention strategy report allowed the Scottish Prison Service to revise its strategy. The result was a greater emphasis on a 'care' and 'teamwork' approach. The document known as ACT (Assessment-Context-Teamwork) was introduced in 1998. This work had a major impact on the development of new ways of thinking for suicide prevention in prisons in England and Wales, particularly the recommendation that all prison staff should have mandatory mental health and suicide awareness training.

After an extensive criticism, the *Caring for the Suicidal in Custody* strategy was replaced by the *Prison Service Order (PSO) 2700: Suicide and Self-harm Prevention*, which commenced in January 2003. The procedure for caring for a prisoner at risk of self-harm/suicide was more clearly defined, as were the specific roles and responsibilities of prison staff. It also highlighted particular factors associated with suicidal risk, such as, the early stages of custody and drug withdrawal.

The Safer Custody Group was established by the Home Office in 2001. The Group (which is now called the Safer Custody and Offender Policy Group within the Ministry of Justice) is a dedicated unit to help and protect vulnerable prisoners. One of its aims is to lead on developing policy and support prisons in England and Wales to implement policy on preventing self-harm/suicide. Between 2001 and 2004, the Prison Service set up a substantial programme of work called *The Safer Custody Programme* which involved major policy initiatives to develop and pilot improved ways of reducing suicides. This included a wide range of initiatives, such as new

forms of prisoner peer support, improvements in reception screening and induction processes, improved integration with healthcare, revised standards for self-harm and suicides including environmental risk assessments, risk information transfer, mental health in-reach, deaths in custody investigations policy, detoxification units, the funding of suicide prevention coordinators in high-risk prisons and the development of a revised care planning system for at risk prisoners called Assessment, Care in Custody and Teamwork (ACCT).

In view of criticisms of the F2052SH system, a pilot risk management system was developed called ACCT (HM Prison Service, 2005) and was initially introduced into five pilot prisons. This system retains much of the philosophy of the F2052SH with a multi-disciplinary approach. Once monitored under this system, the ACCT is said to be 'open' and following acceptable reductions in the perceived risks, the prisoner is no longer monitored under the system and the ACCT is said to be 'closed'.

Compared to the previous F2052SH system, notable differences under the ACCT system are that case reviews are held proportional to need and this gives staff flexibility in deciding when a case review is appropriate rather than being conducted at fixed intervals. Another change to policy was based on findings by Senior et al.'s (2002) study which reported that external agencies, such as prison escort staff would frequently open an F2052SH document based on historical risk factors, such as previous self-harm. The recommendations made by Senior et al. (2002) were acted upon with a Suicide/Self-Harm Warning form introduced for use by prison escort staff (HM Prison Service, 2003a).

Reception into prison has been the focus of much attention due in part to a heightened risk of suicide during this time (Shaw et al., 2004; Towl & Crighton, 1998). In line with national prison policy, all new prisoners are seen at reception by a member of prison health care staff using a prison questionnaire, designed to screen for physical and mental health problems. The reception screen was developed by Grubin and rolled out across the prison estate in a parallel development to the main ACCT process (Gavin, Parsons, & Grubin, 2003). The screening inquires about the prisoner's past medical history and current medical needs, including previous self-harm/suicide attempts and current ideation. The tool is suitable for general nursing staff that supplements basic questions on psychiatric history, allowing the identification of high-risk problems, such as self-harm/suicide risk in the first 48 h of custody. Immediate and urgent needs or problems identified at reception include self-harm/suicide risk identification. Such identification would require an at risk document (F2052SH/ACCT) document to be opened as per policy to for procedural monitoring and management to be initiated.

This study evaluated one part of a wider programme of work which targeted the improved identification, monitoring and management of prisoners at risk of self-harm/suicide in England and Wales. This evaluation of a pilot initiative was conducted in five prisons deemed to be representative

of the prison estate as a whole. The current self-harm/suicide risk monitoring system (ACCT) in prisons in England and Wales was initially piloted in five prison sites. The authors sought to compare the previous self-harm/suicide risk monitoring system (F2052SH) with the newly implemented system (ACCT) on reception screening and procedure for managing self-harm/suicide risk, care planning and management of risk and clinical presentation of prisoners with an open at risk document including the provision of mental health care.

Method

Sampling

A representative sample of prisons in England and Wales were used for the pilot initiative. ACCT was piloted in five prisons, including three adult male local prisons; one with high secure facilities, one female establishment housing both adults and young offenders and one male young offender institution.

Design

A before and after design was used to evaluate the differences between F2052SH/ACCT systems. The census date was September 2003 for the before phase (F2052SH) and October 2004 for the after phase (ACCT) with a time period of ~12 months between each phase to allow ACCT to be embedded within the pilot sites.

Procedure

One the first day at each site, the researchers obtained a list of:

- (1) Five hundred consecutive prisoners' names and identification numbers that were received into custody, which commenced 3 months prior to the census date.
- (2) prisoners' names and identification numbers of the most recent 100 consecutive closed F2052SH/ACCT documents.
- (3) all prisoners who were on an open F2052SH/ACCT document.

