HMIPS
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REPORT ON AN EXPERT REVIEW OF THE PROVISION OF MENTAL HEALTH SERVICES, FOR YOUNG PEOPLE ENTERING AND IN CUSTODY AT HMP YOI POLMONT

MAY 2019

"Preventing suicide is a global imperative and requires services and communities to work together to provide support to vulnerable individuals."

(The World Health Organization, 2014)

"The Scottish Government believes that no death by suicide should be regarded as acceptable or inevitable."

(Scotland's Suicide Prevention Action Plan: Every Life Matters)

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1. EXECUTIVE SUMMARY

1.1 Introduction

Every death of a young person is a tragedy, for them, their families and their friends, but also for Scottish society that has lost the opportunity of their talent and potential contribution.

I was asked by the Cabinet Secretary for Justice, Humza Yousaf MSP, to undertake an expert review of the provision of mental health services, for young people entering and in custody at HMP YOI Polmont. Specifically:

- The information available to the Scottish Prison Service (SPS) prior to entering custody;
- reception, screening and assessment arrangements;
- health and wellbeing culture linked to ongoing support and supervision;
- treatment and interventions during their time in custody; and
- arrangements by SPS for their return to the community.

The full remit is set out in **Appendix A**, and the methodology adopted is described in **Section 6 – The Review Methodology**.

The review explored the wider issues of young people entering custody; it did not consider the specific circumstances or details of individual cases.

1.2 Context

It is important for any review to set its findings in context, in order that its purpose can be fully understood and appreciated.

The World Health Organization highlighted choose life – A National Strategy and Action Plan to Prevent Suicide in Scotland as exemplary in their approach to improve responses to people in distress.

The 2018 Scotland's Suicide Prevention Action Plan: Every Life Matters, has been designed to continue the work of the suicide prevention strategy and the strong downward trend in suicide rates in Scotland.

Action 8 of Scotland's Suicide Action Plan states that the national suicide prevention leadership group will ensure that all of the actions consider the needs of children and young people.

The approach to youth justice in general in Scotland builds on the key principles and ethos of the highly influential Kilbrandon Report, published in 1964. Concerned with legal provisions and systems to treat "children in trouble", it concluded that there was little distinction between those who commit offences and those in need of care and protection and advocated a welfare-based approach.

Its visionary recommendations led to the establishment of the Children's Hearing System, a distinct system with the responsibility of making decisions in the best interests of the child and where, for all but the most serious offences, children and young people who commit offences, and those in need of care and protection, are dealt with in the same forum, in the same way.

Over 50 years later, research has established a strong association between young people who have experienced some form of Adverse Childhood Experiences (ACEs) and those engaging in harmful or risk-taking behaviours, bringing them into contact with the criminal justice system. The Edinburgh Study evidences that contact with the criminal justice system is often detrimental to young people's wellbeing and development.

The recognition of the impact of prolonged exposure to stress and trauma in childhood resonates with the central premise of the Kilbrandon Report; that many young people who present a high risk of offending are often highly vulnerable, with complex needs but importantly also resonates with the SPS strategy for young people in custody.

The focus on early intervention and a welfare-centred approach to children and young people saw the development of the Whole System Approach (WSA), Scotland's framework for young people involved in offending behaviour and the accompanying principles of Getting it Right for Every Child (GIRFEC) – offering the right help at the right time. It is a child-centred, welfare-focused approach, promoting in a multi-agency context early interventions to respond to the first signs of harmful behaviour. All of these issues emphasise the importance of a continued commitment to early and effective interventions and diversion.

The SPS commitment to 'Unlocking Potential and Transforming Lives' is echoed in their vision for young people:

"Using the time a young person spends in custody to enable them to prepare for a positive future".

(SPS Vision for Young People in Custody, published December 2014)

This is in line with the Scottish Government's national outcomes:

"Our young people are successful learners, confident individuals, effective contributors and responsible citizens".

"We have improved the life chances for children, young people and families at risk".

HMP YOI Polmont's strategic plan is therefore built around the principles of improving life chances, GIRFEC, and the Curriculum for Excellence.

The SPS focus on managing risk within this framework is supported by their regular evaluation of their suicide and self-harm strategy, Talk to Me (TTM)[1] and the analysis of deaths in custody figures across Scottish prisons.

1.3 Findings

What has become clear in the evidence reviews and academic research is that being traumatised, being young, being held on remand and being in the first three months of custody increases the risk of suicide.

In positioning Scotland in comparison with other settings and jurisdictions, previous Council of Europe data indicates that Scotland performs comparatively well in having low levels of suicide in custody in contrast to a wide range of European jurisdictions. However, within the evidence review conducted at my request by the Scottish Centre for Crime and Justice Research (SCCJR) this positive finding is challenged, with their alternative analysis indicating that Scotland may have one of the highest rates of suicide amongst developed countries. This discrepancy only serves to highlight the challenges that exist in comparative analysis of prison suicide; with differing definitions of suicide and the varying quality of data on suicide.

In addition, the very small numbers of young people who take their own life in Scottish prisons inhibits robust extrapolation, and this review was therefore forced to conclude that further work should be undertaken to better understand Scotland's position relative to other jurisdictions.

The UK Justice Policy Review notes that in Scotland:

"younger prisoners and ex-prisoners have the highest risk of death relative to people of the same age in the general population".

Care needs to be taken regarding interpretation of any figures, given the very low numbers and the fact that fluctuation will be significant in percentage terms. For these reasons, there is a need to search for data that throws further light on the vulnerability of young people, levels of suicide and self-harm across their whole justice journey, including in the community, on supervision and in the period following release.

1 Obtainable on request from the SPS

It can be very difficult to identify those who might or intend to take their own life and, despite the best efforts of committed and caring staff; the evidence suggests that not all suicide incidents can be prevented; even though this must remain the aspiration. Suicide and self-harm are complex issues and many of those who go on to take their own life in custody do not display any obvious presentation that would identify them as at risk. Recent academic articles suggest:

> *"That there are no simple ecological explanations for prison suicide. Rather, it is likely to be due to complex interactions between individual-level and ecological factors. Thus, suicide prevention initiatives need to draw on multi-disciplinary approaches that address all parts of the criminal justice system and address individual and system-level risk factors".* (Fazel et al 2017)

During the HMIPS inspection of HMP YOI Polmont, we found that the wellbeing opportunities afforded for young people were evidence-based, leading edge and impressive. However, the take up of the remarkable opportunities remained consistently poor. This was compounded by a high level of staff absence and a cultural acceptance that remand prisoners are not given the same level of opportunities to make the best of their time in custody.

As our review has progressed, we have identified other themes or issues that either set our work in context or set parameters around our conclusions. Over the last 10 years for example, Scotland has seen a welcome dramatic reduction in the level of children and young people coming into custody, following a decisive shift towards prevention. The reasons behind these reductions is partly attributed to the Whole System Approach (WSA), but are again likely to represent a more complex combination of government strategies.

What is clear is that as numbers reduce in custody, the needs of those few who are imprisoned are likely to be more complex; with young people reporting multiple types of trauma exposure in their lives and consequent significant vulnerability.

There is increasing evidence and legislative support from the Children and Young Person's Act 2018 that young people are experiencing later maturation and require individualised age and stage appropriate services and supports. The youth justice processes should therefore be considered for extension to a wider age group, taking advantage of the success of the WSA and the evidence in respect of maturation. In this regard, the Scottish Association for Mental Health (SAMH) report recommends that:

> *"By 2020, let children and young people stay in specialist services till age 25".*

Including a wider age group raises new possibilities for prison population management and distribution; retaining the possibility for specialism, but potentially allowing young people to be closer to home.

Arguably, there is also a need for a more integrated policy approach to meet the specific needs of adolescents, who too often fall between services designed for either children or adults. The SAMH report also usefully draws attention to this issue as follows:

> *"The extensive inequalities in mental health outcomes by gender, age and SIMD[2], demonstrate the need for a range of national policies to give direction to and support this agenda, these include policies on nutrition and physical activity, drugs, alcohol, suicide prevention, poverty, inequality and also many others that less directly shape the context for mental health".* (Tod et al 2013)

A number of previous reports stress the need for a more strategic approach to prison healthcare overall, addressing key service issues such as staff recruitment and retention.

> *"It was highlighted that nurses working in the prisons had low morale because of recruitment and retention issues and a lack of understanding from the wider NHS of the role of prison healthcare. Furthermore, the Health and Sport Committee (2017) revealed difficulties in recruiting staff to work in prisons and an underutilisation of skills".* (Draft TTM Evaluation 2018)

2 Scottish Index of Multiple Deprivation

The well-evidenced background of young people in custody, who are generally from marginalised communities with poor access to primary healthcare, suggests that services should be based on levels of assessed need, which often exceed those within the general population. The Scottish Parliament's Health and Sport Committee (2017) report concludes that providing prisoners with the best possible healthcare has advantages for the individual, the community, and the NHS, and represents a:

> *"Unique opportunity to tackle health inequalities within a discrete section of the population".*

Engaging with young people, their families and staff from all agencies has been a critical part of our review process, and we have sought at all times to take account of their views and experiences when considering our conclusions and recommendations. What is remarkable is the extent to which the views and experiences of the different focus groups chimed with each other and with findings in the evidence review.

1.4 Conclusions

Many of our conclusions build on recommendations made previously to the Scottish Government, the SPS and its partner agencies. For some issues, like the capacity to share information electronically between agencies, previous work may have been initiated, but ambitions not yet fully realised. Other recommendations seek to offer fresh perspectives on longstanding challenges that face the many dedicated, caring, and compassionate individuals in the NHS, SPS, and partner agencies who work so hard to help our young people, some with the most complex mental health needs, levels of distress and challenging behaviours.

The Scottish Government is taking forward an ambitious penal reform programme that includes increasing the use of community sentences and reducing the use of short-term sentences and remand. HMIPS welcome this initiative, but to support real progress in penal reform, Scotland will need to make further strategic and cultural shifts. These include maximising support for those held on remand, information sharing to inform the management of young people[3], facilitating the maximum use of diversion[4] (where appropriate) and recognising the growing evidence about maturation.

Some of these shifts have the capacity to change our youth justice landscape substantially but, like the WSA, will take an investment from all partners of time, effort and resources. In a time of increasing pressures on the SPS and its partner agencies, both from rising prison populations and fiscal challenges, that will not be easy. Like the introduction of WSA and accompanying initiatives, the upfront investment of additional resources may yield significant benefits downstream. However, the risk of a further rise in incidents of self-harm and suicide amongst young people in custody will only intensify if action is deferred.

1.5 Key recommendations

There are two high level strategic issues that merit specific attention:

1. The lack of proactive attention to the needs, risks and vulnerabilities of those on remand and in early days of custody.
2. The systemic interagency shortcomings of communication and information exchange across justice that inhibits the management and care of young people entering and leaving HMP YOI Polmont.

The review's seven key recommendations, with a wide range of detailed supporting suggestions, are set out with a summary of the findings and conclusions in Section 13.

1. Social isolation, as a key trigger for self-harm and suicide, should be minimised, with a particular focus on those held on remand and during the early weeks in custody.
2. To support more effective risk management, the Scottish Government and other agencies should work together to improve the sharing and transmission of information for young people entering and leaving custody.

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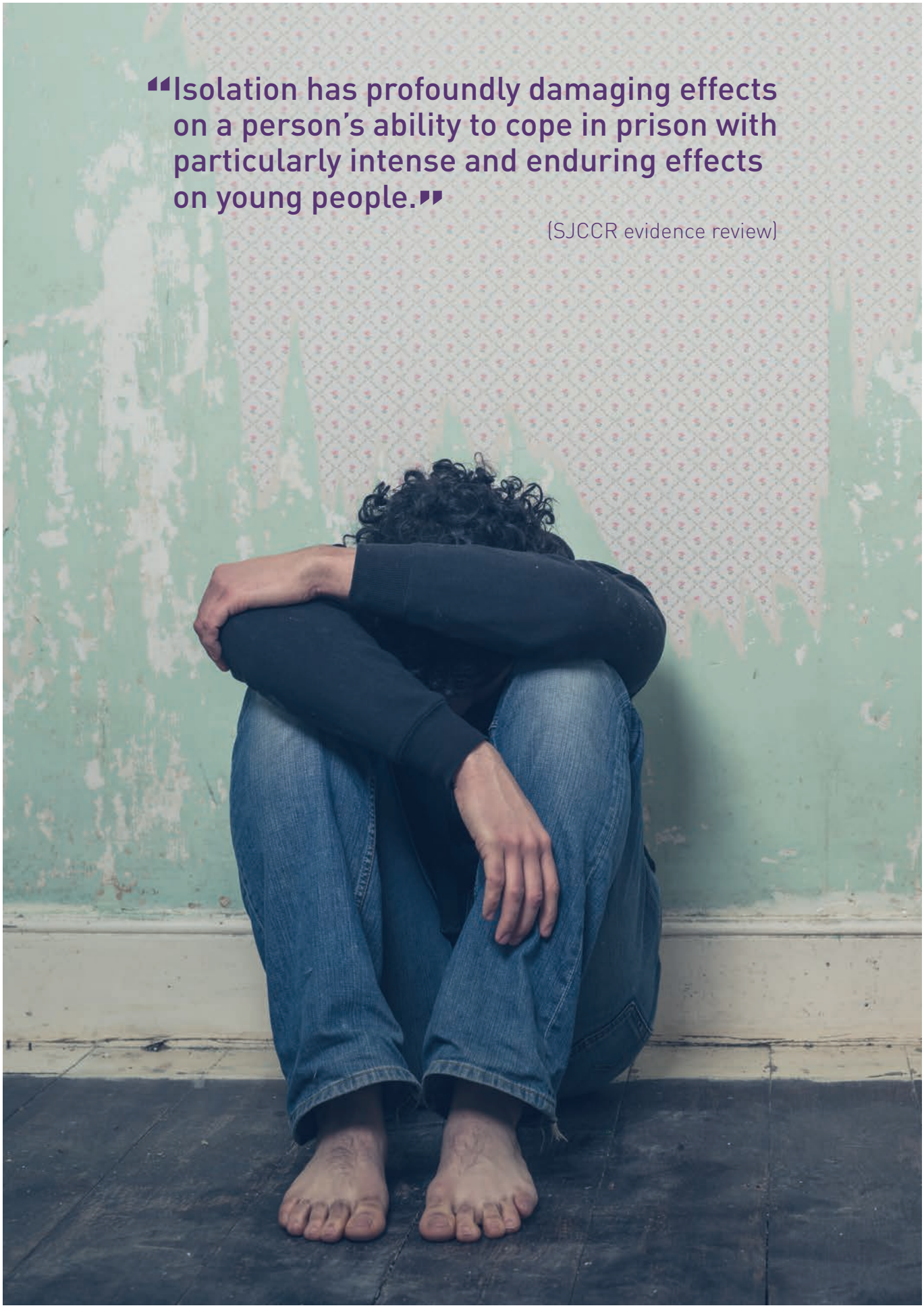
3 Echoed in recommendation 7 in the IPS Thematic Report on the Prosecution of Young People (2018)

4 Recommendation 5 of the IPS Thematic Report on the Prosecution of Young People (2018)

3. A bespoke suicide and self-harm strategy should be developed by the Scottish Prison Service and NHS Forth Valley for young people that builds on the strengths of the existing framework.
4. NHS Forth Valley should develop a more strategic and systematic approach to prison healthcare, with accompanying workforce capacity review and improved adolescent and young people specific training.
5. An enhanced approach should be developed, by the Scottish Prison Service, for the Talk to Me Strategy (TTM) suicide prevention work, with more intensive multi-disciplinary training and a more gradual phased removal for those placed on TTM.
6. Enhanced and more consistent Death in Prison Learning Audit and Review (DIPLAR) processes, by the Scottish Prison Service, are required to maximise learning from previous incidents.
7. Further work should be undertaken by Scottish Government to provide a central coordination point for Government reviews, use the existing analytical expertise to analyse comparative performance on suicides, and consider how the justice system can better respond to international evidence about maturation and alternative models of secure care.

Wendy Sinclair-Gieben

Her Majesty's Chief Inspector of Prisons for Scotland


“Isolation has profoundly damaging effects on a person’s ability to cope in prison with particularly intense and enduring effects on young people.”
(SJCCR evidence review)

2. CONTEXT FOR THE REVIEW

2.1 Commissioning of the review

The Cabinet Secretary for Justice, Humza Yousaf MSP wrote to Her Majesty's Chief Inspector of Prisons (HMCIPS) on the 23 November 2018 (**Appendix B**) to request an expert review of the provision of mental health services for young people entering and in custody at HMP YOI Polmont (the review).

HM Inspectorate of Prisons for Scotland (HMIPS) had recently undertaken a formal inspection of HMP YOI Polmont, during which the health and wellbeing of prisoners at the establishment was inspected by Healthcare Improvement Scotland (HIS). It was anticipated that this review would complement work already undertaken by the HMIPS inspection team.

On the 18 January 2019, the Cabinet Secretary for Justice further announced that he had instructed HMIPS to work with a mental health expert. The review was led by HMCIPS, Wendy Sinclair-Gieben, assisted by Dr Helen Smith, Consultant Forensic Child and Adolescent Psychiatrist, (clinical lead for West of Scotland CAMHS and Honorary Senior Clinical Lecturer at the University of Glasgow) as the mental health expert for the review. Dr Smith has extensive experience of working with young people with mental health and wellbeing issues, including within the care and justice systems.

2.2 Scope and terms of reference

The terms of reference were agreed with the Cabinet Secretary for Justice and were set as follows:

> *"To review arrangements for young people, both untried and convicted, with mental health and wellbeing needs, entering and in custody, including:*
>
> - *The information available to the SPS prior to entering custody;*
> - *reception, screening and assessment arrangements;*
> - *health and wellbeing culture linked to on-going support and supervision;*
> - *treatment and interventions during their time in custody; and*
> - *arrangements by SPS for their return to the community".*

The full scope and terms of reference are set out in **Appendix A**.

In Scotland, the definition of a child or young person differs depending on the context. Throughout the review, we have used the term young person or prisoner to include all children and young people.

2.3 Policy and strategic context

It is important for any review to set its findings in context in order that its purpose can be fully understood and appreciated.

The commissioning of the review reflected the Cabinet Secretary for Justice's desire to ensure that everything possible is being done to minimise the risk of suicide and self-harm in HMP YOI Polmont, and support the mental health needs of young people entering custody, in custody and on return to the community.

> *"Preventing suicide is a global imperative and requires services and communities to work together to provide support to vulnerable individuals"*. (The World Health Organization, 2014)

The World Health Organization highlighted Scotland's choose life – A National Strategy and Action Plan to Prevent Suicide in Scotland, as exemplary for these very reasons. The Scottish Government set out key themes in their Suicide Prevention Strategy 2013-2016, which were namely to improve responses to people in distress.