There were three parts to the evaluation, with each undertaken before and after the ACCT system was introduced, including:

Tracking of care pathways from reception into prison

Within each phase, 2500 clinical records were examined with 500 consecutive clinical records in each of the five prison sites (which depended on the proportion that could be obtained at that time). The clinical record

was examined for each prisoner including the completed Grubin reception screening questionnaire (Gavin et al., 2003) which had been introduced into the pilot sites prior to the study commencing. This screening questionnaire and the first entry in the clinical record were examined for documentation of a positive screen for a history of self-harm and/or current self-harm/suicidal ideation, which was self-reported by the prisoner at reception into prison. The screening questionnaires referral checklist for any urgent or immediate needs identified, such as opening an at risk document, was examined and then the subsequent entries in the clinical record were then tracked for 4 weeks of the prisoner's custodial stay for evidence of the opening of an F2052SH/ACCT and healthcare assessment. Researchers deemed that the opening of an F2052SH/ACCT would require an entry into the clinical record as per policy guidelines, which specifies that a healthcare assessment must be conducted within a specified time of a document being opened.

Care planning review (closed F2052SH/ACCT documents)

The F2052SH/ACCT document is said to be closed when a case review has been held and it has been decided that the prisoner is at a lower risk following acceptable reductions in perceived risks and they are no longer subject to the at risk management system. A closed document is then archived within prison records. Within each phase, 500 closed at risk documents were examined with 100 consecutive at risk documents in each of the five prison sites (which depended on the proportion that could be obtained at that time).

F2052SH (before) and ACCT (after) documents were examined by several researchers across prison sites. All researchers were given relevant training by prison service staff on policy and procedure for the identification, monitoring and management of prisoners under at risk systems and inter-rater reliability between researchers was obtained. Researchers examined the identification, monitoring and management of prisoners at risk of self-harm/suicide using information provided in F2052SH/ACCT closed documents only including identification of risk; quality of entries, observation levels, evidence of fulfilling document policy frequency, completion of care plans; multi-disciplinary teamwork, case reviews and post-closure reviews.

For the purpose of this study, a simple rating system was employed to examine evidence of 'quality' entries made by staff in F2052SH/ACCT documents. 'Quality' entries included entries related to elements of the care plan, such as, a mental health state examination/assessment, assessment of level of self-harm/suicide risk and documented evidence of engagement/communication with the prisoner. 'Surveillance' included descriptions of the prisoner, such as their behaviour or situation in the cell, that is, 'sleeping', 'lying on bed' and 'watching television', which were unrelated to elements of the care plan.

Clinical interviews with prisoners at risk of self-harm/suicide

All prisoners under the F2052SH/ACCT system on the census date were deemed eligible for interview. Several researchers conducted the clinical interviews. The researchers comprised both researchers with no psychiatric training and professionals with psychiatric training and all were given relevant training on the psychometric assessment tools. Inter-rater reliability was obtained. All prisoners were approached for interview if inclusion criteria (prison staff deemed the prisoner suitable for interview, English language, able to provide informed consent) had been met. The interview was designed to establish symptoms of mental illness, including suicide ideation and health and social need. Interviews comprised:

Brief Psychiatric Rating Scale (BPRS) (Overall & Gorman, 1962); which is a scale that comprises 18 symptom constructs chosen to represent relatively independent dimensions of psychopathology. The severity of 18 distinct signs and symptoms of psychopathology based on clinical interview were recorded. Each symptom construct was assessed and ranging from 1 (not present) to 7 (extremely severe). This is an interviewer-rated scale based on information provided by the respondent.

Beck Scale for Suicidal Ideation (BSSI) (Beck & Steer, 1991); which is a 21-item instrument that is used to detect and measure the severity of suicidal ideation. Each item consists of three statements scaled from 0 to 2 points, reflecting increasing gradations of the severity of suicide ideation. The first five items act as a screening instrument, and only those respondents who have contemplated suicide attempts are administered the remaining questionnaire. The total BSSI score can range from 0 to 38 points. The next 19 items measure various facets of suicide ideation: the wish to live, the wish to die, reasons for living or dying, frequency and duration of suicidal ideation and active suicidal behaviour. This scale was verbally administered by a researcher and self-rated by the respondent.

Camberwell Assessment of Need, Forensic Short Version (CANFOR-S) (Thomas et al., 2003); which is a version of the CAN, including forensic/offending history domains (Slade, Thornicroft, Loftus, Phelan, & Wykes, 1999). It covers 25 domains of frequent or important problems for people with severe mental disorders in forensic settings. It rates met and unmet needs in each of these domains. This is an interviewer-rated scale based on information provided by the respondent.

Mental health care

Of those interviewed, each prisoner's clinical record and F2052SH/ACCT document was reviewed and caseloads of mental health agencies in the prisons cross-referenced for evidence of mental health care provision. The level of mental health care being received at the date of interview was

divided into: secondary care (specialist mental health services from prison in-reach teams or prison healthcare in-patient for mental health reasons); primary care (receiving psychiatric medication and/or outpatient support from primary care mental health services); or no mental health care (receiving no psychiatric medication or formal mental health support).

Prescribed psychotropic medication

Of those interviewed, each prisoner's clinical record was examined for evidence of prescribed psychotropic medication on the date of interview.

Statistical methods

The differences between variables in the before and after phases were examined using simple parametric and non-parametric tests. Chi-squared tests of association were conducted for categorical variables. Kolmogorov–Smirnov tests of normality for continuous variables were performed. Both *t*-tests and Mann–Whitney tests for continuous variables were used, as appropriate (Statistical Package for Social Sciences, Version 16).

Ethical approval

Ethical approval was granted by the Prison Service and Local Research Ethics Committees. Informed consent was obtained from each prisoner to be interviewed and for their clinical records to be accessed.

Limitations of before and after design

A summary of the limitations of this design are described in the discussion. The authors were not aware of any other factors apart from the limitations of the design within this study which may have impacted upon the results, such as any changes in policy not otherwise specified in this article, changes in the compositions of the prisoner population or changes in prison facility type or category which may have influenced the findings.

Results

Tracking of care pathways from reception into prison

The clinical records of 2498 prisoners entering custody were examined in the before phase (F2052SH), and 2166 in the after phase (ACCT).

The same proportion of prisoners in both phases had suicidal ideas on reception into prison (81; 3% vs. 59; 3%). There was no significant difference found in the proportion of prisoners with current suicidal ideas for whom an F2052SH or ACCT document was opened (54; 67% vs. 42; 71%).

In both phases, 17% of prisoners had a history of self-harm and/or suicide attempts (431; 17% vs. 374; 17%). For these prisoners, there was a significant reduction in the after phase in the proportion for whom an ACCT document was opened. This fall was most significant in the sub-group of prisoners who had a history of self-harm and/or suicide attempts, but had no current suicidal ideas (Table 1).

Care planning review (closed F2052SH/ACCT documents)

Four-hundred and fifty-three closed F2052SH documents were examined in the before phase, and 475 closed ACCT documents in the after phase (Table 2).

There were significantly fewer ACCT documents opened before reception into prison (199; 44% vs. 8; 2%), by for example, court staff, police or court escort services. A document was significantly more likely to be opened at reception into prison or while in prison in the 'after' phase.

Documents often listed more than one reason for the initial identification of risk. Significantly fewer ACCT than F2052SH documents were opened following an act of self-harm (162; 35% vs. 129; 27%), while ACCT documents were more likely to be opened following the expression of suicidal ideas with intent (186; 41% vs. 240; 51%), unusual behaviour or

Table 1. Tracking of care pathways from reception into prison.

	Phase						χ^2	df	$p \leq$
	Before			After					
	<i>N</i>	%	95% CI	<i>N</i>	%	95% CI			
Clinical records examined	2498	—	—	2166	—	—	—	—	—
Current thoughts of self-harm	81	3	(3–4)	59	3	(2–3)	—	—	ns
F2052SH/ACCT opened	54	67	(56–77)	42	71	(60–83)	—	—	ns
History of self-harm	431	17	(16–19)	374	17	(16–19)	—	—	ns
F2052SH/ACCT opened	164	38	(33–43)	74	20	(16–24)	31.21	1	***
History of self-harm, no current thoughts of self-harm	362	14	(13–16)	328	15	(14–17)	—	—	ns
F2052SH/ACCT opened	118	33	(28–37)	37	11	(8–15)	43.68	1	***

When percentages are quoted, these refer to 'valid' cases, that is, for those for whom the information was available. Those for whom information was missing were excluded from the analysis.

*** $p \leq 0.001$.

Table 2. Care planning review (closed F2052SH/ACCT documents).

	Phase						
	Before			After			$p \leq$
	<i>N</i>	%	95% CI	<i>N</i>	%	95% CI	
Closed documents examined	453	–	–	475	–	–	–
Document opened							
Before reception into prison	199	44	(39–48)	8	2	(1–3)	***
At reception into prison	52	11	(9–14)	147	31	(27–35)	***
After reception into prison	199	44	(39–48)	298	63	(58–67)	***
Unknown	3	1	(0–1)	22	5	(3–7)	***
How long was document opened							
≤24 h	13	3	(1–4)	55	12	(9–14)	***
25–72 h	63	14	(11–17)	35	7	(5–10)	***
73 h – 6 days	90	20	(16–24)	83	17	(14–21)	ns
1–4 weeks	207	46	(41–50)	224	47	(43–52)	ns
>4 weeks	62	14	(11–17)	76	16	(13–19)	ns
Unknown	18	4	(2–6)	2	0	(0–1)	***
Reason/s for opening document							
Self-harm/suicide attempt	162	35	(31–39)	129	27	(23–31)	**
Self-harm/suicide ideation	186	41	(37–46)	240	51	(46–55)	**
Unusual behaviour/talk	25	6	(3–8)	95	20	(16–24)	***
Low mood	159	35	(31–39)	230	49	(44–53)	***
Drug/alcohol withdrawal	20	4	(3–6)	77	16	(13–20)	***

(continued)

Table 2. (Continued).