The approach to youth justice in Scotland builds on the key principles and ethos of the highly influential Kilbrandon Report, published in 1964. Concerned with legal provisions and systems to treat "children in trouble", it concluded that there was little distinction between those who commit offences and those in need of care and protection and advocated, for both, a welfare-based approach.

Its visionary recommendations led to the establishment of the Children's Hearing System. A distinct system with the responsibility of making decisions in the best interests of the child and where, for all but the most serious offences, children and young people who commit offences, and those in need of care and protection are dealt with in the same forum, in the same way.

Over 50 years later research, underpinned by scientific evidence, has established a strong association between young people who have experienced some form of Adverse Childhood Experiences (ACEs) and other adversities and those engaging in harmful or risk-taking behaviours, bringing them into contact with the criminal justice system, whether as a perpetrator or as a victim. Children involved in a pattern of offending, or who are involved in more serious offences, are almost always our most vulnerable, victimised and traumatised young people.

> *"The link between vulnerability and offending is retrospective not predictive, in that most children who experience ACEs and trauma do not go on to seriously offend, but children who are involved in serious offending or frequent offending almost always have experienced trauma".* (CYCJ Key Messages 2016)

The recognition of the impact of prolonged exposure to stress and trauma in childhood resonates with the central premise of the Kilbrandon Report; that many young people who present a high risk of offending are often highly vulnerable, with complex needs.

The focus on early intervention and a welfare-centred approach to children and young people is at the heart of the current approach to youth justice in Scotland – the WSA and the underpinning principles of GIRFEC. It is a child-centred, welfare-focused approach promoting, in a multi-agency context, early interventions to respond to the first signs of harmful behaviour.

A number of other Scottish Government strategies and approaches are clearly relevant in this context and underpin the need to focus on the health and wellbeing of young people, notably:

- Mental Health Strategy 2017-2027
- Scotland's Suicide Prevention Action Plan: Every Life Matters
- Justice in Scotland: Vision and Priorities – which identified improving health and wellbeing in Justice settings as a priority
- Whole Systems Approach (WSA)
- Rights, Respect and Recovery: Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths

Some planned legislation currently before the Scottish Parliament is also potentially relevant, notably:

- The Management of Offenders (Scotland) Bill
- Age of Criminal Responsibility (Scotland) Bill
- The Extension of the Presumption against short-term sentences in the Criminal Justice and Licensing (Scotland) Act 2010

Our review commissioned a policy mapping exercise supported by the current legislative background, planned legislation and relevant strategies. These are set out in **Appendix E**. What has become clear is that there are multiple reviews being commissioned with a considerable degree of overlap. There is a clear need for central coordination to prevent fragmentation, reduce duplication, ensure knowledge management and develop clear guidelines for user voice research.

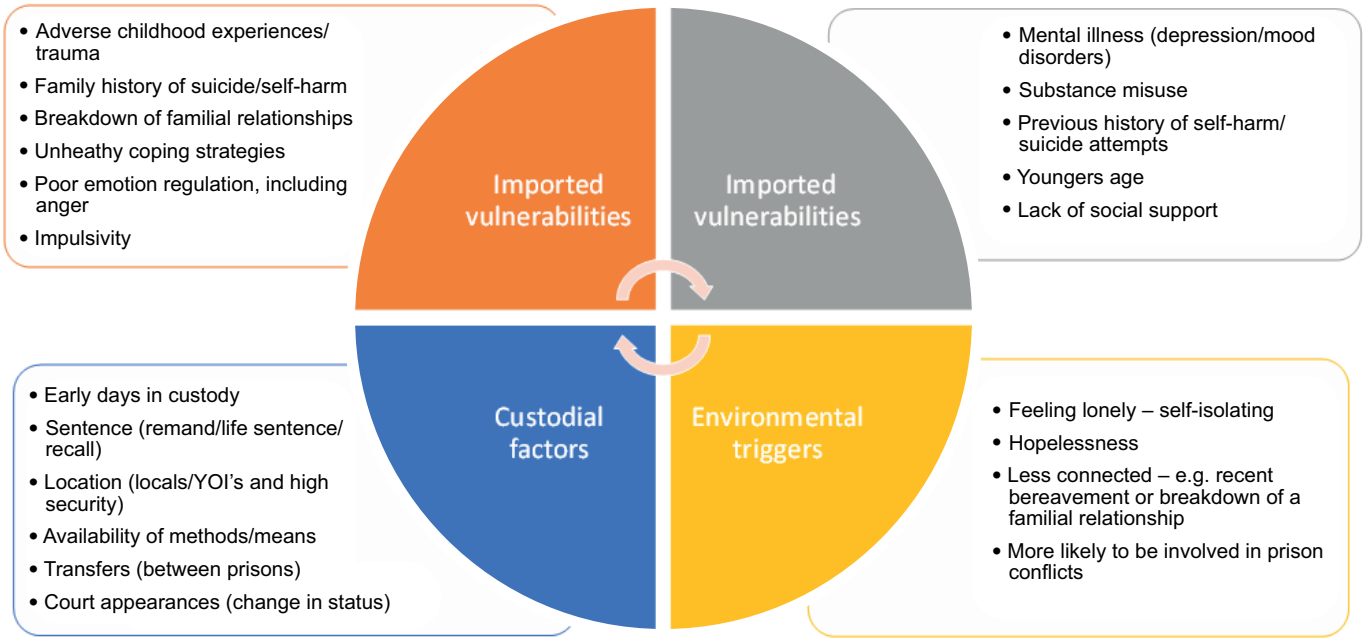
All of these strategies and initiatives will inform Scotland's drive to improve the health and wellbeing of each one of its young people, including those who are most vulnerable within the justice system. Indeed, the Scottish Government has made clear in their Scotland's Suicide Prevention Action Plan: Every Life Matters that:

> *"The Scottish Government believes that no death by suicide should be regarded as either acceptable or inevitable".*

This review strongly concurs with this view, but acknowledges that it can be very difficult to identify those who might or intend to take their own life, despite the very best efforts of committed and caring staff. Suicide and self-harm are complex issues and many of those who go on to take their own life in custody do not display any obvious presentation that would identify them as at risk. Academic articles suggest:

> *"That there are no simple ecological explanations for prison suicide. Rather, it is likely to be due to complex interactions between individual-level and ecological factors. Thus, suicide prevention initiatives need to draw on multi-disciplinary approaches that address all parts of the criminal justice system and address individual and system-level risk factors".* (Fazel et al 2017)

The Ministry of Justice summarise these multiple inter-related factors helpfully in the following diagram, contained within their report 'Review of Self-inflicted Deaths in Prison Custody in 2016 (for England and Wales).



What is clear however is that being traumatised, being young, being held on remand and being in the first three months of custody compounds the risk of suicide.

As the review has progressed, we have identified other themes or issues that either set our work in context or set parameters around our conclusions. Over the last 10 years for example, Scotland has seen a welcome dramatic reduction in the level of offending and incarceration by children and young people. The reasons behind these reductions. while nominally attributed to the WSA are again likely to represent a complex combination of factors. However, what is clear is that as numbers reduce in custody, the needs of those few who are imprisoned are increasingly complex. With young people reporting multiple types of trauma exposure in their lives and significant vulnerability as a result, identifying and managing risk becomes a priority.

The UK Justice Policy Review notes that:

> *"Younger prisoners and ex-prisoners have the highest risk of death relative to people of the same age in the general population".*

3. INTERPRETING THE STATISTICS ON SUICIDE

3.1 Comparative Data

Before looking at support for mental health in HMP YOI Polmont, we began our review by trying to understand how Scotland compared with other countries in terms of suicide rates.

Young people are known to be a high-risk group in both the community and within custody, with under 24 year olds accounting for 10% of all suicides in Scotland over the last five years.

A range of national and international quantitative data is available to assist our understanding of how, when and where suicides occur. The review has sought to supplement this with qualitative information to provide a rich picture of the nature of the problem we face. Numbers are useful, but often only represent one perspective on the issues and sometimes are not of significant assistance in identifying effective solutions.

Our evidence review (commissioned from the Scottish Centre for Crime and Justice Research (SCCJR) and set out in **Annex A**), notes both the relatively small absolute numbers of suicides and the difficulties in analysis that can arise because of differences in definition and data collection methodologies between international jurisdictions. From the reviews perspective, the key point is that:

> *"The death of a young person in prison remains a relatively rare phenomenon in Scotland".*
> (SCCJR evidence review)

We agree with our evidence review that further analysis of Scotland's comparative performance, focused on potential best practice solutions across international jurisdictions would be worthwhile.

Although our evidence review concludes that Scotland has a higher rate of suicide than many other developed countries, it also highlights the challenges that exist in comparative analysis of prison suicide:

> *"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".*
>
> *"The importance of exercising caution in both analysing and interpreting prison suicide data".*

For the purposes of statistical analysis, differences in methodology between studies to include or exclude even one or two deaths by suicide can lead to huge differences in the calculated rate of suicides in custody in Scotland when extrapolated as per 100,000, because the numbers involved are very small in absolute terms. This is particularly problematic when that calculated rate is used in comparison with other jurisdictions where both the number of suicides and the total prison population are significantly larger.

Our evidence review authors concluded that:

- 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; and
- most suicides of young people take place within three months of being detained.

Recommendation

The review team recognise that some of the conclusions on suicide rates reached in the evidence review may be challenged. The review team is aware of the difficulties in interpreting potentially conflicting statistical data, including comparative suicide rates. We therefore recommend that the Scottish Government undertakes further work to better understand Scotland's position relative to other jurisdictions.

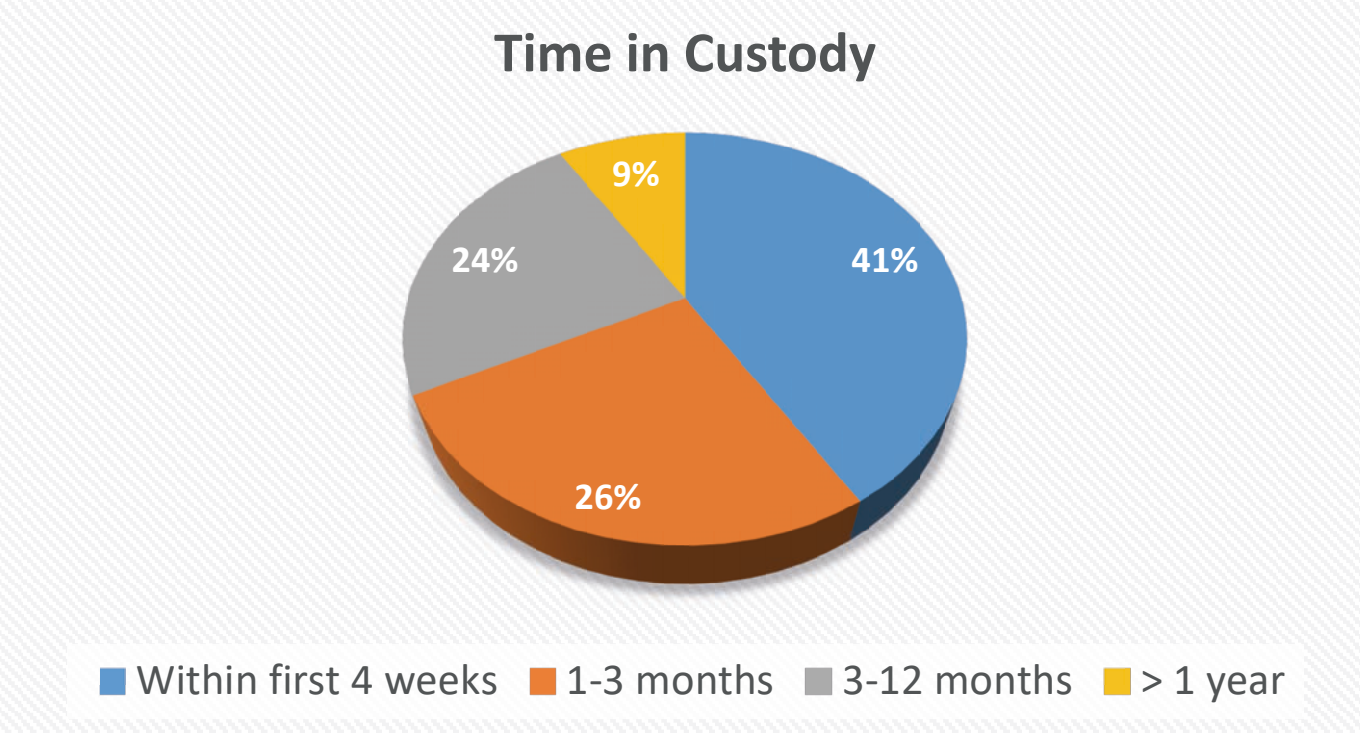
3.2 SPS Data

The review team were given ready access to internal SPS management information which assisted their considerations.

Again, care needs to be taken regarding interpretation of any figures given the low numbers and the fact that any fluctuation could be significant in percentage terms.

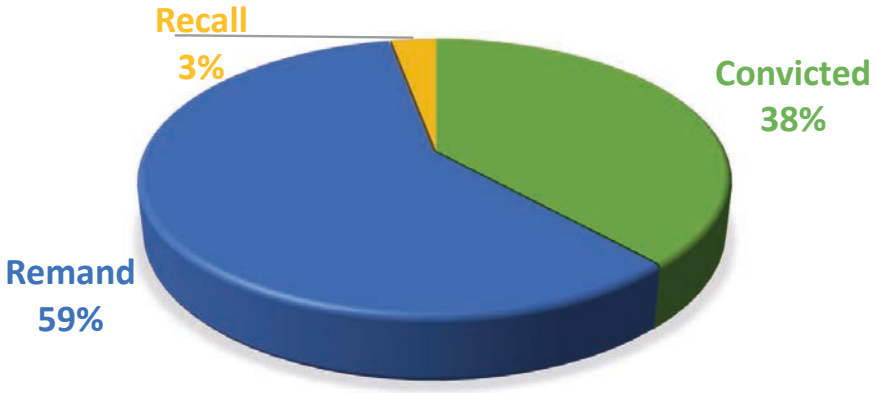
In general, the data shows a relatively stable picture, with increases in 2017 and 2018. Rolling averages are described as being within the parameters of the static trend of the last 15 years. Figures for the three years for 2016-2018 appear to show that HMP YOI Polmont is over-represented with regards to the percentage of apparent suicides, compared to their percentage of total population. The data suggests some interesting areas for consideration, including in relation to early admission and remand.

In this context, the SPS note that 67% of all deaths by apparent suicide in prison occurred in the first three months of being in custody.



This chart shows time in custody prior to apparent suicide

In the three years from 2016-2018, of the 34 total prisoners across all SPS establishments who died by apparent suicide, 13 were convicted, 20 were being held on remand and one had been recalled. While on a single day approximately 80% of the prison population is convicted and 20% are held on remand; the churn factor shows that over a 12 month rolling period the population split is nearer 50:50.



The chart shows the percentage of those who died across all SPS establishments by apparent suicide, by legal status:

In addition, 24 of the total individuals committing apparent suicide in custody had a history of previously being managed on the SPS Suicide and self-harm strategy, previously ACT2Care and currently TTM and three of them were on ACT2Care/TTM at the time of their death.

71% of those who died by apparent suicide had previously been managed on ACT2Care/TTM.

Other SPS data suggests that around 25% of all young people placed on TTM were assessed as no longer at risk and removed from TTM within three days. **Given the number of suicides where the individual was previously on TTM, a more gradual, phased reduction of care may be appropriate.**

3.3 Understanding the characteristics of those most at risk of suicide

Academic evidence argues that the circumstances of those who die whilst under supervision in the community have been neglected. There are further opportunities to focus our collective data gathering efforts to better understand the full life journey and risk factors of young people who experience the care or justice systems.

> *"In England and Wales there has been significant public (and academic) concern for deaths in custody, the deaths of those subject to community supervision has not been studied nearly as much".*
> (Suicide and Community Justice, Phillips et al (2018))

Suicide rates are strongly correlated with gender. Rates are significantly higher for men than for women, but the increased risk of suicide for women in prison has been noted.

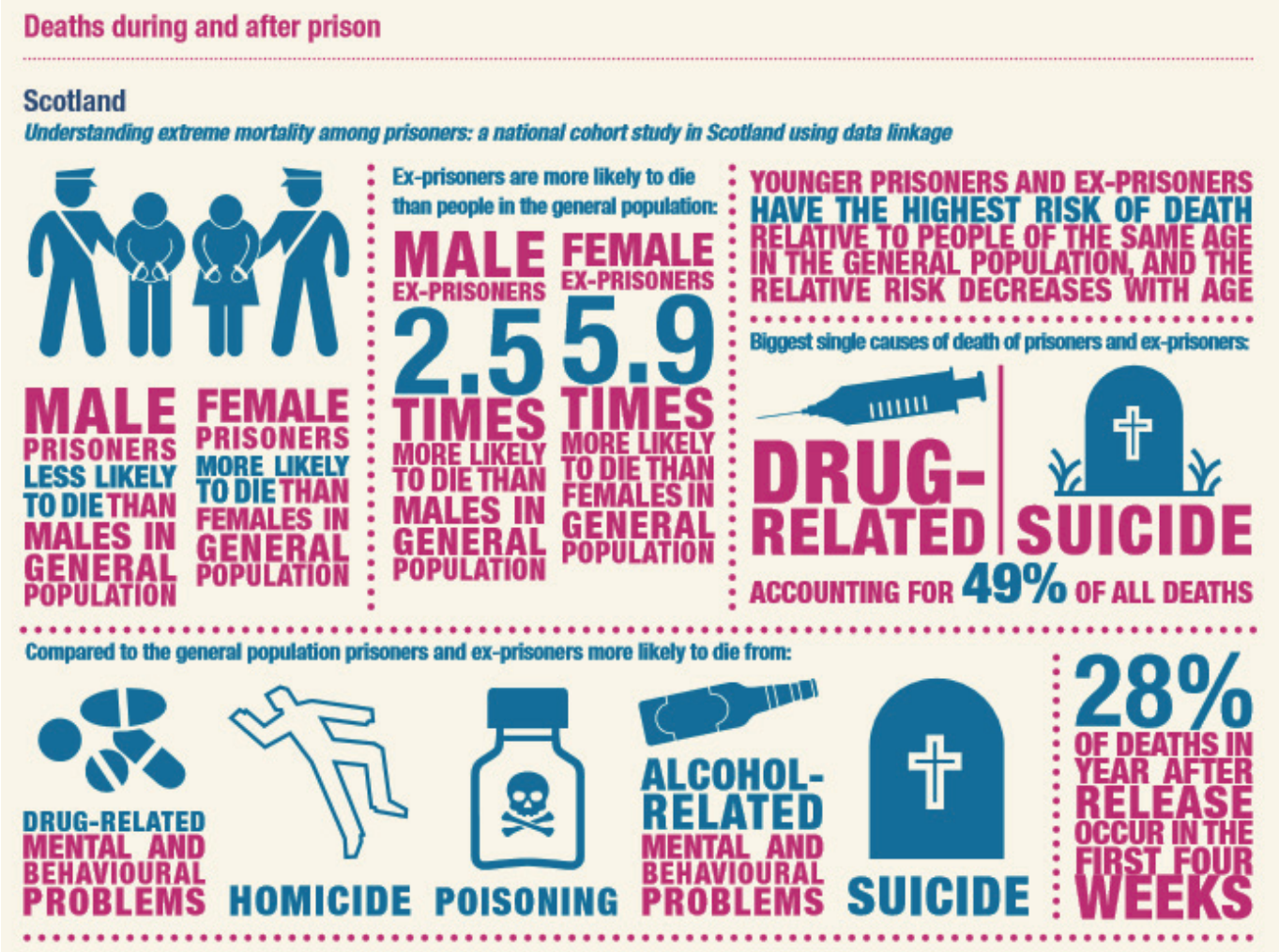
> *"Suicide rates are strongly correlated with gender with death rates from suicide being four-to-five times higher for men than for women across the European Union".* (OECD, 2018)
>
> *"The increased risk of suicide for women in prison has long been recognised (Sandler and Coles, 2018) and our analysis suggests that the risk for women offenders in the community is even higher".*
> (Suicide and Community Justice, Phillips et al (2018))

Liberation should be a focus of concern. A well-established trend is that mortality risk from all causes of death, including suicide, for those leaving prison is at its highest in the 30 days following release (Graham et al).

The rate of suicide in the first four weeks in the post liberation period account for 28% of the deaths in the year (Suicide and Community Justice, Phillips et al (2018)).

> *"Ideally, those individuals leaving custody with mental health issues should be fast-tracked into support, taking into account the evidence that it is the first few weeks out of prison that can be the most challenging".* (Draft TTM Evaluation)

The following figure shows that the disproportionate number of self-inflicted deaths early in custody is echoed in the disproportionate number of self-inflicted deaths in the early period post release.



UK Justice Policy Review

4. HMP YOI POLMONT

Having considered how suicide rates in Scotland compare with other countries, and how the suicide rate in HMP YOI Polmont compares with other Scottish prisons, it is important to consider the ethos of HMP YOI Polmont and the particular characteristics of the young people in custody there.

HMP YOI Polmont holds a complex mix of cohorts; young men across the full remand and convicted sentence range, young female offenders and adult female offenders.

All young offenders have provision under the Prison rules to be held until age 23, recognising maturation. All courts admit to HMP YOI Polmont. The design capacity of the establishment is 758 with 607 single rooms.

It is important to recognise that the number of young people in custody has significantly reduced since the introduction and implementation of successive governmental Youth Justice Strategies, the WSA in 2011, and the accompanying principles of a rights-based GIRFEC ethos. This approach drives early effective interventions and has as its basis a determination to prevent young people offending and subsequently entering custody.

The SPS are committed to 'unlocking potential and transforming lives' and specifically in HMP YOI Polmont to working with the youngest in their population. Since 2012, HMP YOI Polmont has been working with strategic partners such as Education Scotland to create a 'Learning Environment' for young people, based around the underpinning principles of GIRFEC and the key capacities identified in Curriculum for Excellence, (Successful Learners, Confident Individuals, Responsible Citizens and Effective Contributors). The SPS Vision for Young People in Custody , December 2014) has as a key aim:

'Using the time a young person spends in custody to enable them to prepare for a positive future'

The establishment recognised, early in its developmental journey the need to support learning by developing a broad underpinning range of health and wellbeing supports, in recognition of the levels of childhood trauma experienced by the young people being admitted.

The SPS has commissioned research to better understand the vulnerabilities of the young people accommodated within HMP YOI Polmont. This forthcoming research, commissioned by the SPS, by Cesarani highlights the comparatively high levels of ACEs amongst young offenders in HMP YOI Polmont:

- 33% were looked after and accommodated (LACC) as a child;
- significantly higher experience of traumatic bereavement (murder, suicide or drug overdose) in their family or close friends;
- exposure to multiple types of trauma;
- over a third had experienced at least one head injury;
- half displayed learning difficulties; and
- a high number of school exclusions.

The research highlights that young people's childhood experiences add to the challenging nature of their behaviour, but also to their vulnerability.

Following the deaths in custody in 2018, the Chief Executive of the SPS took the additional measures at HMP YOI Polmont on the prevention of suicide. These actions included:

- The development of a specification for additional support for Prison Officers engaged in the management of young people through periods of heightened stress and risk at HMP YOI Polmont, to be led by the local SPS psychology team. This included a proposal for a Multi-disciplinary Mental Health Team (MDMHT);
- the allocation of an additional senior manager post with specific responsibility for the oversight of the effective operation of the suicide prevention strategy;
- the development of a training plan for staff at HMP YOI Polmont to ensure continuing professional development in areas specific to working with young people in states of heightened stress anxiety or depression. This included additional capacity for the delivery of internal training and procurement of Scotland's 'Mental Health First Aid (MHFA) for Young People' for delivery in 2019;
- a health needs assessment for the HMP YOI Polmont population, in collaboration with NHS Forth Valley; and
- a trend analysis of ligature use and an audit of in-cell ligature points at HMP YOI Polmont to inform a safer spaces workstream.

5. HMIPS 2018 INSPECTION OF HMP YOI POLMONT – FINDINGS

5.1 General Findings

HMIPS 2018 Report on the Inspection of HMP YOI Polmont

A full inspection of HMP YOI Polmont took place between the 29 October and 9 November 2018. An impressively wide range of external partners engage with the establishment in the delivery of services. The inspection report concluded that:

> *"HMP YOI Polmont is a leading edge prison, clearly demonstrating the SPS investment in attempting to break the offending cycle at an early age, through evidence-based practice".*

In recent years, efforts had been made to ensure that both the activity and living environments for young people were less institutional and more welcoming. Although evidence suggests that:

> *"Prison suicides are likely to be the result of a complex interaction of different factors, and not merely due to the prison environment".* (Fazel 2017)

The Harris review recognised that:

> *"Prisoners experience a worsening of health problems, anger, frustration and anxiety sleep disturbance fatigue, and depression as situational factors. The nature of imprisonment itself does real harm to people".*

The Scottish Governments WSA advocates that secure care should be used where possible, rather than YOIs. For these reasons, the inspection team felt that there might be merit in an alternative model that combined the expertise of the SPS and secure care providers for young people:

> *"To review the appropriate location for the removal of liberty for children in detention. HMIPS would like the Scottish Government and the SPS to consider a hybrid model of secure care for children".*
> (HMIPS 2018 Inspection report of HMP YOI Polmont)

The review notes the current tight timescales for commissioning of the Secure Care contract, and the opportunity of the ongoing Independent Care Review deliberations on this area of service provision, and urges the Scottish Government to consider alternative possibilities to influence the shape of future services.

A number of positive factors were highlighted during the inspection that have relevance to mental health outcomes for our review:

> *"There was a comprehensive strategy in place for the prison's future, with a clear communication plan. Staff were trained, experienced, informed and engaged to manage the complex cohorts in their care. Staff openly acknowledged that they had benefited from the additional training and awareness sessions delivered, which underpinned the strategic direction".*
>
> *"Overall, staff and prisoner relationships were admirable, with most staff able to articulate and apply the principles behind the operating imperatives, philosophy and underpinning research. Prisoners and staff reported that they felt safe, and inspectors saw evidence of positive and respectful relationships between staff and prisoners".*
>
> *"The healthcare team at HMP YOI Polmont was a well-motivated and caring workforce, committed to providing a high quality of care to their patients".*
>
> *"An impressively wide range of external partners engage with the establishment in the delivery of services. Inspectors welcomed a number of very positive initiatives, including the impressive partnerships with the community to deliver an enticing and relevant regime with multiple opportunities".*

It is to be expected that inspections, in the process of supporting continuous organisational improvement, will identify issues that require to be addressed, and sometimes concerns that are pressing and require more immediate action.

5.2 Health

The provision of mental health had many examples of good local practice and inspectors particularly welcomed the approach to substance misuse, the screening assessment by trained mental health staff and the rapid referral to psychiatry if required.

There were however a number of areas identified for improvement that contributed to the HMIPS Standard 9 (Health and Wellbeing) attracting an overall rating of 'poor'.

Concerns included:

- Staff shortages leading to inadequate support and supervision compounded by senior staff shortages;
- non-standardised assessments which reflects the national picture, in mental health and reception screening; and
- lack of a multi-disciplinary approach to mental health.

Many of the challenges, in particular staff recruitment and retention experienced by NHS Forth Valley in HMP YOI Polmont, are a reflection of national themes experienced in many prisons across Scotland.

5.3 Social Isolation

There was a cultural acceptance that remand prisoners need not be proactively encouraged to attend the purposeful activities and wellbeing opportunities available. This meant that opportunities were being lost to address social, criminogenic and community barriers to living a crime free life. Unintended isolation from this approach was a key concern for HMIPS.

6. THE REVIEW METHODOLOGY

6.1 Overall approach

As indicated previously, the review tasked us with reviewing arrangements for young people, both untried and convicted, with mental health and wellbeing needs, entering and in custody at HMP YOI Polmont, including:

- The information available to the SPS prior to entering custody;
- reception, screening and assessment arrangements;
- health and wellbeing culture linked to ongoing support and supervision; and
- treatment and interventions during their time in custody and arrangements by SPS for their return to the community.

The terms of reference, as set out in **Appendix A**, guided the scope and direction of the review, its methodology and the membership of the review group, but left the specific methodology at the discretion of HMIPS.

We were clear from the outset that a key focus of our review should be to draw directly on the views and lived experiences of staff, young people and their families.

We were tasked with making recommendations to improve current process to Scottish Ministers, escalating any issues of immediate concern and suggesting any further reviews that arose out of the investigation.

We put together a short life steering group (the Roundtable) to:

- Agree the scope of the review, terms of reference, and timescales for completion;
- assess the scope for other Inspectorate/Agency involvement;
- agree required input, information-sharing, and involvement going forward; and
- invite members to share their experience of recent reviews and taskforce activity that could inform this Expert Review on Mental Health and Young Offenders.

Three multi-agency short life working groups were then established, reporting into the Roundtable. My grateful thanks go to the many agencies who supported and contributed to this review:

6.2 Short Life Working Groups

Short life working group 1

"To critically review the process and information sharing on admission to HMP YOI Polmont, and subsequently on liberation from the prison into the community".

Short life working group 2

"To critically review the clinical and wellbeing support that young people receive in custody". (Including the SPS TTM Strategy process).

Short life working group 3

"To critically review the current Death in Prison Learning Audit and Review (DIPLAR) process for deaths in custody in HMP YOI Polmont". (This was a review of the process only, recognising the sensitivity of including the circumstances of individual cases still subject to Fatal Accident Inquiry (FAI)).

These three groups operated independently of one another, but had some common members for continuity and sharing of information.

6.3 Methodology Activities

Collectively, our review undertook the following activities:

Evidence review

- Commissioned a review of academic evidence and gathered relevant policy documentation from other sources; and
- mapped current Scottish Government policy, legislation and ongoing related reviews.

User Voice

- Organised focus group discussions with volunteer young people in HMP YOI Grampian (for those who had previously been in HMP YOI Polmont) to hear directly from those with lived experience. The groups included young men and young women who were serving a sentence or were being held on remand. Young people across the full age range held in HMP YOI Polmont were consulted throughout the review where possible. Standardised questions were developed to support the focus group process and ensure consistency of approach. Questions were themed around the following issues:
  a. Support on arrival in prison
  b. Available services to support mental health and wellbeing
  c. Seeking help and availability of support
  d. People and processes that work well
  e. Potential concerns and areas for improvement;
- gathered information from focus groups with nominated NHS and SPS staff. SPS staff who attended were drawn from all operational areas of the establishment, representing the interests of the full range of population groups;
- held one-to-one discussions with families of young people; families indicated a willingness and desire to speak to the review; and
- interviewed staff from representative agencies working within HMP YOI Polmont.

Information Sharing

- Developed a matrix to identify gaps and inform thinking in respect of information sharing and transmission at key decision points.

Health and Wellbeing Clinical Review

- Walked the 'young persons' admission journey' from court to custody, including reception screening and allocation to a cell at HMP YOI Polmont;
- undertook a healthcare case record review for those young people in HMP YOI Polmont with identified mental health issues. Looking specifically for evidence of:
  a. Information received at the point of entry to custody
  b. Initial assessment on the point of entry to custody
  c. Joined up inter-agency working
  d. Frequency of patient review
  e. Indication of engagement with wellbeing opportunities
  f. Handover information at decision points
  g. Information forwarded to facilitate ongoing care on the point of liberation
  h. Examination of assessment of mental health difficulties and risk assessment processes;
- completed a review of NHS clinical mental health provision in HMP YOI Polmont; and
- concluded a wider review of available preventive services to support health and wellbeing at HMP YOI Polmont.

TTM

- Undertook targeted one-to-one interviews with vulnerable young people who were part of the mental health team caseload and who had recent experience of TTM;
- attended a TTM case conference; and
- reviewed the work of Dr Briege Nugent (completed in March 2018) in respect of the TTM Strategy.

DIPLAR

- Reviewed the SPS and NHS Forth Valley DIPLAR and Adverse Events processes respectively, (including access to joint DIPLAR review papers in HMP YOI Polmont for cases in the last five years, where FAI hearings had concluded, and learning plans from cases not yet heard at FAI).

Visits

- Visited secure care facilities (The Good Shepherd Centre and St Mary's Kenmure) for comparative purposes; and
- visited the Separation and Reintegration Unit (Dunedin) in HMP YOI Polmont and spoke to staff and young people.

Throughout the review, care was taken to ensure that practice was examined by those members best suited with the required technical and professional expertise. Evidence gathering processes were standardised for consistency. Evidence collated was triangulated and review members worked together wherever possible to cross check information and understanding. Learning from the review was compared with recent inspection outcomes.

The extent and depth of information gathering was necessarily limited by the timeframe for the review. However, outcomes were consistent when compared with evidence sources internal and external to HMP YOI Polmont, providing reassurance in respect of the validity of findings and subsequent recommendations.

A further Roundtable discussion was held at the end of the review to test the emerging conclusions and recommendations with the wider review group, and the full draft report was also circulated to a selection of review team members and an editing panel made up of representatives from the Roundtable, for comment and a factual accuracy check.

7. THE EVIDENCE REVIEW

7.1 Terms of reference

"An evidence review of mental health and wellbeing support for young people in custody, including any areas of best practice".

7.2 Approach

HMIPS commissioned from the SCCJR, University of Glasgow an evidence review of '***Mental Health and Wellbeing Young People in Custody**, including any areas of best practice'.*

The full report can be found at **Annex A**. We are indebted to the authors Sarah Armstrong and John McGee for their diligence and assistance in supporting HMIPS.

The SCCJR developed an executive summary entitled 'Key Messages of the SCCJR Evidence Review' reproduced below. However, HMIPS recommend that the full evidence review is read to gain contextual understanding.

The evidence review noted the very small number of suicides of young people in custody in Scotland, which made it difficult to examine, extrapolate and reach conclusions. The authors therefore included evidence from the UK and USA where there has been recent significant work on self-inflicted deaths of young people that bore examination for comparison.

A full Bibliography can be found at the end of **Annex A**.

The evidence review highlights a number of high-level issues that are echoed in the HMIPS review findings, in particular:

- The frequency of interagency failures in communication and information sharing and the need for greater consensus, data sharing and ease of transmission;
- the increased risks associated with being held on remand or early in their sentence;
- the criticality of reducing isolation to an absolute minimum;
- the importance of family and peer contact as significant protective factors;
- **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'**;
- recognising that traditional methods of keeping people safe can actually add to the distress – **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**;
- the potentially powerful influence of prison staff, and the need for appropriate resourcing, support, 'age and stage' and cohort specific training; and
- lost opportunities for early diversion of young people out of the justice system.

> '**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'** (evidence review)

7.3 Key Messages

7.3.1 Evidence Search and Approach (Annex A – Chapters 1 and 2)

The review considered existing evidence on the mental health and wellbeing of young people in custody, focusing on suicide risk and prevention in settings of confinement. It abandoned a systematic review approach early on as this produced highly unsystematic results that over-represented clinical and medical/health evidence, and under-represented a range of disciplines and forms of evidence.

Evidence was collected internationally, limited to English language documents. The evidence was dominated by work from England and the USA.

Evidence was organised into a 'frames and factors' approach to take account of the quite distinct ways that the issue of mental health issues are positioned. These shape alternative and sometimes contradictory understanding of what the problems are, and what can or should be done about them. Different frames (and the factors they emphasise as relevant) cannot easily be reconciled or prioritised; they should be considered in the round.

7.3.2 Comparative Context of Prison Suicide (Annex A – Chapter 3)

- Suicide is the leading cause of death of young people (16-24 years) 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 suicide of young people in prison takes place within three months of being detained.

7.3.3 Institutional and Environmental Frames and Factors (Annex A – Chapter 7)

- 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.
- 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.

7.3.4 Social Isolation and Relationships Frames and Factors (Annex A – Chapter 6)

- 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.
- 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 that can reduce feelings of isolation 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 that support and allow social development.

7.3.5 Operational, Situational and Management Frames and Factors (Annex A – Chapter 5)

- Situational factors consistently observed in self-inflicted deaths in prison include:
  - being in the early days or weeks of a sentence
  - being isolated
  - being held 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 engagement can be impoverished.
- 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.

7.3.6 Rights-based and Person-centred Frames and Factors (Annex A – Chapter 8)

- Dignity, respect, a sense of care and 'being treated like a person not a number' emerged as dominant concerns.
- 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 frameworks see vulnerabilities of those in prison as a ground 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.

7.3.7 Individual/clinical Frames and Factors (Annex A – Chapter 4)

- Individual predictors 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' also are found among those who have died from self-inflicted causes in prison, but 'vulnerability' is a contested concept on the grounds of being over inclusive and over individualising.
- Individual level and clinical frames recognise the contribution to excess suicide in prison, but often employ simplistic or limited understandings of other forces, especially institutional factors.

7.3.8 Conclusions (Annex A – Chapter 9)

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.

The full evidence review, summary and tables can be found in the **Annex A**.