	Phase						χ^2	df	$p \leq$
	Before		After		95% CI	95% CI			
	N	%	N	%					
Prisoner had a care plan in place	403	89	392	83	(86–92)	(79–86)	7.82	1	**
Multi-disciplinary care plan in place	241	53	292	61	(49–58)	(57–66)	91.96	1	***
Multi-disciplinary review/s	304	67	195	41	(63–71)	(37–45)	63.33	1	***
Level of observation specified									
None	143	32	168	35	(27–36)	(31–40)	–	–	ns
Random/routine	109	24	28	6	(20–28)	(4–8)	59.38	1	***
Evidence of fulfilling document policy	429	95	438	92	(93–97)	(90–95)	–	–	ns
Quality entries at least daily	107	24	335	71	(20–28)	(66–75)	204.52	1	***
Post-closure review	351	77	187	13	(74–81)	(10–16)	136.70	1	***

When percentages are quoted, these refer to ‘valid’ cases, that is, for those for whom the information was available. Those for whom information was missing were excluded from the analysis.

* $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$.

speech (25; 6% vs. 95; 20%), low mood (159; 35% vs. 230; 49%) and/or drug/alcohol withdrawal (20; 4% vs. 77; 16%).

The ACCT system was significantly less likely to specify a 'routine' or 'random' level of observation for prisoners than the F2052SH system (109; 24% vs. 28; 6%). There were significantly more 'quality' (not related to surveillance, but specifically relating to care plan actions/interventions) entries daily in the ACCT system than in the F2052SH system (107; 24% vs. 335; 71%).

Compared with the F2052SH document, there was a significant fall in the proportion of ACCT documents which contained a care plan (403; 89% vs. 392; 83%), but the care planning in the ACCT system was significantly more likely to be multi-disciplinary (292; 61% vs. 241; 53%). However, compared to the ACCT system, the F2052SH system evidenced significantly more multi-disciplinary reviews (304; 67% vs. 195; 41%).

There was a significant difference in the duration of care provided under the systems, with more ACCTs than F2052SHs opened for less than 24 h (13; 3% vs. 55; 12%). Post-closure reviews were significantly less likely under the ACCT system (351; 77% vs. 187; 13%).

Clinical interviews with prisoners at risk of self-harm/suicide

On the census day in the before phase, 115 prisoners had open F2052SH documents. Of these, 7 (6%) were designated by prison staff as unsafe to interview, 3 (2%) were unable to provide informed consent and 10 (9%) had left the prison before they could be approached for interview. Of 95 (83%) remaining, 82 (86%) agreed to participate. In the after phase, 109 prisoners had open ACCT documents. Of these, 3 (2%) were unsafe to interview, 6 (6%) were unable to provide informed consent and 16 (15%) had left the prison before they could be approached. Of the remaining 84 (77%), 76 (91%) agreed to participate (Table 3).

Compared to the before phase, prisoners on an open ACCT document were significantly more likely to be rated as having clinical depression (43; 52% vs. 57; 75%) and had significantly higher BPRS total scores (mean = 42 vs. mean = 46).

There were no significant differences between the before and after phase in the number of prisoners scoring above the BSS cut-off point (which indicates a level of suicidal ideation requiring further clinical assessment).

When comparing scores on the CANFOR-S, there were significantly fewer unmet and total needs in the after phase, but no significant difference in the proportions of met needs between the two phases. In the before phase, the most common unmet health and social needs were support for psychological distress (45; 55%), daytime activities (41; 50%) and safety to self (34; 42%). In the 'after' phase, the most common unmet needs were for support for psychological distress (41; 54%), safety to self (39; 51%) and money (25; 33%).

Table 3. Clinical interviews with prisoners at risk of self-harm/suicide.

	Phase					
	Before			After		
	N	%	95% CI	N	%	95% CI
Interviewed	82	—	—	76	—	—
BPRS						
Clinical depression	43	52	(42–63)	57	75	(65–85)
Clinical anxiety	38	46	(36–57)	42	55	(44–66)
Clinical suicidality	31	38	(27–48)	38	50	(39–61)
BPRS total score	Mean	SD		Mean	SD	
BSS	42	11.43	—	46	11.04	—
Above cut-off	N	%		N	%	
CANFOR-S (unmet needs)	39	48	(37–58)	34	45	(34–56)
Food	N	%		N	%	
Daytime activities	33	40	(30–51)	23	30	(20–41)
Psychotic symptoms	41	50	(39–61)	23	30	(20–41)
Information about condition and treatment	25	31	(21–40)	20	26	(16–36)
Support for psychological distress	33	40	(30–51)	20	26	(16–36)
Safety to self	45	55	(44–66)	41	54	(43–65)
Money	34	41	(31–52)	39	51	(40–63)
	28	34	(24–44)	25	33	(22–43)

(continued)

Table 3. (Continued).