8. USER VOICES – The views of young people, their families and staff

8.1 Terms of Reference and Approach

We were asked, as part of the terms of reference, *'to draw directly on the views and lived experience of young people, staff and the families of those with identified mental health and wellbeing needs both currently in custody at HMP YOI Polmont and those with lived experience of custody'.* Therefore, we set up various focus groups.

Engaging with young people, their families and staff from all agencies has been a critical part of our review process, and we have sought at all times to take account of their views and experiences when considering our conclusions and recommendations. What is remarkable is the extent to which the views and experiences of the different focus groups chimed with each other and with findings in the evidence review.

Focused discussions took place on site at HMP YOI Polmont, and additionally with a group of slightly older young people who had spent time in HMP YOI Polmont but who had since moved on to HMP YOI Grampian. The latter discussion allowed for some helpful reflection and some limited comparison with another establishment experience. Individual interviews also took place with young people who were on the TTM Strategy within HMP YOI Polmont who had access to the available mental health service supports.

8.2 Key findings

Some similar opinions were expressed by the focus groups, regardless of their age or their personal/professional perspective. The issues that attracted the most attention or the greatest level of debate included the need to:

- Further adapt TTM procedures to meet the specific needs of young people, and specifically to address the sterility of the 'safer cell' environment and the manner of its use;
- place greater emphasis on the provision of therapeutic interventions and wider wellbeing supports to address underlying issues for young people;
- ensure quality time and ready access to build and maintain relationships with staff, families and peers; and
- build staff confidence with trauma informed, gender, and 'age and stage' specific training.

8.3 Young people

There were similarities of view between the groups of young people consulted, raising sensitive subjects such as trust, confidence to disclose and the impact of drugs. Young women tended to place slightly greater emphasis on access to services. Young men (over age 21) in HMP YOI Grampian commented about their more recent experience there and issues that centred around staff shortages, which could impact on access to basic services. One young man indicated that in comparison, the regime structure in HMP YOI Polmont was helpful, consistently available and relaxed.

> *"I would go back to Polmont in a heartbeat".* (young person)

Critically, young people commented on the need for earlier intervention in their lives.

> *"A lot of the boys in here have been in and out of secure. It's too late to intervene now, it should have been done earlier in the care system".* (young person)

Some of the other issues emerging from discussions with young people included:

- **It can be difficult to spot those at risk of attempting suicide** as they can look *"perfectly fine";*
- **there was recognition that mental health problems were widespread** amongst the population;
- **the experience of being sent to HMP YOI Polmont was worrying and scary for all young people,** though these fears often proved not to be realised once admitted;

> *"I felt freaked out coming in".* (young person)

- **some processes, especially those during the reception process could feel like a 'tick box' exercise**. Being asked repetitive questions about self-harm and suicide was unhelpful. Speaking to the nurse in private in reception was reassuring. Some young people were concerned about confidentiality in relation to mental health disclosure;
- '***practical support like an admission pack mattered and made you feel better****. Admission was often difficult to remember because of being under the influence. Being given clothes of poor quality or that did not fit you properly affected how you felt about yourself.*';
- **safety was a concern,** which was felt to be mediated by the young person's perceived status. Some young people felt at risk from staff, others felt intimidated and bullied by other young people;
- '***a room to yourself was generally better than cell sharing****, unless you already had a close relationship with the person you were sharing with and it was jointly agreed to be supportive.*';
- **access to activity and some services when held on remand was limited and unhelpful**. There was a lack of access to services such as addictions until the point of sentence, which could leave young people held on remand for several months without much needed support;
- **TTM procedures, especially the room design, observation routines and special clothing felt like a punishment.** Rooms could be cold. Lack of access to TV or other things to occupy the mind in safer cells could lead to further deterioration in mental health and intensify suicidal thoughts. These issues prevented young people from talking to SPS staff or NHS nurses about their mental health because:

  "If you talk about your mental health everything gets stripped and you get put in a safer cell; it's like a punishment". (young person)

- **access to family is critical, especially on arrival, when feeling low, and out-of-hours.** Some young people felt that family should routinely be alerted when someone is on TTM, particularly if they have attempted suicide or are threatening to do so, as family *'have a right to know'* and can potentially provide helpful emotional support;
- '***phones in rooms would be good****, as having to request a phone to be put in during patrol periods for support was stigmatising.*' Having only 30 pence to use on the phone on arrival was unhelpful, and time available to make phone calls was limited. In HMP YOI Grampian lack of access to activity meant that young people could not earn enough money for the phone;
- **young people thought the peer mentors and listeners schemes might help some, particularly during the reception process, but said they personally wouldn't use them** as you could be *'seen as a 'grass'*;
- **informal peer support groups could help access other support**, led by someone trusted (with a perceived neutral relationship to the prison) such as chaplaincy or youth work. This might help young men in particular to feel more able to talk. Young people wanted more informal facilitated opportunities to talk to their friends about how they were feeling;
- access to sport was a good thing to cope with stress, **but there also needed to be services which helped people deal with their underlying issues**. *'Smash-ups'* happened when people were depressed or frustrated;
- **issues for young women were similar, but placed greater emphasis upon accessibility of services.** Some services were not known about or appeared unavailable to all populations. A specific barrier appeared to be the mental health referral form, especially for those with literacy difficulties. It was felt that 'drop in' sessions rather than clinics and a waiting list might assist. There had been delays in getting medications for a number of young women. Young women also wanted more staff training and available to provide gender sensitive support to women;
- **staff attitude was key … asking about you, how you are feeling, not being treated like a number.** It was important that staff, especially those during the reception process, listened. NHS staff were said to sometimes make throw away comments in front of other prisoners about medication, which could result in young people being bullied. Contact with staff who cared was remembered, but personal officer contact was felt to be lacking;

  "Talk to Me saved my life. I have been on it three times. The last time I was in a bad way. Staff were very good and listened to me, and only took me off it when they thought it was safe. They did a great job, and it (TTM) is a great thing". (young person)

  "Personal officers don't come to visit you". (young person)

- **young people recognised the resource pressures for staff,** talking about **the need for more specialist staff training, the need for more mental health nurses (with 24 hour access for young people);**
- **there are growing issues about the relationship between substance misuse and mental health, especially with Psychoactive Substances, just as there are in the wider community.** More advice was felt to be needed at reception and on admission about the potential adverse impact of Psychoactive Substances, as this was not always understood by young people. Drug misuse was not felt to be particularly prevalent, however some young people did use drugs to pass time when there was little to do, especially those held on remand; and

  "Trips is how you get through it". (young person)

- **young people sometimes felt judged for taking drugs**.

  "I felt like I was treated like a junkie, staff really judge you". (young person)

It is of note that there has been a 200% increase in possible drug-related deaths over the three year period January 2016 to December 2018, compared to the previous three years (for the whole SPS population) which is concerning (SPS Death in Custody report 2018). The extent to which changes in drug misuse may be contributing to suicides in custody is not known.

8.4 Families

Engaging with families proved more challenging, but we are indebted to those who contacted us for their openness. A number of themes emerged from the discussions:

- **The need for early effective intervention**. Some discussions highlighted the need for early intervention and support services responsive to the immediate needs of young people, at all stages of their life journey. One mother, who was critical of the support her child had received earlier in his life, said that in HMP YOI Polmont her child had;

  "Been better cared for and better respected than when he was at school".

- **information about mental health can be difficult for families to access,** and the mental health of the young person concerned means that they are often not able to explain clearly what is happening, which leads to confusion and concern. In one instance, a young man was placed in a 'safer cell' on arrival. The family did not know what was happening and found it very difficult to get any information that explained the process. The SPS website was perceived to be poor and gave little guidance on how things work in practice. Some families find it difficult to read or do not have access to the internet. Some families had no idea who to contact for advice and, although their son was given information verbally, he was unable to take it in or retain it. An information pack for families about how the system works, with details of mental health support would have been helpful. This lack of information exacerbated stress both for the family and for one young person, who couldn't work out the system for buying things and was left frustrated for a month about not getting access to essential items. Not understanding that their son was not yet sentenced, so remand arrangements remained in place for visits, presented further difficulties;
- **responsiveness of healthcare provision.** A family had raised concerns repeatedly, and at one point, an SPS family liaison officer emailed the health centre in their presence to try to assist, but they received no response until the next day. The family understood that their son may have been given mental health support, but because of his condition did not seem to be aware of that. Another family reported being constantly worried about her son's physical and mental health, and delays in being able to see a physiotherapist to assist with a range of physical issues which were affecting their son's ability to attend work, education or the gym (please note that prison healthcare operates under the principle of equivalence and comparable waiting times to those in the community);
- **the social isolation of being locked up for anything up to 23 hours a day** was mentioned by several families and perceived to be affecting the mental health of their young men, who were increasingly withdrawn and suffering low mood;

- **emotional support.** Some families felt that the HMP YOI Polmont family help hub staff and organisations, like 'Families Outside', had been really helpful. One young man's mother felt that her son was being emotionally supported and had confidence that some staff would be able to pick up when something was *'not right'*, but was worried that others who did not know him so well would not recognise that his mental health was deteriorating. A 'traffic light' system in young people's rooms so that they could flag up that they wanted to talk to someone without having to ask for help directly was suggested. Despite some frustrations, one family commented that overall the access to development opportunities in HMP YOI Polmont had been positive for their son;

  "Being in here has been really good for him and the education programme has been really positive for him".

- **drug use and bullying**. Less positively, others suggested that the key concerns for families of prisoners in HMP YOI Polmont are drug use and possible bullying, which were a constant worry that contributed to their own stress.

8.5 SPS Staff

SPS staff who attended discussions represented all parts of the establishment where different population groups were accommodated. Views centred on issues such as training provision, the increasingly acute needs of the young people being admitted, and the appropriateness of the TTM process to the needs of adolescents.

Emerging issues included:

- **Training had been available in 2016 on issues specific to the needs of young people, though roll out of this seemed to have stalled.** This had included input on bereavement trauma and loss, child growth and development, learning difficulties and the adolescent brain. Some staff had found this helpful, but not always at a practical level. A Unit Manager felt that he had noticed an improvement in practice when the training had been delivered. One staff member highlighted the usefulness of the 'women in custody' training. In respect of mental health specifically, staff had received TTM training and some had accessed extra training themselves through a mental health module at the West of Scotland College;
- **staff felt there were areas where more training would be helpful.** These included input in respect of learning difficulties, Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity disorder (ADHD) and Borderline Personality disorder (BPD). Roll out of Mental Health First Aid training is currently being planned. This is a 14-hour programme, which includes workbooks, face-to-face training and reflection. This training may require adaptation for the specific needs of the very complex young people in custody, and to ensure that it covers the areas of specialism requested by staff;
- **staff felt that although the number of young people being admitted had reduced, they had much more acute and complex needs that demanded more resources and specialist input,** including a desired increase in mental health nurses. Staff felt they had a high level of expertise in dealing with young people, which was not always recognised outside the establishment, and that there was good communication between SPS and NHS staff, with trusting professional relationships. Occasions were noted, however, where other professional 'civilians' within the prison could be reluctant to start young people on TTM, and SPS staff then felt left with the responsibility;
- **staff agreed that there were not enough activities for young people on remand** who could be in the establishment for extended periods;
- **all staff agreed that TTM was not very flexible in its approach and not specific to the needs of young people**. This meant that staff had to exercise greater discretion in its deployment;

  "TTM is fine as far as it goes, but it is not bespoke for young people". (staff)

- **staff felt there were not enough safer cells in the prison, and that consideration should be given to moving all those with mental health needs who required observation to one location**. It was felt that this would allow more acute young people to be better supported, and for staff to meet the needs of other young people better; and
- **staff expressed concern about the amount of shouting outside of the windows by young people which could lead to fights and bullying**. The building design meant that staff were unable to hear and identify the young people responsible from inside the hall and therefore could not challenge their behaviour effectively.

8.6 NHS Staff

Emerging issues included:

- **Issues associated with the availability of time and resources.** Whilst they welcomed the support they got from their team, there were insufficient staff to meet demand for services and maintain practice standards. For example, access to psychiatrist sessions was not thought to be sufficient for the caseload. The role of prison nursing staff could encompass more than just mental health and primary care, and this was often felt not to be recognised outside the establishment. The dispensing of medication was time consuming and there were delays in medications being delivered to the prison, which impacts on the ability of clinical staff to deliver therapeutic interventions;
- **operational issues could impact on healthcare delivery.** Simple issues like the time to get around the establishment and regime timetabling, meant delays were built into NHS staff duties. Dealing with new admissions could often be very busy, and staff could be asked to stay on at night to complete assessments if young people arrived late from the courts. There was a strong feeling that health service provision was often dictated by operational SPS priorities;
- **concern was expressed that staff were having to prioritise dealing with crisis behaviours and risk management to the detriment of being able to deploy therapeutic interventions,** which could address underlying issues. This seemed to be particularly the case when working with the female population. It was difficult to deliver interventions for those held on remand. Safety and stabilisation therefore became the focus, with underlying issues being left unaddressed. Triage work, attendance at case conferences and report writing seemed to be prioritised over intervention delivery, and the environment in the health centre felt very clinical and unsuitable for the delivery of therapeutic interventions. Some staff commented that it would be helpful to reinstate the previous 'health and wellbeing' first night in custody area;
- **working with partner organisations could present challenges.** It was felt that a poor understanding of learning disabilities and mental health was sometimes displayed by SPS staff, which could lead to inappropriate referrals. There was a lack of information from community-based social workers in respect of young people in custody, with community agencies frequently cutting ties with young people whilst they were in custody. While third sector organisation support was welcomed, on occasion a young person might have multiple workers involved which was unhelpful;
- **concern was expressed about the deployment of TTM.** It was felt that young people were often accelerated into TTM with no 'in between' measure. TTM processes were felt to be traumatic for some young people. Young people had explained to health staff that being on TTM was viewed by them as a punishment. **The group were particularly clear that SPS suicide-related training was insufficiently context specific for those in their care at HMP YOI Polmont;**
- the healthcare team had received training in personality disorder management, safety and stabilisation. They also had access to the SPS training products rolled out in 2016 and were routinely trained in TTM. **The group felt that clinical support and supervision was available but there were barriers to access**.

9. INFORMATION SHARING

9.1 Terms of reference

An investigation of information sharing practices and flows to inform the provision of information to SPS (including from other agencies outwith the justice system such as health, education, social work 3rd sector agencies; and including any relevant factors arising from their experience prior to entering the custodial system) and whether the information can be better utilised to assess and act upon identified risk factors or specific vulnerabilities whilst in custody.

9.2 The availability and sharing of key information

The availability of information about a young person's needs and circumstances, and the professional assessments on them, underpins our collective ability to make good decisions and secure the best outcomes for young people entering and in custody. It also impacts on the safety of the community on their release.

INQUEST and the Prison Reform Trust analysis of 169 children and young people's deaths in custody in England and Wales between 2003-2011 found that 85% were self-inflicted. The review offers compelling evidence in support of its findings that the children and young people who had a self-inflicted death in custody had a range of situational factors including:

- Having 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; and
- 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.

The Prisons and Probation Ombudsman for England and on Risk Factors in Self-inflicted Deaths in Prison between 2007-2013, published 2014, concluded that

> *'reception screening needs to take fully into account concerns raised by police, escort services or the courts'*

Both reviews emphasise the importance of information (e.g. having a known mental health issue, substance abuse problems, history of self-harm or prior suicide attempts) being available at key points of vulnerability i.e. the point of admission into custody where there is an identified increased risk of self-harm.

Previous research has shown that information-sharing failures, leading to a paucity of knowledge on admission into custody, occur between the prison and external services, agencies, families and friends (PRT/INQUEST, 2012). In particular, opportunities have been missed in prisons communicating with those in the community, professionals and families, who can fill in the picture of a person's situation and identify subtle, but important, signs indicating deterioration of mental health (Harris Review, 2015).

Information recording, reporting and analysis is instrumental in identifying and informing care planning and future strategy. The Harris Review (2015) noted that key information may not be recorded or available. This was also the case in our inspection of HMP YOI Polmont, where information about young people on remand, such as time out of cell, access to visits, and attendance at wellbeing activities, was not recorded or analysed to determine vulnerability or social isolation.

Good quality information sharing at all points of the process, and between all key agencies, is a key component of the WSA. Currently applied to children under the age of 18; in some local authority areas this has been extended to young people aged under 21 or 26. The WSA recognises that **good information and sharing is critical if decision makers are to secure positive outcomes** that:

- Effectively address harmful behaviours linked to offending;
- deal with underlying wellbeing and/or welfare needs or concerns which may be linked to that young person's offending;
- contribute to the vision of Scotland as the best place to grow up for all of our children and young people; and
- help ensure communities are safe from crime and disorder.

In considering the information sharing between agencies in support of the WSA, we examined the opportunities to share information, not just in relation to the immediate period prior to a young person entering custody post-sentence, but also in the key decision making points between potential arrest, prosecution, disposal and custody (including remand). This approach was deemed to be essential in reflecting the totality of a young person's journey through the justice system prior to entering HMP YOI Polmont, and examining where information was available that could be transmitted. This is consistent with the remit of the review, which includes:

> *'an investigation of information sharing practices and flows to inform the provision of information to SPS, including any relevant factors arising from their experience prior to entering custody'*

We found that there were significant opportunities for information to be shared on a young person's welfare, wellbeing and mental health in order to inform decision makers and the approaches needed to support young people entering custody.

However, there were important inconsistencies and gaps in information sharing between agencies, even though that information was likely to have been available. This would have assisted optimal handling at admission and the subsequent management of young people during custody.

Despite a wealth of evidence showing that information to support the admission and management of young people is available; our review also identified a significant and concerning divergence between young people arriving after conviction and sentence, young people arriving on remand, and young people transferred from secure care.

Sentenced young people should arrive with a comprehensive dossier from Criminal Justice Social Work (CJSW), enabling HMP YOI Polmont to take immediate steps to mitigate risk and build interventions or coping strategies on known data and, where relevant, current care planning. However, remand and secure care receptions have a varied and at times impoverished level of information available, creating unnecessary risk.

With clear evidence that young people held on remand are disproportionately represented in self-inflicted deaths in custody in Scotland[5], **missing critical information at an acute point of vulnerability, such as admission into HMP YOI Polmont, is a lost opportunity for managing risk**.

At best, the remanded young person being admitted to custody without prior history or information has to repeat their story multiple times, creating additional stress factors. The Mental Welfare Commission for Scotland found that:

> *'young people benefit from continuity in their care and from not having to repeat their issues every time they have to move through the care system. We found that those young people who were coping best had support from **staff groups who shared information** well. Continuity in how information is managed and shared across services is basic good practice and should be seen as an achievable goal for all services and agencies involved in caring for these vulnerable young people.'*
>
> (Visits to young people in secure care settings, published 2018)

Evidence suggests that the benefits that could accrue from a consensus agreement to develop one model of sharing information and transmission include reducing the potential for risk and distress, and enabling the SPS to develop an appropriate care package.

Electronic transmission of risk alerts or the results of a holistic age-appropriate risk assessment, allowing HMP YOI Polmont to take more informed decisions on interventions, could radically improve safety, information sharing and outcomes.

5 Fazel 2017

9.3 Young people's needs on release

Research indicates this is a key transition, which is often traumatic for young people, exacerbating existing mental health and wellbeing issues. This is therefore a key stage of risk management, as outcomes can be poor regarding suicide, self-harm, and repeated offending post release.

Inter-agency review arrangements, streamlined for young people who are due to be released and have been released from custody, are also critical to success. This is undermined by young people being released following an appearance in court without adequate preparation prior to release, and without adequate sharing of information on mental health risks.

Quality assurance and scrutiny – moving towards national standards on sharing information and minimum data sets

There is currently no legislative duty placed on authorities to work together to implement the policy presumptions from the WSA on the sharing of information at key points of vulnerability.

Recommendation

We recommend that relevant authorities and agencies are encouraged to cooperate and develop a minimum information data set and a framework for data transmission.

There is no doubt good practice has already been developed based on research, existing guidance and legislation. Our review however has shown inconsistencies in practice, which ultimately can have significant impacts on outcomes for young people. The argument for national standards on information sharing to support the WSA is compelling, and learning from development of the National Standards for Secure Care and Youth Justice National Standards may prove invaluable.

Recommendation

Once information requirements and minimum data sets have been agreed, consideration should be given to a sustainable quality assurance and scrutiny mechanism to ensure the systematic flow of information.

Recommendation

We would also recommend considering extending the benefits of the WSA to the age of 26, and that the underpinning presumption and practices of WSA are given a more formal status.

This extension has been encouraged by the Scottish Government in recognition of the vulnerabilities of these young people, and in keeping with other legislative provisions (for example, corporate parenting entitlements for care leavers). This would further encourage public agencies to work together, share information readily, and have a common goal to minimise the use of custody for children and young people other than when it is in the public interest to do so.

We believe our recommendations would support the Scottish Government's aspiration that, where possible, children and young people should be kept out of the criminal justice system and attending court should be a last resort. This is echoed in the WSA and UNHRC and in keeping with the recommendations from the Inspectorate of Prosecution in Scotland report Thematic Report on the Prosecution of Young People, published 2018. For this to be a practical reality, decision makers across the justice sector need to have timeous access, on a daily basis, to good quality information to inform their practice, approaches and decisions.

10. HEALTH AND WELLBEING, CLINICAL REVIEW

10.1 Terms of reference

Under the terms of reference, we were asked to review the following issues:

1. *staff training and awareness of mental health and wellbeing needs*
2. *the provision of wellbeing and mental health support in custody*
3. *the treatment and interventions in custody*

10.2 Wellbeing

Mental health is defined by the World Health Organization as a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. The definition makes it clear that wellbeing and mental health are irrevocably linked.

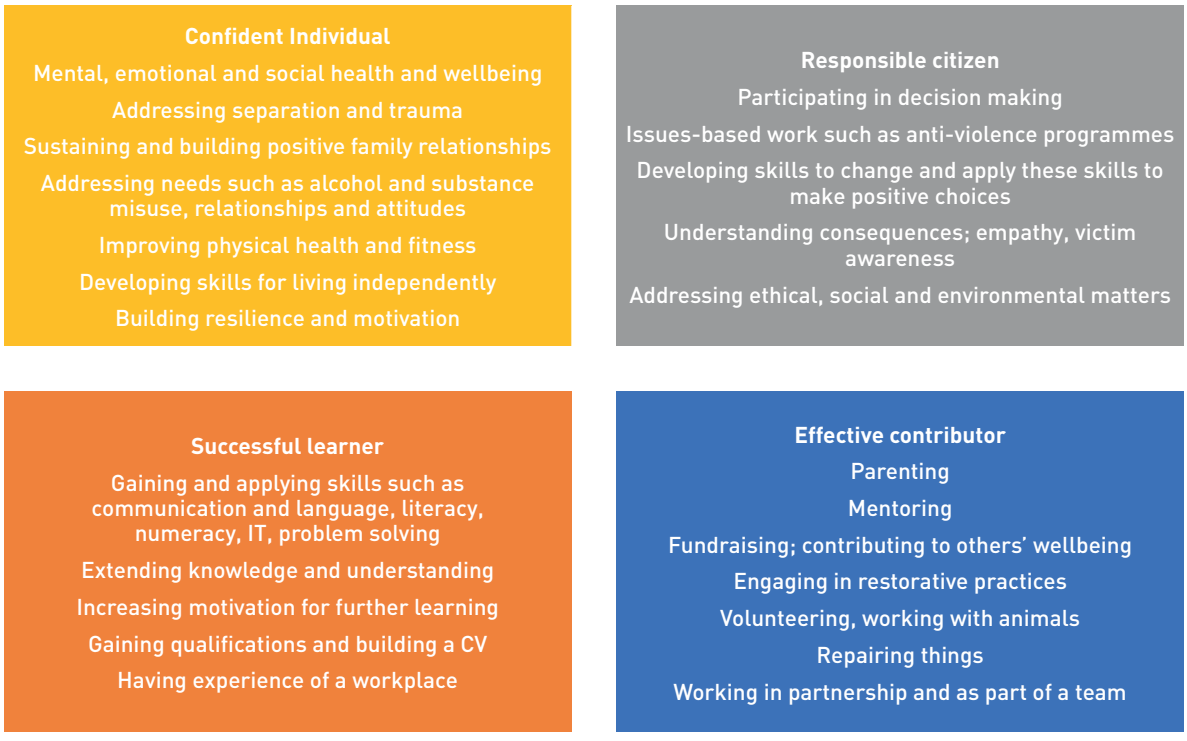
Tweed et al (under review) makes the point that wellbeing is not the same as reducing distress. Wellbeing is an optimistic approach to positive health and is a preventative measure.

Increasingly, there is recognition that interventions and services are needed for young people in any setting to proactively support positive wellbeing, and that these are important for the prevention of mental ill health.

HMP YOI Polmont has focused on developing a 'whole establishment' approach to learning, which seeks to promote health and wellbeing and recognises that the vast majority of young people present with low mood, anxiety and self-isolating behaviours. Whilst many young people are suffering from psychological distress, in practice few are diagnosed clinically. Clinical practitioners therefore agree on the need to focus on broader strategies to improve wellbeing. The Draft TTM evaluation, commissioned by the SPS also commented that:

> *"There is growing recognition that suicide prevention sits within a wider agenda about health and wellbeing".*

Moreover, as previously indicated, development of the regime in HMP YOI Polmont has been based around government policy already recognised as effective in community settings, including the principles of GIRFEC and Curriculum for Excellence (see figure below).

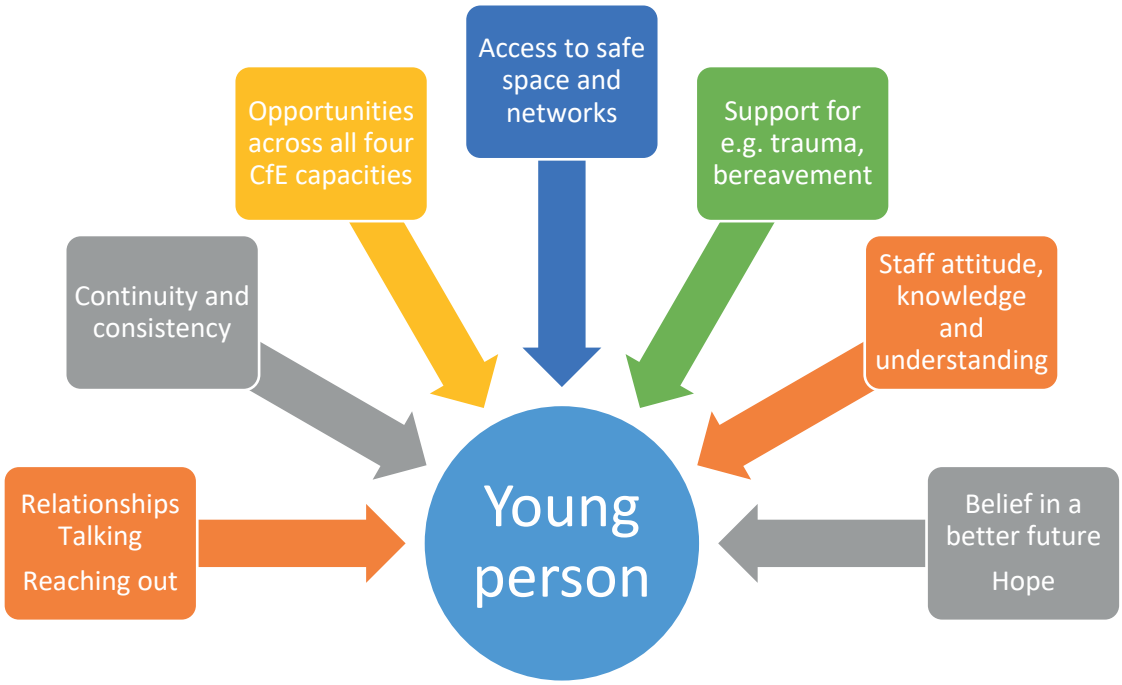


Provided by SPS and adapted for young people in custody

These principles have provided a platform for designing services to respond to the specific needs of young people, including:

- Embedding and integrating education support throughout a wide range of activities where prison staff and other providers work together with young people in small groups;
- using approaches such as Youth Work which start from 'where the young person is' and build thematic project-based learning around their needs;
- rights and equalities work embedded throughout the curriculum to challenge attitudes, values and beliefs;
- investing in co-design approaches that promote user voice and empowerment so that young people are able to practice making decisions and choices;
- building skills for independent living and resilience;
- creating an environment which is welcoming for young people and supports safe engagement in activity;
- focusing on young people being 'effective contributors' to build self-worth and increase motivation;
- asset based planning which focuses on identifying and building on the strengths of young people;
- promoting an understanding of trauma and addressing underlying trauma experiences;
- focusing on parenting skills for the next generation;
- addressing barriers to engagement and learning such as speech and language deficits and learning difficulties, and providing inclusive learning experiences;
- providing alternative opportunities for self-expression and relaxation for those who find it hard to engage in other ways; and
- building hope and celebrating success so that young people feel valued.

Evidence suggests that the following issues are important for young people and their personal development:



Provided by the SPS

There is an impressively wide range of wellbeing activities available in HMP YOI Polmont, which was recognised in the HMIPS 2018 inspection report. These are at least comparable to those that young people could access in secure unit settings or in the community.

Further details on the range of activities focused on promoting health and wellbeing are detailed in **Appendix D** under the following broad themes:

- My Life with Others
- Supporting Inclusion
- Skills for Work
- Support on admission and with transitions

10.3 Key findings

Our review suggests that **the curriculum is well constructed and specific to the needs of young people**. There was strong support from all those interviewed for continuing a holistic approach, with an emphasis on broad preventive support. **However, the wellbeing agenda would benefit from being re-energised**, refreshing the previous innovative training for staff, and restating the strategic direction. It is also critically important that HMP YOI Polmont extends the wellbeing activities, and proactively engages young people held on remand.

Those interviewed referenced a variety of outcomes that outline improvements in confidence, development of new interests, consideration of loss and the need to heal, and the development of coping strategies for those who participate in programmes.

The 'whole establishment' approach in HMP YOI Polmont has brought about a welcome culture shift, but this continues to be a work in progress, with different staff groups engaging to varying degrees. There is recognition that transitions take time, but the establishment appeared to be on a progressive path in the care and support of its young people.

However, some aspects of delivery are under financial threat, and some excellent community services dealing with key issues such as domestic and sexual abuse have been lost. **The establishment requires long-term sustainable funding for key services**. **These wellbeing activities need to be recognised and funded as core services.**

Moreover, HMIPS found that some good practice **services are currently not available because of staff absence.**

> *"The offer of vocational training was, however, negatively impacted by staff vacancies, staff absence, and at times the need for prison staff to be placed elsewhere".* HMIPS 2018 Inspection

While the range of services and activities that support health and wellbeing is excellent, **more needs to be done to identify and address those young people not engaging**, and then track progress against their care plan. Whilst positive future plans existed, they were still not embedded and reviewed regularly. In addition, they are not available to those held on remand.

As the inspection report on HMP YOI Polmont highlighted, those held on remand have a very limited regime, often suffering long periods of social isolation and a lack of purposeful activity. In view of the significantly higher number of suicides occurring with those held on remand, this is particularly worrying. **Providing protective factors of activities to reduce isolation and encourage nurturing relationships** for remand prisoners deemed to be at the highest risk of self-harm, must in future be part of the suicide and self-harm strategy**.**

There may also be merit in reopening the previous 'Health and Wellbeing' admission and enhanced induction area to support young people in their early weeks in the establishment, as this appeared to have positive outcomes at this stage of their custody. Early days in custody is regularly mentioned in research evidence as a key point of vulnerability.

As indicated in the evidence review, a forthcoming study by Tweed et al (under review) on the Scottish Prisoner Survey shows a relative decline in wellbeing scores between 2013 and 2017, with lower scores for younger people and those held on remand.

The welcome development of young person specific quality indicators linked to the SPS 'Vision for Young People' strategy should continue to draw evidence from the Prisoner survey.

10.4 Health Clinical review

10.4.1 Terms of reference

We were specifically asked to review the processes for mental health and wellbeing assessment, and referral processes in custody, including the management of the risk of self-harm or suicide or other complex vulnerabilities.

10.4.2 Context

In 2011, responsibility for the provision of healthcare in prisons transferred from the Scottish Prison Service to the NHS. The provision of healthcare to people in HMP YOI Polmont is now the responsibility of the NHS Forth Valley. At transfer of responsibility, a Memorandum of Understanding and Information Sharing Protocol (ISP) between the SPS and the nine health boards with prisons in their area was agreed, setting out the responsibilities, governance and accountability relationships for prison health services.

A review by the Royal College of Nursing (RCN), conducted five years after this change, highlighted that there was still much to be done and in particular, continuity of care remained a challenge.

Concerns were also raised about IT systems, information sharing, health's involvement in throughcare, registering with GPs and out-of-hours care. This view of concern about IT systems was echoed in 2017 by the Scottish Parliament's Health and Sport Committee report (2017) on Healthcare in Prisons:

> *"The difficulties and dangers inherent in the current lack of IT functionality and connectivity have been known for many years. This also prevents proper planning, monitoring of delivery of services and collection of robust data including outcome and performance measures. It is disappointing prisons have been omitted from ongoing IT developments for the wider NHS and we recommend this is now addressed and rectified as a matter of urgency".*

Access to wider clinical expertise and links with some community health services appear to have improved since the transfer (RCN, 2016: 5). It was highlighted that nurses working in the prisons had low morale because of recruitment and retention issues and a lack of understanding from the wider NHS of the role of prison healthcare. Furthermore, the Scottish Parliament's Health and Sport Committee report (2017) revealed difficulties in recruiting staff to work in prisons and an underutilisation of skills. Difficulties recruiting and retaining staff is both a national and a local problem experienced (HMIPS inspection of HMP YOI Polmont, 2018). Two additional pointers from the Scottish Parliament's Health and Sport Committee report (2017) also stand out as still relevant to mental health and HMP YOI Polmont:

> *"The issue of remand prisoners arose throughout our inquiry, particularly in relation to continuation of care"; and*
>
> *"We are disappointed to discover the unique opportunity to address health inequalities within the prison environment is not being taken. We recommend the extent to which this is tackled should be a key performance indicator for all of those involved".*

The RCN and Scottish Parliament's Health and Sport Committees reports were two of the drivers in establishing the subsequent Health and Justice Collaboration Improvement Board. This Board draws together senior leaders from Health, Justice and Local Government. Its purpose is to lead the creation of a more integrated service response to people's needs in key areas where Health and Justice services intersect.

The Health and Justice Collaboration Improvement Board has three priority areas:

- The improvement of services for victims of rape and sexual assault;
- **mental health and distress; and**
- health and social care delivery in prisons.

HMIPS look forward to seeing improved outcomes from this Board.

10.5 Workforce Review

We reviewed the range of healthcare services provided in HMP YOI Polmont, and numbers and grades of staff in each team, noting this included:

- A primary care team with a GP once per week and an Advanced Nurse Practitioner twice a week, along with other nurses and healthcare assistants;
- pharmacy; and
- a mental health team, integrated with an addictions service, with specialist psychiatrists, psychologists, and mental health nurses and addictions case workers.

In our review, all the clinical review focus group participants thought that there should be more mental health nurses available. The SPS staff found the nurses very helpful[6] and communication between the staff groups was reported as good to the review team. At present, however, TTM processes are taking priority over routine clinical work, delivery of therapeutic interventions and reviewing of patients. However, we note that commendably, ability to access mental health services in HMP YOI Polmont was better than in the community. Some of the young people[7, 8] felt it was difficult to see a mental health nurse, but **the average wait to be triaged by the mental health service is eight days[9], considerably better than in a community setting**, although the actual time to start treatment is not consistent.

It was noticeable, however, that there are relatively junior grades of staff, some of whom were very experienced, in the health teams. All staff benefit from support to work in the autonomous and flexible way needed in prison healthcare. We are therefore pleased to see that multi-disciplinary team meetings have recently been introduced, as an early response to the HMP YOI Polmont inspection findings, allowing more experienced staff to support junior and less experienced staff. However, this new approach needs to be fully embedded.

The Health and Social Care Prisons Programme Board, as part of the Health and Justice Collaboration Board, is considering workforce issues as part of their remit in partnership with relevant Scottish Government policy teams. HMIPS welcomes the joint focus on this national issue. The Standards for the Quality Network for prisoner mental health from the Royal College of Psychiatrists contain clear guidance on staffing and training issues, which would represent useful benchmarks for NHS Forth Valley to consider in this context.

The Scottish Government's Mental Health Strategy 2017-2027 included a commitment (Action 15) to increase the mental health workforce by 800 additional mental health workers in our hospitals, GP surgeries, prisons and police stations. This is a welcome development for an ongoing issue impacting healthcare.

We note that, like other prison establishments, NHS Forth Valley has had difficulty in recruiting specialist mental health staff, and that this may be partially linked to the grading of posts. The recruitment strategy needs to take this into account.

Recommendations

1. A workforce and capacity review should be undertaken by NHS Forth Valley, and a workforce recruitment and training strategy completed, to enable appropriate staffing levels and caseloads to be implemented.
2. The workforce capacity review and recruitment strategy now being undertaken should consider the grading of posts and other actions that might be taken to address vacancies that are difficult to fill.
3. There should be improved links between NHS Forth Valley and SPS at all levels of seniority to improve leadership and accountability.