	Phase							
	Before				After			
	N	%	SD	95% CI	N	%	SD	95% CI
CANFOR-S unmet need	Mean 7.15		5.33		Mean 4.93		3.26	
CANFOR-S met need	3.17		2.43	–	3.04		2.19	–
CANFOR-S total need	10.35		5.06	–	7.79		3.20	–
Prescribed psychiatric medication	N	%	%		N	%	%	
Anti-depressant	25	31		(21–40)	22	29		(19–39)
Anti-psychotic	25	31		(21–40)	17	22		(13–32)
Benzodiazepine	4	5		(0–10)	4	5		(0–10)
None	12	15		(7–22)	7	9		(3–16)
Not known (records not available)	6	7		(2–13)	0	0		(0–0)
Mental health care provision								
Primary mental health care	27	33		(23–43)	13	17		(9–26)
Secondary mental health care	31	38		(27–48)	30	39		(28–50)
No mental health care	24	29		(19–39)	33	43		(32–55)
							T	df
							3.12	156
							–	–
							3.50	156
							χ^2	df
							–	–
							–	–
							–	–
							3.95	1
							χ^2	df
							4.42	1
							–	–
							2.84	1

When percentages are quoted, these refer to ‘valid’ cases, that is, for those for whom the information was available. Those for whom information was missing were excluded from the analysis.
* $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$.

There were no significant differences between the proportions of prisoners who were prescribed psychotropic medication, including, anti-depressants, anti-psychotics and benzodiazepines and also no significant differences in the number of prisoners on no mental health medication.

Prisoners were significantly more likely to be receiving primary mental health care input in the before phase (27; 33% vs. 13; 17%) and in the after phase were more likely to have no formal mental health care (24; 29% vs. 33; 43%) while on an ACCT document. There were no significant differences between the two phases in the proportion of prisoners who were receiving secondary mental health care while on an at risk document (31; 38% vs. 30; 39%).

Discussion

Main findings

At reception, fewer ACCT documents were opened prior to reception into prison by external agencies which may have reflected the parallel implementation of a Suicide/Self-Harm Warning form introduced for use by prison escort staff as a replacement for the F2052SH document (HM Prison Service, 2003a).

In both phases, the same proportion of prisoners received into prison had current suicidal ideation, yet only around two-thirds were placed on an F2052SH/ACCT document. A key element to effective risk management in prison are the care pathways from reception screening to care planning for any immediate risk identified (Konrad et al., 2007). Good practice should involve screening each prisoner carefully and comprehensively with both self-report and information requested from any external relevant agencies, identification of self-harm/suicide risk or factors associated with risk, such as mental health needs, communication between different disciplines within the prison, availability of mental health care and referrals to necessary services being made. Previous studies have shown that suicides are more prevalent in the early stages of custody (Shaw et al., 2004; Towl & Crighton, 1998). Problems with reception screening for prisoners' mental health on arrival have been identified including that it is brief, many prisoners arrive without medical notes, the number of prisoners arriving varies making it difficult to predict the resources require to conduct assessments, there is a lack of communication within prison and between prisons which means that problems are likely to remain hidden if they are not picked up on reception, some prisoners are adamant that they do not want to discuss their vulnerabilities on reception and many prisoners feel frustrated at having to undergo repeated assessments (Sainsbury Centre for Mental Health, 2008a).

Prisons should ensure that all those expressing current suicidal ideation at reception should have an ACCT opened, pending a comprehensive mental health and self-harm/suicide risk assessment as soon as possible by a suitably qualified mental health professional.

Previous studies have shown that F2052SH documents were opened on the basis of historical suicide risk alone (Senior et al., 2007). This study showed that significantly fewer ACCT documents were opened at reception into prison for those with a history of self-harm/suicidal behaviour, but no current suicidal ideation, suggesting that the ACCT system more appropriately targeted current self-harm and/or suicide risk. This was appropriate, although those with a history of suicidal behaviour remain at risk of future suicidal behaviour (Humber, unpublished thesis; Zahl & Hawton, 2004). Prisoners with a history of self-harm/suicide attempts should have a comprehensive mental health assessment, with early warning signs, likely triggers to self-harm and at risk times noted, with their level of self-harm/suicide risk regularly reviewed and re-assessed.

While in prison, ACCT documents were less likely to be opened following an act of self-harm, but significantly more were opened following the expression of ideas of self-harm/suicide, unusual behaviour, low mood or drug/alcohol withdrawal. This suggested a more pro-active approach under ACCT and a greater awareness of risk indicators which may have been due to concurrent improvements in mental health and suicide awareness staff training (HM Prison Service, 2005) and an improvement on the previous largely reactive F2052SH system (Senior et al., 2007). Prisons in England and Wales train all staff who come into contact with prisoners in ACCT procedures (HM Prison Service, 2008) with skills based and suicide awareness training an integral part of the ACCT programme. The main aim is to ensure that all the relevant personnel within prisons obtain Mental Health Awareness Training (MHAT) (Brooker & Sirdifield, 2006) and/or ACCT to ensure 'best practice' when dealing with prisoners who have mental health issues, are self-harming or pose a suicidal risk.

While identified as being at risk, prisoners under F2052SH had more care plans developed; a vital aspect for comprehensive intervention to meet complex needs. However, the ACCT system evidenced more multi-disciplinary care planning suggesting the need for different agency input had been recognised. Multi-disciplinary teamwork, care and review are essential for the effective management of self-harm/suicide and all prisoners identified as being at risk should have input from various disciplines and agencies to address need (Humphreys, 2000). The ACCT system had fewer multi-disciplinary reviews but this finding may have reflected the changes in policy which specified flexible reviews based on staff discretion of prisoner need, rather than reviews at fixed intervals, such as in the F2052SH system. However, this study did not identify whether given this flexible guidance, there was an appropriate number of reviews proportional to prisoner need. One of the aims of the ACCT system is to ensure that only those professionals involved in the direct care and supervision of the prisoner should attend review meetings. What is important is that a consistent, minimum, multi-disciplinary team should review a prisoner's progress, with

staff directly involved in the prisoner's care and supervision attending from each area stipulated in the care plan to ensure all aspects of prisoner need can be reviewed.