6 SPS staff focus group completed: 08.02.19

7 Young Males Focus Group completed: 04.02.19

8 Young females Focus group completed: 08.02.19

9 Standard 9 of HMIPS HMP YOI Polmont report November 2018

10.6 Training, supervision and competency issues for NHS staff

NHS staff in HMP YOI Polmont are compassionate and caring towards the young people in their care and have empathy for the difficulties they face. There are, however, no NHS staff with training in adolescents, and none of the clinical staff have undergone the Essential CAMHS competency training that would be routine in staff appointed to a CAMHS service. This training is delivered by NES, the national training body for NHS Scotland, and would cover a range of topics that would be of benefit for staff dealing with young people. This is to develop a specialist CAHMS service but to provide enhanced training to work with adolescents as part of a generic mental health service.

Supervision is available for clinical staff from the clinical psychologist, though uptake of the supervision has been difficult due to workload pressures. As indicated above, we are pleased to note that multi-disciplinary meetings are now happening. These will allow more systematic discussion of the care of patients and junior staff to gain support from more senior members of the team.

> *"Reflective practice is the process by which professionals reflect on their own actions, learn from their experience and consider how to make improvements in their practice. This is part of continuous self-learning by professionals and it requires them to be self-aware and appropriately self-critical. There is evidence that this stance can improve the way care is delivered".*
>
> (Self-Harm And Suicide Prevention Competence Framework: Children And Young People)

The SPS are investing in adolescent mental health training for all SPS staff, but those interviewed indicated that priority will be given to Unit Managers and those with specific TTM responsibilities. This training is a 14-hour programme previously delivered to education staff in the community. It includes workbooks to explore areas, four hours face-to-face teaching and periods of reflective practice to embed the learning. The provisional content of this programme looks highly relevant to SPS staff, but does require setting in the context of HMP YOI Polmont.

Recommendations

- The proposed adolescent mental health training should be delivered in a phased manner to SPS staff in HMP YOI Polmont and partner organisations working in the establishment, with refresher training provided at appropriate points thereafter;
- there should be a rolling programme of Continued Professional Development for NHS staff, to include topics relevant to adolescent mental health such as ASD, ADHD and other developmental disorders;
- refresher training in TTM for all SPS and NHS staff should be undertaken, and adaptations made for specific populations such as adolescents. This training should not just include the processes and paperwork of TTM, but broader aspects of self-harm and suicide;
- the competency framework and Essential CAMHS training should be considered for NHS staff dealing with young people;
- clinical and case load supervision should continue to be offered, and any barriers to lack of attendance examined and overcome; and
- all other recommendations must be implemented, including recommendations regarding mandatory training and appraisals of staff.

10.7 Access to services

On admission to HMP YOI Polmont, young people are assessed by SPS staff and then have a private consultation with nursing staff[10]. This is excellent practice and should continue. All staff were knowledgeable, warm and compassionate in how they undertook the admission and induction processes.

The nurse that assesses the young person during admission also reviews the young person if they are placed on TTM, and attends their case conference. **This continuity of care represents best practice** and may ease some of the anxiety of coming into custody, and prevent the young person continually repeating their story. Having nursing staff available at reception may assist young people in disclosing information on which to base a care decision. Healthcare rooms are however quite 'clinical' and not very 'therapeutic', which does not promote conversation and engagement. However, we recognised there is a need for the rooms to have dual purpose.

The process for referral to the Mental Health Team, outwith staff, is through self-referral. Poor literacy skills in the population can be a barrier. Some young people with literacy difficulties do not feel supported to complete the referral forms[4] and suggested that a regular 'drop in' session would help them discuss issues regarding mental health.

However, the biggest barrier to young people accessing mental health services in HMP YOI Polmont and other establishments, is young people's concerns about the stigma of acknowledging the need for help and their perceptions of safer cells:[11]

> *"If you talk about mental health everything gets stripped off you and you get put in a safer cell; it's like a punishment".* (young person)

The use of safer cells is controversial from an ethical point of view. Safe cells can help to preserve life, but they can be overused and are not effective in dealing with underlying mental health difficulties.[12] The young people complained of negative emotional effect; (being locked in a room with nothing but your negative thoughts) and social isolation[3, 4]. As indicated previously, social isolation has a powerful negative effect on mental health and wellbeing.

Young people stated that they would use their friends to get support regarding mental health. They were aware of peer mentors and listeners, but were concerned about confidentiality. Young people were impressed by the Barnardo's youth workers and indicated they would use them to access other support.

Other reports underline the importance of educating young people about their rights when accessing mental health support. For example, the HMIPS Out of Sight report, 2008 notes:

> *"The provision of advocacy support varies. In some prisons there was no provision, or it was virtually non-existent. Prisoners generally had no awareness of their right to access advocacy support".*

Young people felt that they struggled to access services, in part due to being held on remand. Young people who are remanded do not have the same access to activities and services as those who are sentenced. This was particularly noticeable in relation to help for substance misuse. Whilst it is difficult to know how long a young person on remand will be in custody, it is important for services to recognise that "**every interaction is an intervention that could make a difference**". Even if the interventions could only be relatively brief for prisoners held on remand, opportunities to make a difference do exist.

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10 Prisoner Journey completed: 04.02.19

11 Young females focus group completed: 08.02.19
Young males focus group completed: 04.02.19
Focus Group completed in HMP Grampian with young people who had experience of YOI Polmont completed: 08.02.19

12 Nugent (2018) Evaluation of the Scottish Prison Service's Suicide Prevention Strategy 'Talk to Me': Phase 2

10.8 Access to specific aspects of treatment

Medication

A number of NHS staff and focus group participants reported delays in getting medication prescribed. The GP is in the establishment one day a week and the Advanced Nurse Practitioner (ANP) two days a week. If they are not on duty, there is an out-of-hour's service available.

Medication administration takes up a lot of time for nursing staff and is a major part of their work load[5]. The level of medication administration does not allow for other clinical activities and interventions as much as would be appreciated by both young people and staff[5, 3, 4, 6].

Medication for withdrawals are assessed on admission to HMP YOI Polmont, and follow a protocol for withdrawal from alcohol, opiates and diazepam. This is discussed with young people as part of the admission process by nursing staff and should be considered best practice.

The clinical IT work stream of the health and social care in prisons programme board is working to ensure a more comprehensive clinical IT solution in prisons that facilitates better clinical care within the prison, as well as continuity of care with community services. This includes ensuring more robust electronic prescribing functionality.

At present, there are difficulties on liberation in regards to medication. Some young people are released without registering with a GP practice and without any medication. Young people can be supported by Throughcare Support Officers (TSO), Community Based Social Work and or Prison Based Social Work, and other throughcare organisations, but sudden releases from court can make it difficult for health services to make appropriate arrangements. Given that the early days of release are also a period of acute vulnerability, this should be reviewed.

Psychological Intervention

There were previously limitations in access to psychological interventions for young people under the age of 18 years, though this has now been resolved, as a clinical psychologist has been employed by NHS Forth Valley to address this inequality. Expert clinical supervision will be provided for this individual within NHS Forth Valley. This move is welcomed by HMIPS.

Psychiatry

Psychiatry input is currently provided by The State Hospital. There are plans to return responsibility for service delivery to NHS Forth Valley, with a dedicated consultant forensic psychiatrist for HMP YOI Polmont. This consultant will require CPD and mentoring in terms of dealing with young people, and NHS Forth Valley have this in hand. This development is imminent and will better support the provision of day-to-day clinical leadership for the team. No waiting list to access a psychiatrist exists in HMP YOI Polmont, which is an improved position in comparison with access in the community. The review team considered that arrangements should be made for regular audit and examination of service delivery, enhanced by following the process and standards of the Royal College of Psychiatrists for prisoner mental health. The process for this is outlined on page 41.

10.9 Release from Custody

Recommendations

- The use of a discharge checklist to help standardise the process when people are being managed by the Mental Health Team and released from HMP YOI Polmont; and
- The NHS Forth Valley SBAR format is used in hospital settings, and this could be used in similar circumstances where patients are discharged from prison mental health services.

11. REVIEW OF THE SPS TALK TO ME (TTM) STRATEGY

11.1 Terms of Reference

Reviewing the governance and decision making arrangements for implementation of the Talk to Me process in custody including the evidence for its implementation, operational procedures, staff training and awareness.

11.2 About the SPS 'Talk to Me' Strategy

We were asked to review the governance and decision making arrangements for implementation of the SPS Talk to Me Strategy process in custody, including the evidence for its implementation, operational procedures, staff training and awareness.

The SPS Prevention of Suicide in Prison Strategy 'Talk to Me' (TTM) was launched on 5 December 2016, and built on the previous 'Act to Care' Strategy documentation. An evaluation of the process was commissioned by the SPS from Dr Briege Nugent (Draft TTM evaluation) and reported in two phases in March and October of 2018. HMP YOI Polmont was involved in the study which covered more than one establishment with representative population groups.

11.3 The Draft Evaluation of the TTM Strategy

The first phase of the TTM evaluation assessed the effectiveness of the implementation of training programmes and governance arrangements. It found that the TTM Strategy and guidance was robust and promoted person-centred planning and multi-agency working:

> *"Across all the sites the resounding message was that the Strategy had reinforced the message that the assessment of risks was to be individualised as well as the support given".*

The second phase of the TTM evaluation noted that:

> *"The strategy and guidance are comprehensive, but there are many challenges staff face to effectively implement it".*

The draft evaluation sets out the perceived barriers to implementation, many of which are echoed by our review:

- Overcoming cultural barriers around information sharing;
- the need for more integrated partnership and multi-disciplinary working;
- the lack of sufficient mental health nurses;
- high prisoner to staff ratios, reducing quality contact time for relationship building;
- young people (adolescents) falling between 'policy gaps' for children and young adults, failing to get a diagnosis because of their age and then being unable to access appropriate services; and
- the availability of consistent role holders for the role of the suicide prevention coordinator at establishment level.

11.4 HMIPS clinical review findings on the Strategy

Our review similarly found that the TTM process was generally followed well, and that staff of all agencies were aware of their responsibilities. In addition, the TTM process was found to be well audited by SPS, though it was unclear where the clinical governance for the NHS part of the TTM process was located.

At the time our review was conducted, there were increasing numbers of young people on TTM due to heightened concern. TTM was sometimes being used for purposes which seemed potentially inappropriate (like supporting individuals undergoing detoxification or palliative care) and it was clear that the level of young people being placed on TTM was not sustainable at this elevated level within existing resources.

We concur with the majority of recommendations in the Draft TTM evaluation by Dr Nugent, which should be implemented, but would wish to highlight additional points:

Despite the best of intentions, the draft TTM Strategy was capable of being used in quite a **mechanistic way by staff,** and this cultural dimension underpinned a number of other issues potentially undermining the Strategy's intent. Young people reported that they found the questioning regarding self-harm and suicide very repetitive and like a '**tick box'** exercise. This impacted on their experience of the care offered. This finding is echoed in other jurisdictions by the NHS Health Education England & National Collaborating Centre for Mental Health (2018) Self-Harm And Suicide Prevention Competence Framework: Children And Young People which reported that:

> *"When children and young people who have self-harmed present to services, they can experience their care as being 'protocol driven' rather than personalised (for example, being taken through a standardised set of questions or checklists that the organisation uses to assess risk)".*

The review team understand that the concern about the 'tick box' approach was highlighted by suicide prevention experts as ineffective when determining the risk of suicide. Staff are now trained in effective interviewing techniques and active listening.

Staff commented during the Draft TTM evaluation that monitoring and quality improvement processes could also be quite mechanised:

> *"The auditing exercise is a tick box exercise. I think instead it should be a thematic approach and try to develop a body of expertise that sits operationally and also have continuous improvement groups in each prison".*

Some of this focus on task i.e. 'was the process followed?', and risk assessment leads to less focus being placed on the quality and implementation of care planning, and whether the distress of young people is being eased and their wellbeing improved. The Draft TTM evaluation suggested that:

> *"At present, the auditing process 'on the ground' is about ensuring the paperwork is in place, signed and gives some scrutiny of whether rationales for decision making have been given and procedures followed. However, it does not fully interrogate the quality of the Care Plans and whether or not the Strategy is being implemented effectively. It is suggested that quality improvement guidelines are developed to support person-centred care plans".*

The review team understand that the TTM audit now requires an audit of the quality of the care being delivered, not just an audit of process.

The Draft TTM evaluation noted good practice in some establishments, with flexible care planning arrangements for individuals at different times of the day and night, and the inclusion of wider services in the care planning process such as education and that best practice should be shared and adopted more widely. **Ensuring more consistency in role for Suicide Prevention Coordinators would potentially assist with the sharing of best practice and culture change required**.

Risk assessment requires consistent practice and assessment tools and considered application. When we began our review risk assessments for mental health were not standardised. **We welcome the fact that this has already been rectified and that standard NHS Forth Valley mental health risk assessment documentation is now in place**. This should now be subject to regular monitoring and audit.

It is clear from various sources however that risk assessment is not a precise science. The Self-Harm And Suicide Prevention Competence Framework: Children And Young People noted that:

> *"When working with children and young people who have self-harmed or who experience suicidal ideation there are many factors associated with risk [and] evidence indicates that our ability to accurately predict risk is limited. It is possible to both over estimate and under estimate the actual risk of suicide in a child or young person at a given moment in time".*

There are no simple explanations for prison suicides, which are likely to be due to complex interactions between different factors. This suggests that it is better to move away from prediction as a 'stand-alone' approach, and instead use regular risk assessments to inform the compassionate management of a care plan alongside the individual concerned. Having all of the relevant information to inform judgement about potential increased risk of suicide is critical, and even where this information is available it may still be difficult to assess risk unless the young person discloses how they are feeling.

11.5 Managing distress

One of the most significant issues identified by young people was the use of safer cells for those who were felt to be at most acute risk, and the subsequent impact that this social exclusion had on their emotional wellbeing. The SPS have informed the review team that safer cells are used in approximately 21% of occasions where a young person is placed on TTM.

> *"Restrictive practice, including restraint, seclusion and the 'informal seclusion' that often results from current enhanced observation practice, can increase stigma, isolation and the risk of harm; it can adversely affect people with a trauma background and this too can increase the risk of harm".*
>
> (Scottish Patient Safety Programme)

Young people expressed mixed thoughts about safer cells, a few felt that more time to reflect had helped them to set their thoughts in perspective**. The majority however thought that safer cells felt like a punishment,** with nothing to distract them from thinking about their problems. The Draft TTM evaluation notes that this is not the intention of the TTM Strategy, in fact:

> *"Unlike in the previous guidance [ACT], it is emphasised that the Safer Cell should only be used in exceptional circumstances and if an individual is located in a Safer Cell for 72 hours or more, a Unit Manager must attend the next case conference and all subsequent case conferences until they are accommodated in normal accommodation".*

Whilst SPS is considering options for ligature free cells at the request of the Scottish Government (a consistent specification for safer cells is also required), **this approach needs to be carefully considered or it could lead to unintended consequences**. More sterile environments may seem like the answer from an external perspective, but may cause further harm by discouraging disclosure or displacing self-harming behavior. Creating discrete areas to locate young people within safer cells may have both advantages and disadvantages, and all of these issues need to be carefully considered.

Recommendation

Alternative options for helping to cope with acute distress and the potential to share good learning from other secure environments, including the use of softer environments, buddy cells and multi-sensory rooms must be considered.

Young people were asked separately about the current routine policy of single room allocation in HMP YOI Polmont, which was broadly welcomed. Young people indicated that sharing rooms could be useful in some circumstances for support. However, these circumstances were limited and that sharing was best used only in specific circumstances where young people had a prior supportive longstanding relationship.

What is clear is that young people generally respond well to offers of relationship building, and whilst there were mixed views expressed, many indicated that they were able to talk to staff and say how they felt. One young person commented that:

> *"These are the best (SPS) staff that I've ever come across".*

The Draft TTM evaluation also however found evidence that:

> *"Half of the prisoners interviewed felt that they were listened to in case conferences and the remaining number said it depended on staff present or that they did not feel listened to".*

All of this suggests that an overreliance on safe spaces could do more harm than good, and that a more proportionate response to risk is needed, with more focus on prompting meaningful engagement with young people who are distressed. Staff who were interviewed clearly wanted to be able to do this, but said that this could be very challenging when prisoner to staff ratios were high. Our review suggests that the SPS should collect data on the use of safer cells, and their use should be reviewed taking account of alternative options that are trauma informed.

Recommendation

There may also be value in consideration of introducing a refreshed prison visitor schemes to further reduce isolation.

We note that enhanced patient observation has been transformational in some settings as an alternative to isolation, and that the Scottish Patient Safety Programme (SPSP) suggests that observations are an opportunity for interventions. Ideally, observation should be accompanied by clearly planned specific psychotherapeutic interventions or activities, related to the young person's clinical needs and strengths. The aim should be to return to a frequency of interventions that is less intrusive as quickly as possible. We note however, that at present nursing staff are struggling to deliver interventions that would enable a reduction in observation levels due to medication dispensing and attending case conferences.

Recommendation

Our review suggests that the SPS and NHS Forth Valley should consider working with the Scottish Patient Safety Programme to examine the use of observation within the TTM process. This work should take account of the concerns expressed by young people in respect of sleep disruption caused by observation during the night and find more discrete ways of affirming wellness that minimise sleep disturbance.

Further potential options noted by Scotland's Suicide Prevention Action Plan: Every Life Matters include brief interventions to improve distress tolerance, safety and stability.

> *"The Distress Brief Intervention (DBI) is one approach to improving the way in which services respond to people in distress".*

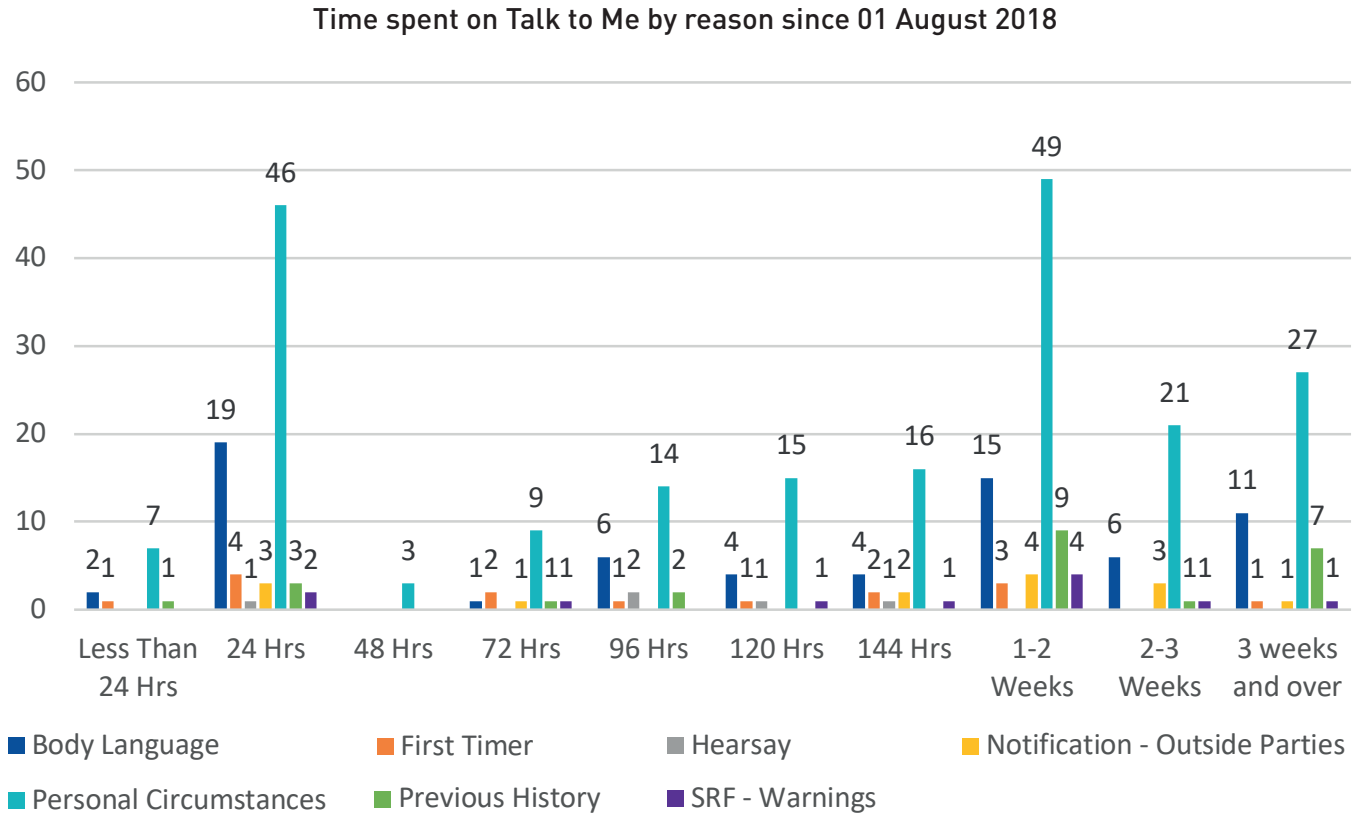
The availability of in-room sensory supports or electronic Cognitive Behavioural Therapy access, particularly on admission and during high risk periods could be considered.

Evidence from the SPS indicates that 31% of young people are taken off TTM relatively rapidly (within three days) and that 71% of total Deaths in Custody in the last three years were at some point on TTM. Whilst the majority of people who take their own life in custody are not on TTM at the time, the SPS Death in Custody report notes that:

> *"Those previously identified as a risk of suicide and managed on ACT2Care/Talk to Me and those with contact with Mental Health services; are at a much higher risk of committing suicide in custody".*

Recommendation

This data potentially suggests the need for a more gradual, phased removal from TTM, with appropriate supports and follow up checks in place.



A few young people are held in isolation for lengthy periods, either as a result of remaining on TTM for a considerable duration, or being held in the HMP YOI Polmont separation and reintegration unit, Dunedin.

Recommendation

Our review concluded that there was a need for greater focus on repeat attendees in the separation and reintegration unit, with more individualised support for prisoners and help for staff in managing challenging behaviour management issues.

In our view, in these circumstances, young people needed more planned access to fresh air, physical activity and to engaging with others. It was not clear why a few young people were repeatedly placed on TTM, or what progress had been made against their plan objectives. Discussion with SPS staff supporting some of these most challenging and traumatised young people indicated that they felt they needed:

- More input from mental health specialists;
- more intensive multi–disciplinary training on mental health issues led by mental health specialists;
- support from psychology in respect of functional analysis of behaviours, formulation and behavioural management programmes;
- a more therapeutic environment, with internal and external activity space where they could interact with young people, guided by occupational therapy support;
- more rapid access to hospital facilities for those young people who are acutely mentally ill; and
- access to a support and advice service in circumstances where the behaviour of young people was concerning.

Staff said that they would particularly welcome more information in respect of behavioural triggers for young people and protective factors, especially those that might be linked to previous adverse childhood circumstances. Our review noted good practice in the secure unit system, where each young persons' case notes identified and highlighted potential triggers and escalation routes for staff, should these occur. The Draft TTM evaluation noted that there were potential gaps in the research in respect of triggers for low mood, and other identified research gaps included the need for more focused study in respect of:

- The extent of use of safer cells;
- self-harm and the identification of good practice to inform training;
- young people held on remand to understand why this group are at risk and what can be done to minimise this;
- tracking the progress of individuals who have been on TTM on return to their communities; and
- the role of families and peers in offering support during difficult times.

Young people were asked what kind of support would be most welcome during difficult times, and repeatedly referred to the importance of family and friends. **Family relationships can be both a powerful protective factor** and also in some specific circumstances (recognising the sometimes traumatic background of ACEs) a potential trigger for self-harm. Accordingly, families should be involved where appropriate and, with the consent of the young person, feeding back to families where required and considering how case conferences could be made more accessible.

Recommendation

Prisons should ensure that young people can access phone helplines quickly and easily in a non-stigmatising manner, and that the financial implications of contact, particularly phone contact between families do not become an inhibitor (access to in-room phones for young people is referred to elsewhere in this report).

Young people also indicated that they would welcome more informal peer group or 'drop in' support opportunities, facilitated by trusted agencies, as a way of overcoming barriers to asking for help. Nina Vaswani comments that boys find it particularly hard to talk about their feelings and SAMH notes that:

> *"Young people experience a range of barriers to help seeking, including fears about not being taken seriously, being judged and about confidentiality".*

All of these issues raise questions about the quality and frequency of training support offered to staff of all disciplines, and the need for personal and professional development to support trauma informed relational practice. Observations about the TTM training strongly indicate that staff rarely consult the guidance, which has now been separated from the TTM forms.

A range of comments from other reports we have studied illustrated the nature of the challenges that have been previously identified, and that further change in approach may still be required:

> *"Staff did not feel as though they had the knowledge of the causes and behaviours of suicide and self-harm to fully address the needs of prisoners. Improving staff capacity and understanding in these areas, for example through clearer guidance and training, could help staff to adapt to different situations and be proactive".* (ACCT review, now replaced by TTM)
>
> *Evidence-based training on mental health and suicide prevention is essential. Mental health and suicide prevention training must be on a par with physical health training".*
>
> (Scotland's Suicide Prevention Action Plan: Every Life Matters)
>
> *Intensive mental health training for staff, training on self-harm, and more emphasis on a person centred personal officer and prisoner, the current situation/process is inadequate for many reasons".* (TSO, Prison 3)

Recommendations

- Training about the TTM process should be regarded as foundation level only;
- the TTM strategy itself needs developed to be more specific to the needs of adolescents;
- all staff need a broad based understanding of adolescent and young adult development and attachment, trauma informed practice, and potential barriers to engagement to help young people co-regulate and respond to distress and challenging behaviour;
- training should be based on reflective practice, with the opportunity to consider case material and individualised care planning;
- multi-disciplinary training is essential to build relationships and respect for shared practice and learning, but individual disciplines will also require specialist input;
- leadership training should include an understanding of trauma informed practice and the organisational implications; and
- training should be delivered (or co-delivered) by those with both expertise in the subject area and understanding of the prison context.

12. THE DEATH IN PRISON LEARNING, AUDIT AND REVIEW PROCESS (DIPLAR)

12.1 Terms of Reference

"Review of the DIPLAR process arrangements when it's an apparent suicide".

All deaths in prison or custody lead to an FAI under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016. However, the decision to hold an FAI is a matter for the Crown Office Procurator Fiscal Service. Section 1(3) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 states that the purpose is to:

(a) establish the circumstances of the death; and
(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

At an FAI, the Procurator Fiscal leads evidence to address the matters upon which the sheriff must make findings, including the cause of death.

The time between the death in custody and the FAI is, however, sufficiently lengthy that it is considered important that organisations are able to rapidly apply any learning to prevent similar occurrences from the circumstances leading up to, and both immediately preceding and following the death.

12.2 Background

The European Court of Human Rights (ECHR) interpretation of Article 2 (Right to life) indicates that:

> *"Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law".*

To support continuous improvement in the handling, review, audit and learning from any death in prison, the SPS commissioned an evaluation of the TTM Strategy from Dr Briege Nugent. Phase 1 that was completed in March 2018 contained a specific section on DIPLAR and Critical Incident Response and Support (CIRS) processes. This first phase of the evaluation concluded that:

> *"A review of the documentation shows that this [DIPLAR] is an effective way of preserving evidence, communicating with appropriate parties and recording learning and identifying actions".*

The National SPS multi-agency Prevention of Suicide Management Group (NPSMG) is the strategic delivery group which collates learning across the prison estate and monitors progress against actions which have been identified.

The remit of the NPSMG is to:

- Ensure effective implementation and impact of the TTM Strategy at a national level;
- inform/change national policy and practice based on lessons learned from management information in this area (including DIPLAR);
- understand the prison population who are at greater risk of taking their own life and respond appropriately to prevent suicides in custody; and
- provide leadership and set the direction for the Tactical and Operational Suicide Prevention Groups.

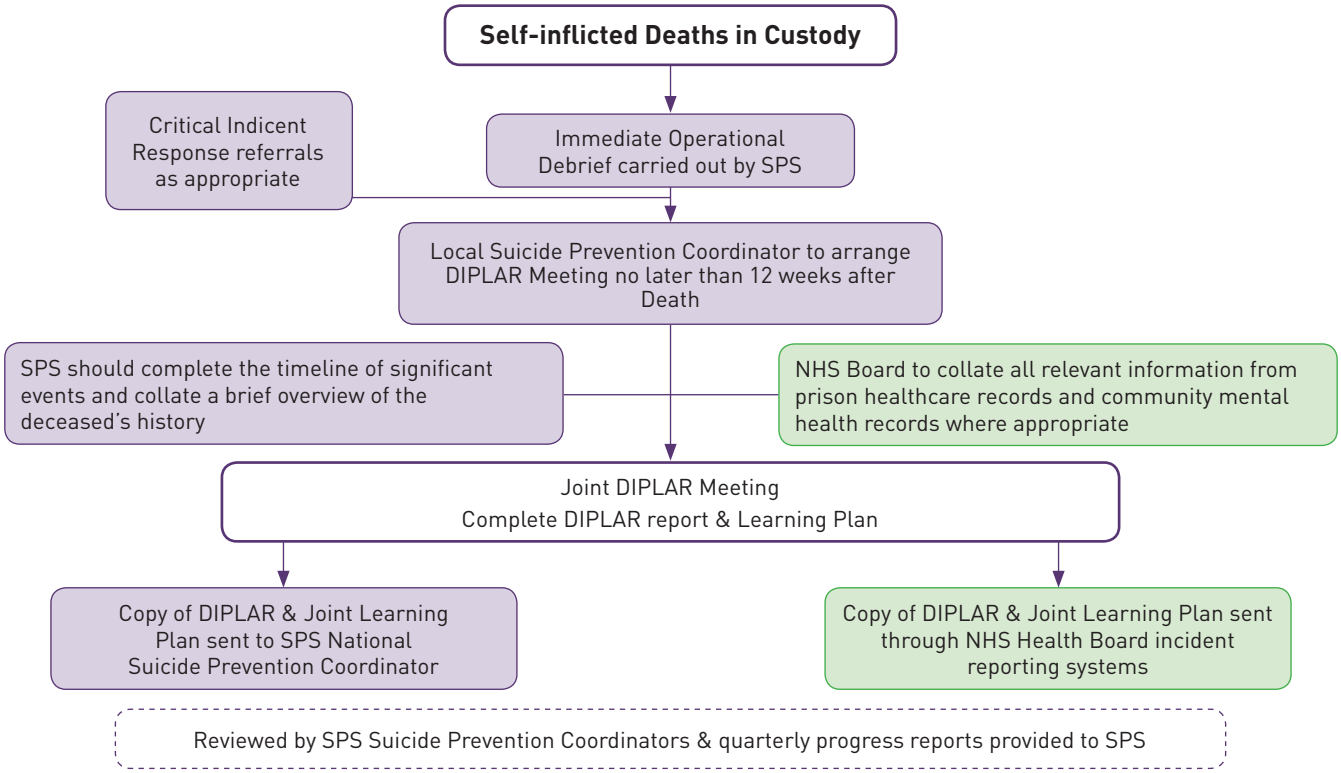
The NPSMG takes the lead in quality assurance ensuring recording, monitoring and review of the DIPLAR process and outcomes.

The DIPLAR process was piloted across individual prisons and health boards for two years prior to its formal introduction in November 2018, and replaced the previous 'Self-Inflicted Death in Custody Audit, Analysis and Review process (SIDCAAR)'.

The DIPLAR arrangements were approved by both the SPS Executive Management Group and NHS Health Board leads and form a joint process for reviewing all deaths in custody, with a view to promote partnership working and the identification of areas for learning and improvement.

NHS Boards also have their own adverse event review processes which may take place prior to the DIPLAR to inform NHS contribution. DIPLAR report formats are provided to aid consistent completion and draw out a learning plan.

Process Map Following a Self-inflicted Death in Custody



DIPLAR process (SPS Documents)

The DIPLAR process may also in some circumstances under legislation be supplemented by a Significant Case Review (led by local authority social work), and a Health and Safety Executive investigation may also be requested by the Procurator Fiscal, so the collation of review outcomes can sometimes be complex.

12.3 Document Review

A range of documents were reviewed including:

- Evaluation of TTM, March 2018;
- SPS DIPLAR action notice process guidance and process map;
- NHS Forth Valley adverse event paperwork;
- SPS Death in Custody (DIC) and self-harm report 2018;
- The Assessment, Care in Custody and Teamwork (ACCT) process in prison: findings from qualitative research MOJ 2019;
- The MOJ publication (2018) A Review of Self-inflicted Deaths in Prison Custody in 2016; and
- Scotland's Suicide Prevention Action Plan: Every Life Matters.

In order to consider both the DIPLAR procedure and the level of effective linkage with the FAI process. These included recent comparative process reviews from England and Wales, current Scottish Government policy documents in respect of suicide prevention, academic evaluations and consultations commissioned by the SPS, and SPS and NHS Forth Valley DIPLAR and Adverse Events processes respectively, (including access to joint DIPLAR review papers in recent HMP YOI Polmont cases for the last five years, where FAI hearings had concluded and learning plans from cases not yet been heard at an FAI).

Special attention was given to issues of learning that had arisen from DIPLARs across the SPS estate, and the governance processes associated with ensuring compliance with required action.

12.4 Considerations

The UK Government effectively signed up to the European Convention on Human Rights by bringing this into UK Law in 2000 through the Human Rights Act 1998.

The ECHRs interpretation of Article 2 indicates that there should be an **independent and effective investigation** into all deaths caused by the State (through use of force or failure to protect life). The ECHR also indicated that the investigation should be **reasonably prompt, open to public scrutiny and involve the next of kin of the deceased.**

As part of the process that ensures that the State meets its obligations in England and Wales, an Inquest is formally opened shortly after the death then adjourned until the death investigation has taken place.

The Prisons and Probation Ombudsman (who is independent) investigates the deaths of any prisoners or detainees in the custody of:

- Prisons;
- Young Offenders Institutions;
- Secure Training Centres;
- Immigration Removal Centres;
- Probation Approved Premises; and
- Court cells (when the person has been remanded or sentenced)

The Ombudsman can also investigate the death of someone who has recently been released from the custody of the above establishments if she/he feels there are particular lessons to be learned.

12.5 Independence and consistency

It is clear that both the SPS and NHS Forth Valley have tried to bring greater independent scrutiny to bear in recent DIPLAR reviews, by appointing joint chairs who have not been directly connected with the incident under review. Despite this, reviews are undertaken by different governors and health boards across the SPS estate when deaths occur in prisons, and by individuals who may have had little specific training in how to maximise learning outcomes from the process. The review found that this resulted in inconsistency.

Whilst it is important that those involved in the review fully understand the operating context of a prison and the implications for healthcare delivery, it is also the case that a **degree of greater independence** in advance of the FAI could be of benefit. For these reasons, the review recommends that a mechanism for the appointment of independent chairs should be considered.

Further, DIPLAR processes may be preceded by varying evidence gathering processes in different health boards, and it is important that there should be greater consistency, both in the investigatory and collation process and the subsequent DIPLAR review meetings to inform future strategy.

Consistent processes should apply in all prisons, both public and private, and the review concluded that there were further opportunities to refresh the shared DIPLAR process and format for information collation through comparison with other agency processes (supported and advised by the Scottish Fatalities Investigation Unit (SFIU)), so that any information feeds helpfully into the subsequent FAI.

It was felt that there would be particular value in strengthening the component of the DIPLAR paperwork which sets out a timeline/chronology of events, and ensuring clarity in respect of essential staff attendance. Feedback suggested that changes in the process, specifically to support **greater involvement by families,** would allow more health boards to participate fully in the DIPLAR process and limit duplication of effort.

12.6 Involving families

The Scottish Government has acknowledged that the family of the deceased may find attendance at a FAI distressing, and the independent strategic review of legal aid in Scotland (and recent high profile cases) has highlighted that there is a need to review the current legislation with regard to eligibility for families involved in FAIs.

As a result, the Scottish Government are consulting on a new Legal Aid Bill for Scotland, which has the potential to change the provision of legal aid to better support families' involvement in the FAI process. DIPLAR information is shared with families at an FAI. However, families often comment that they would like information about what has happened earlier in the process to minimise their distress, and to be allowed to ask questions or contribute meaningfully to the DIPLAR considerations. Contact with families at what is a very distressing time can be a sensitive matter, particularly in a prison context, and one which needs to be handled with respect and dignity at all times. The current SPS position is set out in the Draft TTM evaluation:

> *"Following a death in custody the Strategy outlines that it is the role of Chaplains to act as the first point of contact with the bereaved family. In all cases the Chaplain makes contact with families, offers them support and uses this as an opportunity to make them aware of the other appropriate support services they can access. Chaplains were said to have the advantage of being seen as 'neutral', not part of the prison, and for some families this is important".*

The review recognises that DIPLARs need to be a safe space for staff to establish 'the facts' of the case, and that it would not in these circumstances be helpful for families to attend. However, there could be more opportunities to **engage with families both in advance and subsequent to the DIPLAR,** as is the case in comparable health board procedures, to ensure that they have the opportunity to have their voices heard, raise questions for consideration and receive early feedback in respect of outcomes and actions taken. Whilst contact with families for the purposes of support should remain vested in chaplaincy teams, formal contact for the purposes of informing the DIPLAR process could be initiated by an independent chair. In these circumstances, it will be important to develop a consistent understanding of what information can be shared in advance of FAI proceedings.