Evidence of 'quality' entries (not relating to surveillance, but specifically relating to care plan actions/interventions) was found in ACCT documents daily or more than daily in nearly three quarters of cases suggesting better interaction and communication between staff and those at risk. This was a marked improvement on the previous focus on routine physical observations common under the F2052SH system (Senior et al., 2007). This finding suggests that along with ACCT policy and procedure, mandatory MHAT (Brooker & Sirdifield, 2006) and suicide awareness training are enabling prison staff to provide a more comprehensive assessment of need with effective communication and interaction skills with those who are at risk. This interaction can be instrumental in alerting and referring to healthcare professionals who can further assess the dynamic needs of such prisoners. Improved quality entries made by staff should enable mental health care professionals to make more informed judgement of self-harm/suicide risk. This practice should also provide healthcare staff with valuable information concerning the prisoner's current mental state. Prison wing staff who are involved in the direct supervision and management of prisoners spend more time with them than other members of staff. This daily close proximity to prisoners' means that officers have several key roles in caring for and managing those who are at risk of self-harm/suicide.

The promotion of good relationships between staff and prisoners has an important role in preventing suicide, especially in young offenders (Biggam & Power, 1998). As part of the suicide prevention strategy in Australia, 'Unit Management' has been introduced to create small, manageable units with greater personal interaction between prisoners and staff (McArthur, Camilleri, & Webb, 1999). Studies in the USA have suggested that both unit management and the design of a jail may aid closer relationships between staff and prisoners and therefore better staff knowledge of prisoners, which could improve the prevention of suicide (Hayes, 1995). However, not all prisoners may want to form a close relationship with staff and approach prison officers for emotional support. Certain types of prisoner, such as those in maximum security, may be reluctant to approach staff for help (Hobbs & Dear, 2001). The level of observation and the frequency with which prisoners identified as suicidal must be monitored differs between suicide prevention policies in England and Wales, Scotland and the USA. Studies which have asked how prisoners feel about being observed, uniformly report that they dislike being observed without any emotional support, which they consider to be to staff 'back-watching', rather than providing care (Liebling & Krarup, 1993; Power et al., 2003).

There was little evidence of planned follow-up and support following the closure of an ACCT document, with fewer having a post-closure review

compared to the F2052SH system. This suggested the need for follow-up procedures to be re-addressed and improved. Prisoners needs should be assessed and reviewed following the closure of an ACCT document, as in the period immediately after the removal of close monitoring, tailored input and mental health support, individuals are likely to be at increased risk (Appleby et al., 1999; Senior et al., 2002). The closure of an ACCT document should not signal the closure or end of care for a vulnerable prisoner. Prison staff need to identify a prisoner's 'risk signature' and document early warning signs to prevent relapse and to provide a more pro-active service. Prisoners previously on ACCT documents should receive follow-up support following closure, including regular mental health assessments, with a potential rise in input at any 'risky' periods, such as pre-trial.

Prisoners monitored under F2052SH/ACCT systems had high rates of psychopathology at interview. Rates of mental illness were significantly higher in the after phase, which may indicate improved identification of the most vulnerable prisoners. However, prisoners on ACCT were more likely to be receiving no formal mental health care which could explain this finding. All prisoners under ACCT should undergo a comprehensive mental health assessment. This is particularly relevant as those on ACCT were less likely to be receiving mental health care in spite of more apparent psychopathology. However, those on ACCT did report fewer unmet needs. Many innovative reforms have taken place over the past several years for prison mental health services to provide equivalence in care for this vulnerable population (Department of Health, 2000, 2007; Shaw & Humber, 2007). Prison mental health in-reach teams were introduced in 2002 (the equivalent of community mental health teams) to work with prisoners with serious mental illness. However, a recent report *Out of Sight, Out of Mind* (Brooker & Ullmann, 2008) stated that the original concept of and remit for in-reach teams had been stretched and there had been a blurring of boundaries between primary and secondary mental health care, with a feeling of 'mission creep' (Steel et al., 2007). It has been reported that prison in-reach teams are hugely under-resourced and receive about one-third of the funding required to achieve service delivery equivalent to community mental health services (Brooker, Flynn, & Fox, 2010).

In addition, a review by the Chief Inspector of Prisons cited the Health Care Commission's assessments of commissioning arrangements covering 23 PCTs and 26 prisons showed that prison mental health was a low priority for the PCTs (HMCIP, 2007). Primary mental health care need in prison was reported to be unmet by general practitioners interviewed for the review. The Sainsbury Centre for Mental Health (2008a) reported that over half of all health providers in prison assessed the mental health service as average or poor. As the general prison population has significantly higher levels of mental disorder than the general population (Fazel & Danesh,

2002), there is a great need for effective mental health care and treatment in the prevention of self-harm/suicide.

Recent policy developments and initiatives for the prevention of suicide in UK prisons

After piloting in 2004 (Safer Custody Group, 2004), ACCT was introduced across the prison estate in England and Wales during 2005 and 2007 (DH, 2008). Since it has been implemented a number of policy developments and initiatives have occurred. The responsibility for the transfer of the commissioning responsibility of healthcare services for prisoners was devolved to National Health Service primary care trusts (PCTs) and the transfer of commissioning and provision of healthcare services is complete to enable equivalence in healthcare provision to prisoners (DH, 2000, 2007).

A number of other initiatives have been introduced to reduce or prevent self-harm/suicide in prison, including an increase in prisoner peer-support schemes, safer cells, improvements in reception screening procedures, the establishment of 'First Night Centres' and further expansion and development of mental health in-reach services. An evaluation of these facilities has shown important benefits for the care of prisoners on entry into prison, including reducing distress and improving feelings of safety (Liebling, Tait, Durie, Stiles, & Harvey, 2005). The use of shared accommodation is a method of simultaneously providing companionship and of reducing the opportunity for suicide (Fruehwald et al., 2004; Shaw et al., 2004). This preventative measure is used in England and Wales, Scotland and many Australian states (Aardema et al., 1999; McArthur et al., 1999).

A strong working relationship exists with the Samaritans in providing support to prisoners with the introduction of 'Listener' schemes. In this scheme, prisoner volunteers are trained to support their peers during times of distress or crisis. Evaluations of the scheme report that the majority of prisoners were satisfied with the support received and that being a Listener was of benefit to the peer supporters themselves (Snow, 2000; Syed & Blanchette, 2000). Research has shown a reduction in self-harm incidence with the introduction of Listener schemes and that this service improves the existing provision in supporting vulnerable prisoners (Davies, 1994). This support intervention has been further developed with the introduction of the 'Insiders' peer support scheme. The 'Insiders' are prisoner volunteers trained specifically in targeting prisoners at the early stages of custody, which is known to be a particularly stressful time. The prisoners provide key information which could be useful to those in the first few days of custody and offer reassurance to new prisoners. 'Insiders' are located in first night suites, reception areas and induction wings (HM Prison Service, 2003a) and evidence has suggested that prisoners have found the initiative useful, particularly first time prisoners (Teers, unpublished report).

Some innovative interventions have been developed by individual prisons in response to suicide prevention policy, including, self-injury support groups, courses to encourage and develop assertiveness, communication, emotion management and problem-solving (Howard League for Penal Reform, 2003).

In 2004, the Joint Committee on Human Rights published a report on 'Deaths in Custody' and suggested that there was a need for a system to capture learning points across sectors following such deaths (House of Lords, 2004). From this the independently chaired Forum for Preventing Deaths in Custody was established in 2006, with the primary aims of identifying learning opportunities arising from deaths across the various custodial sectors, and preventing future deaths. One independent review criticised the forum for its lack of authority and for being too large and diverse to be effective as a decision-making body (Fulton, 2008). The review suggested that the forum be replaced by an Independent Advisory Panel on Deaths in Custody, comprising a small group of relevant experts.

A prisoner's propensity to suicide may be influenced by the effects of withdrawing from drugs and/or alcohol (Crighton & Towl, 1998; Shaw et al., 2004) and substance misuse and dependence have been recognised as one of the greatest health problems to address in the prison population (Gore, 1999). There has been major investment in drug treatment services within prisons in England and Wales over several years (DH, 2006; National Treatment Agency for Substance Misuse & National Offender Management Service, 2006; Price Waterhouse Coopers, 2007) with a recent report showing a decline in the number of suicides in prison with a primary diagnosis of drug dependence (Shaw et al., in press).

As yet, specific psychosocial interventions to reduce suicidal ideation or improve coping strategies are not widely reported to be part of prison suicide prevention programmes. However, increasing prisoners' access to psychological therapies in order to treat common mental disorders, such as depression and anxiety, is being introduced into the prison estate (DH, 2009).

Limitations

The before and after study design has limitations when attempting to evaluate a new initiative. Differences between phases which were not directly related to the ACCT initiative may have affected the results, such as fluctuating staffing levels and access to resources.

The effectiveness and efficacy of the two systems for the prevention of self-harm/suicide in terms of rates could not be assessed with the current design. At the time of the data collection, it was not possible to collect data on the actual number of self-harm incidents in the prisons in either phase, as

the monitoring systems in place were not sufficiently reliable or robust. The collection of such data is important in order to further determine and assess the impact of the introduction of ACCT. A randomised study would have provided stronger evidence for outcomes. However, using two systems of risk assessment and management within prisons would have been unfeasible.

Differences between sites across the prison estate precluded the comparison of 'experimental' and 'control' conditions. Clinical interviews with a random sample of prisoners would have improved the ability to reliably evaluate the detection of prisoners with suicidal ideation in the before and after phases, but this was not possible within the scope and timescale of this study.

The use of structured clinical interviews with psychometric tools and the related interviewer and respondent bias, the brevity of the measures used and the absence of qualitative interviews with prisoners and staff are limitations of this study.

In terms of outcome measures, it was not clear from the present study how at risk prisoners' suicidality is affected by the ACCT system.

The study was conducted in five prisons considered to be representative of the prison estate. However, the prison estate in England and Wales contains around 140 prisons and the results may be biased by the specific local circumstances and characteristics of the prisons used in this study.

The study did not determine the profession of the member of staff who conducted the reception screen which may have explain why the number of documents opened did not change in response to suicidal ideation in the before and after phases.

Limitations to this study also included the retrospective nature of data collection with findings based on clinical/prison records and the bias associated with this method.

Recommendations

The findings of this study have suggested that the process of reception screening may need further development to ensure all prisoners who express suicidal ideation are placed under the ACCT system. Care planning, post-closure/ follow up and mental health care for those who have been identified at risk should be improved. The National Offender Management System recently reviewed ACCT as there has been an opportunity to observe the system in operation across the prison estate (Safer Custody News, 2010). The review was conducted with various consultations with groups including Safer Custody Teams, specialist staff, policy and operational managers, interested organisations, prison staff, healthcare staff, stakeholders and prisoners. It demonstrated that there was broad agreement about what areas were working well and what areas needed strengthening. The main improvements suggested included examining and updating ACCT staff

training, doing more to ensure that policy requirements are understood, and that prisoners view ACCT in a more positive light. A main piece of work was deemed to be making the overall policy less complex and more user-friendly. One important area was prisoners' views and findings indicated that prisoners generally understood the purpose of ACCT. Areas for improvement included reducing the stigma associated with being on ACCT; promoting positive staff/prisoner relationships especially the case manager role; and involving others in the support of prisoners during the process, such as their family and other prisoners.

Post-implementation of initiatives and strategies: what works?

It remains to be seen how current policies and initiatives affect the rates of self-harm/suicide in prisons in England and Wales. Has the implementation of the ACCT had a positive effect on the rate of self-harm/suicide in prisons? Which aspects of this procedure have been most effective at improving the management of at risk prisoners? What barriers exist between staff and prisoners that can impinge on the effectiveness of this new process? What improvements still need to be made in the future? Evaluations of support services available to staff and prisoners is necessary. How effective can fellow prisoners be in the prevention of self-harm/suicide? Do initiatives such as the 'Listeners' programme have any effect on the rate of self-harm/suicide? What support services are available to staff and prisoners following critical incidents such as suicide, and are they well received or perceived as effective?

Conclusion: measuring the impact of policy developments

Investigating what works in the reduction and prevention of self-harm/suicide in prisons is a priority for current research (Fazel & Lubbe, 2005). Self-harm/suicide in prisons is a major public health problem and concerted effort exists toward their prevention (Ministry of Justice (MOJ), 2010). The assessment and protection of individuals vulnerable to self-harm/suicide is a difficult task in any setting (Young, Justice, & Erdberg, 2006). Within the prison system, staff have a duty of care to protect and the task of balancing issues of security, punishment and justice with appropriate treatment is undoubtedly complex.

The lessons learned from the Safer Custody Programme have resulted in a new suicide and self-harm policy (PSO 2700) (HM Prison Service, 2008) and there has been a reported overall fall in the number of suicides in prisons in the UK over the past decade from 2000 to 2009 (MOJ, 2010a,b). ACCT was rolled out across the prison estate between 2005 and 2007, with rates significantly reduction from 114 per 100,000 prisoners in 2007 to 73 per 100,000 prisoners in 2008 (Table 4). It appears that a range of joint MOJ

Table 4. Number of SIDs, average annual total population and SID rate (per 100, 000) in prisons in England and Wales from 2000 to 2009 (Ministry of Justice, 2010).

Year	Number of self-inflicted deaths	Average annual total population	Rate per 100,000 population
2000	81	65,194	124
2001	73	66,403	110
2002	95	71,218	133
2003	95	73,657	128
2004	95	74,488	128
2005	78	76,190	102
2006	67	77,962	86
2007	92	80,689	114
2008	60	83,240	73
2009	60	83,611	72

and DH policy initiatives have helped to reduce the rate of suicides in prisons overall as they were introduced in 2003 when the downward trend in the overall rate commenced, but the impact has been variable and the rate of self-harm has remained at a high level in all prisons (MOJ, 2010a, b). However, while the rate of suicides has declined over time, the proportion of those under the care of an at risk document at the time of death has not changed (MOJ; 2010a, b; Shaw et al., in press). In the female estate, although the suicide rate has shown a decreasing trend, the trend in self-harm has increased considerably (MOJ, 2010a,b) and this is likely to be an underestimation of the true figure given that rates of self-harm can be unreliable and staff reporting varies from prison to prison. The suicide rate in high security prisons has increased as has the self-harm rate in high security, female and young offender institutions (YOIs) (MOJ, 2010a,b). Greater understanding is needed as to the reasons for why there are higher rates of self-harm/suicide in particular sub-groups of prisoners and in turn what can be further implemented for such vulnerable groups, with possible targeted suicide prevention strategies and interventions.

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