The review was unable to undertake research with families who had lost a relative in custody to assess their experience of the DIPLAR and FAI processes and accessibility of available supports. We consider that a **small focused study contacting and following up with families would be beneficial.**

Creating a safe environment for learning

There is no doubt that other young people and staff from all agencies are also very distressed when deaths in custody occur, and that this can be exacerbated by the subsequent necessary investigatory processes and hearings. The review is aware of the view from staff that a pending FAI process can place pressure on reflective learning practice and potentially make it less effective. The NHS (England and Wales) Self-harm and Suicide Prevention Competency Framework, 2018 notes:

> *"To enable an organisation to learn from these events, inquiries need to be conducted in a manner that enables **family members, significant others and staff to talk openly**, give evidence and comment on findings. This might be unlikely if there is any sense that the aim is to apportion blame to individuals. Staff are likely to feel considerable distress after a death by suicide, and the inquiry process itself can add to this stress if this is not recognised or is poorly managed".*

It is important to ensure that support for staff is provided (indeed for all agencies working within the establishment) around issues of mental health and wellbeing relevant to the prison environment, including ways to maintain their own and colleagues wellbeing. Whilst the SPS currently offers CIRS as well as counselling services through occupational health providers, the draft TTM evaluation notes that more independent research into how best to provide post incident support for staff would be of benefit:

> *"It is advised that more research into this process and data about the CIRS process, levels of attendance, and follow up, absences from work takes place. Ideally independent research into the reasons why people attend CIRS, what they expect and the reasons why people do not and how they in turn get support could be carried out. Essentially, at present there is not much known about how effective this is and it seems that a review is both timely and necessary".*

Part of helping staff and families to cope with their emotions in the aftermath of a death in custody, would be to further assist everyone's understanding of the FAI process and reduce the fear of blame. In this regard, the recent MOJ ACCT review notes that:

> *"Family members, significant others and staff should be helped to understand the process of both an inquiry and an inquest, and should be supported to understand the legal aspects of an inquest".*

The review notes the potential for **helpful collaboration between the SPS and the** SFIU to develop training and information advice and guidance in this regard.

12.7 Generating learning promptly and sharing it across relevant agencies

COPFS has recently increased the resource available to the SFIU, with a view to reducing the time required to complete complex death investigations and improving the provision of information both to families and next of kin. In addition, COPFS has revised the way the progress of all death investigations is monitored, to ensure that they are completed as efficiently as possible.

One of the concerns expressed to the review team about long delays in the FAI process, has been that to undertake an in-depth inquiry in advance of a court hearing might impede the formal process. As a result, there is a risk that learning opportunities are lost and that actions which might have improved service delivery for others are not implemented timeously. The review explored this issue with both SFIU and the SPS, both of whom have indicated a willingness to explore the parameters within which a full post incident investigation could have benefits and be both progressed and fed into the subsequent FAI process. NHS (England and Wales) Self-harm and Suicide Prevention Competency Framework, 2018 notes the requirement for:

> *"An internal inquiry as well as a public hearing (inquest). These are carried out by an independent team of skilled investigators who have the training, clinical experience and knowledge to conduct a serious incident investigation".*

Once learning outcomes have been agreed, there are obligations on organisations to monitor progress against agreed actions. Scotland's Suicide Prevention Action Plan: Every Life Matters notes that:

> *"Leaders at a national, regional and local level have a key role to play in creating a culture that ensures that learning is taken from every death by suicide, in order to help prevent future suicides. Stakeholder collaboration will be at the heart of our approach".*

The review identified improvements being made in governance structures within the SPS, and the systems and relationships required between SPS Headquarters and prison establishments to ensure that momentum was maintained. We remain of the view that some **independent ongoing scrutiny** of such an important area of business (including the degree to which DIPLAR and FAI outcomes concur) with the opportunity to escalate significant concerns would be of benefit. It is also the case that all relevant agencies do not routinely share lessons learned and the review therefore recommends that a **Memorandum of Understanding is developed or expanded** between relevant agencies on the appropriate methodology for enquiry and reporting. The sharing of lessons learned and the management information systems needed to support effective information capture, analysis and sharing.

Finally, DIPLAR and FAI processes currently tend to prioritise the immediate period pre-incident. This takes a relatively narrow view, even in circumstances where (as is often the case) a young person is only recently admitted, and limits the opportunity to learn more about their needs and experiences.

Recommendations

- Consideration should be given to the benefits of appointing an independent Chair for greater independence and consistency during the DIPLAR review;
- further consideration should be given to the Chair meeting with the family prior to the DIPLAR to understand their concerns;
- consistent processes should apply in all prisons both public and private;
- consideration should be given to reviewing the shared DIPLAR process and format for information collation through comparison with other agency and jurisdiction processes;
- further work is required to analyse the FAI determinations and recommendations against the DIPLAR learning to enhance learning;
- a Memorandum of Understanding is developed or expanded between relevant agencies on the appropriate methodology for enquiry and reporting, the sharing of lessons learned and the management information systems needed to support effective information capture and analysis;
- consideration should be given to commissioning a small focused study contacting and following up with families who have experienced the self-inflicted death of a loved one in custody; and
- the SPS and SFIU should review the DIPLAR process to ensure information collated and shared does not impinge on the FAI process; and whether it could contribute to the FAI process.

13. FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

13.1 High Level Strategic Issues

There are two high level strategic issues that merit specific attention. These are:

- The lack of proactive attention to the needs, risks and vulnerabilities of those on remand, and in the early days of custody; and
- the systemic interagency shortcomings of communication and information exchange across justice that inhibits the management and care of young people entering or leaving HMP YOI Polmont.

13.2 Social Isolation

13.2.1 Findings

Young people in detention have heightened risks and needs compared to young people in the community. A common finding in the evidence review commissioned from the SCCJR (see **Annex A**), is that young people in custody have higher rates of suicide and higher rates of factors associated with self-harm and suicide, including: depression; anxiety disorders; psychotic symptoms; attention deficit hyperactivity disorder (ADHD); and more.

There is also some evidence that young people who experience custody are more vulnerable than young people in the community with histories of abuse, time spent in care, violence and mental health issues prior to detention.

One factor that arises as a consistent theme is the **powerfully negative effect of social isolation**. Isolation can be a function of being placed in segregation or on suicide watch, of having a limited regime (i.e. limited time out of cell), or being separated from supportive peers and family. Having a prior mental health issue or attempted suicide, compounded by feelings of hopelessness commonly experienced by young people in prison, contributes to the heightened risk of self-harm and suicide.

Social isolation is experienced in particular by remand prisoners who also form the highest risk group for suicide.

> *"Isolation is identified as profoundly damaging, with extensive evidence of specific damage for young people".* (SCCJR Evidence Review)

13.2.2 Conclusion

The evidence review echoes the recent inspection of HMP YOI Polmont, which concluded that unintended isolation occurred particularly with the remand population, representing a period of heightened risk. Little information is available prior to admission to prison or during the early time in custody, to support the management of remand prisoners at the acute points of vulnerability. This is compounded by remand prisoners not being expected to attend important preventative activities such as prisoner induction and wellbeing opportunities; thus reducing the opportunities for interaction with staff, risk assessment and prevention of social isolation.

The quality of staff/prisoner relationships in identifying distress and providing support is a fundamental part of reducing isolation. In the Comparative Study of draft Incarcerated Young Adults in Scotland and Canada Part 1: Scotland, Carla Cesaroni noted that staff at HMP YOI Polmont:

> *"clearly understand their population and the challenges of working with young adults. Their input is critical to the success of Polmont".*

13.2.3 Recommendations

Key Recommendation 1: Social isolation, as a key trigger for self-harm and suicide, should be minimised, with a particular focus on those held on remand and during the early weeks in custody.

There should be a collective understanding and agreement that reducing social isolation and maintaining community ties are a critical factor in reducing the risk of self-harm and suicide. Whilst it is difficult to know how long a young person on remand will be in custody, it is important for organisations to recognise that "every interaction is an intervention" and that brief interventions are valid and effective. To ensure this is addressed:

13.2.3.1 SPS policy recommendations

- The SPS should collect and analyse the data for all young people, regardless of status, on time out of cell, attendance at purposeful activity opportunities, visits, letters, and phone calls, to identify those young people who are experiencing unintended isolation and develop care plans to address this;
- all purposeful activity opportunities related to wellbeing, apart from offending behaviour programmes, should be made available to all young people regardless of status, e.g. remand and protection prisoners who traditionally have impoverished regimes and pose the highest risk;
- good existing practice in multi-disciplinary approaches to co-designing the regime should be extended to all aspects of HMP YOI Polmont's strategy;
- staff confidence in dealing with distress and challenging behaviour should be enhanced by regular and refresher training and awareness in trauma informed gender and age specific behaviour management, supported by individual behaviour management advice from the prison psychology team; and
- the SPS should consider the re-introduction of the volunteer Prison Visitor Scheme for those young people that identify as having limited family or friendship contact.

13.2.3.2 The Scottish Government and other agencies recommendations

- Consideration should be given to reviewing the legislation to require all young people in custody to engage in wellbeing activity; and
- expert community services, activities and therapeutic supports which underpin improvements in health and wellbeing, and which may help address the underlying trauma behind the desire to self-harm, need sustainable core funding.

13.3 Information Sharing

13.3.1 Findings

Children and young people who have sadly died in custody have often had significant interaction with community agencies before entering prison. Yet information about their history or changes in risk, whilst readily available, are not consistently and routinely shared at the acute point of vulnerability – on admission to prison.

Information to support informed judgements at the point of entry to HMP YOI Polmont is varied and dependent on status and/or local authority information sharing protocols. Historical understanding and knowledge of young people presenting at HMP YOI Polmont, including identifying subtle but important signs of deteriorating mental health, may therefore be missed in the early stages of assessment.

In addition, there is no common electronic platform for rapid data transmission to support and enable effective information transfer. The Scottish Parliament's Health and Sport Committee Report (2017) also noted in respect of the IT issue that:

> *"The difficulties and dangers inherent in the current lack of IT functionality have been known for many years".*

Relevant available information to support the assessment, treatment and management of all young people entering custody is not communicated routinely and timeously to support preventive actions, for remand prisoners for whom there is no CJSWR, information relies heavily on the Prisoner Escort Record (PER) for risk alerts.

INQUEST and the Prison Reform Trust analysis of 169 children and young people's death in custody in England and Wales between 2003-2011, found that 85% were self-inflicted. This Review offers compelling evidence in support of its findings that young people who died in custody had a range of situational factors including significant histories with community agencies:

> *Having 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;*

A very high number of young people do not leave HMP YOI Polmont having completed a sentence; around 65% are released or bailed following a court appearance. The good practice of enhanced integrated case management giving rise to a case conference planning for release is therefore missed.

13.3.2 Conclusions

As public bodies, we are committed to upholding human rights, and within that, the specific rights of children and young people. For young people who are looked after we have specific duties as corporate parents to promote young people's wellbeing.

The availability of information and professional assessment of a young person's needs and circumstances underpins our collective ability to make informed decisions, most likely to secure positive outcomes for young people and ultimately the safety of the community. The critical understanding that contributes to our assessment and management of young people is inhibited by the lack of information available at the acute points of vulnerability; on admission to prison and during the early time in custody. Information sharing protocols and a platform for electronic transmission are lacking.

13.3.3 Recommendations

Key Recommendation 2: To support more effective risk management, the Scottish Government and other agencies should work together to improve the sharing and transmission of information for young people entering and leaving custody.

The flow of information on entering and leaving custody should be improved to support effective risk management as follows:

> Consideration should be given to developing and adopting a standardised approach, conforming to the GIRFEC policy, across the justice system to ensure relevant history and information accompanies **all** young people entering custody;

13.3.3.1 SPS policy recommendations

- The SPS and NHS Forth Valley NHS should consider the use of holistic age appropriate risk assessment tools on induction, to inform the management of young people in their care who arrive with little significant information about any risk and arrange a 72-hour case conference once further information has been gathered; and
- inter-agency review arrangements should be considered for all young people in readiness for their release.

13.3.3.2 The Scottish Government and other agencies recommendations

- The Scottish Government should consider developing and adopting a standardised approach, including developing minimum information data sets, conforming to the GIRFEC principle, across the justice system to ensure relevant history and information accompanies **all** young people entering custody;
- the Scottish Government should re-energise its work to introduce the electronic transmission of information across the justice system and children's services;
- consideration should be given to risk alerts completed by a named person or lead profession being shared electronically across the justice system;
- the template for risk alerts should be reviewed and consideration given to including information on identified needs and vulnerabilities, including wellbeing and welfare assessments, e.g. risk of harm to self or others and health and wellbeing matters (including any physical and mental health concerns, medication, alcohol and substance use). This information should be shared with whoever is transporting the young person and included in the PER;

- on the day a child or young person is remanded or sentenced, their Child's Plan and Criminal Justice Social Work Report (CJSWR) (where a CJSWR has been completed) should be shared electronically;
- once information requirements and minimum data sets have been agreed, consideration should be given to a sustainable quality assurance and scrutiny mechanism to ensure the systematic flow of information;
- if a young person is at risk of a custodial sentence, where possible and without disturbing the court process, consideration should be given to their hearing being listed as early as possible in the court day, to support their transition into custody and ability to access appropriate support; and
- similarly, where practical, liberations should be arranged for times when those with complex support needs can receive appropriate support.

13.4 Suicide and self-harm strategies for young people

13.4.1 Findings

The development of an optimistic approach to suicide prevention is central to achieving reductions in self-harm and suicide. Adverse and potentially unbalanced media coverage can make the task of achieving that positive cultural environment more difficult.

Trauma informed leadership (specific to the needs of adolescents), which promotes rights, dignity and a nurturing and relational culture is key. Staff cannot nurture young people unless they have enough time and support to build relationships. These are the issues that will ultimately support the attitudes and values required for culture change. The Independent Advisory Panel on Deaths in Custody reminds us that:

> *"People in custody emphasise(s) relationships, dignity and hope over more technical procedural and policy-based approaches to change such as ensuring staff are good, decent people who will treat prisoners with humanity, respect and common sense".*

At corporate levels, there is a requirement for organisational practice which seeks specifically to address the identified needs of young people as separate from adults, and **eliminate stigma and re-traumatisation**. The review of the SPS TTM Strategy by Dr Briege Nugent commissioned by the SPS, gives a range of useful recommendations, but does not take the suggestion further to adapting the strategy for young people.

> *"Prison suicides are likely to be the result of a complex interaction of different factors, and not merely due to the prison environment".* (Fazel 2017)

However, the impact of the physical and institutional environment of a prison, linked to a suicide and self-harm strategy that is perceived as punitive rather than supportive, compounds the risk posed by the most vulnerable population in the prison service. Help seeking behaviours are inhibited by a perception of the suicide and self-harm strategy as punitive and stigmatising.

Many young people regarded the suicide and self-harm screening and procedures as 'tick box exercises', or interventions that exposed them to further distress. **The room design, observation routines and special clothing were particularly highlighted as punitive inhibitors to help seeking behaviours.** They complained of negative emotional effects, such as being locked in a room with nothing but your negative thoughts, and social isolation.

Young peoples' self-harm or suicide vulnerability can also be connected to:

> *"their ability to cope with the custody environment itself".* (Liebling 1999)

The inherently depressing nature of 'safer' cells and segregation housing is a feature that has arisen across research addressing physical environment. Safe cells can help to preserve life but they can be overused and ineffective in dealing with underlying mental health difficulties. **Alternative options to care in distress include the use of softer environments, greater interaction with trained staff, buddies and multisensory rooms.**

HMP YOI Polmont is not 'grim' or 'bleak' in comparison with the English experience described by the Harris Review. However, prison environments are not designed to nurture young people and the Harris Review commentary is still relevant in that it recognises that:

> *"Prisoners experience a worsening of health problems, anger, frustration and anxiety, sleep disturbance fatigue and depression as situational factors. The fact and nature of imprisonment itself does real harm to people".*

These issues have significant implications for potential prison estate design going forward. Not all 16-21 year olds are currently held in HMP YOI Polmont (though numbers are small elsewhere in the prison estate) and this has benefits in respect of the provision of a comprehensive tailored wellbeing regime.

The potential to extend age and stage appropriate approaches, to include a wider 'adolescent' age group (up to age 25) raises new possibilities for population management and distribution to prevent future offending.

It is not always helpful to scrutinise one part of a system in isolation from others. We need to search for data which throws light on the vulnerability of young people, levels of suicide and self-harm across their whole justice journey, including in the community on supervision and in the period following release. Suicide and self-harm strategies in prison are disadvantaged by the lack of comparable information and liaison with community strategies. One possibility is to include the 12 Point General Health Questionnaire[13] as well as the wellbeing elements into the Prison Survey to measure the level of distress across the SPS and inform future strategy.

There is increasing evidence that young people need individualised age and stage appropriate services and supports. A needs-based approach to understanding maturation and child and adolescent development should therefore be seen as a priority. Effective youth justice processes could be extended to a wider age group, consistent with the evidence in respect of maturation. In this regard, the SAMH report recommends that:

> *"By 2020, let children and young people stay in specialist services till age 25".*

13.4.2 Conclusions

There should be greater recognition that the reasons why young people take their own life in HMP YOI Polmont are not just about their individual vulnerabilities, but a combination of wider social justice and embedded systemic issues, including the influences of poverty and adverse childhood experiences. Suicide prevention initiatives therefore need to draw on asset based multi-disciplinary approaches that address all parts of the criminal justice system, encompassing both individual and system-level risk factors that can contribute to assessing and managing the risk from admission.

With 71% of those who died by apparent suicide having previously been managed on the TTM Strategy, there is a real need to examine the process for removal from TTM and any ongoing support.

Continuing and expanding on the achievements of the GIRFEC principles and WSA policy by considering a renewed focus on early intervention and prevention of custody, particularly for the youngest and those on remand may be beneficial. Therefore, the benefits of extending the WSA to those up to the age of 26 may also be worthwhile when considering the evidence of age and stage maturation.

A more integrated policy and strategic approach is required to meet the specific needs of adolescents who often fall between services designed for either children or adults. A bespoke strategy that includes an understanding of young people's cultural reliance on social and technological media is needed. The use of incell technology to provide ready access to family and support agencies can assist in preventing unnecessary harm. The Strategy needs to build on existing expertise in child and adolescent health and wellbeing, as well as address the perception of the Strategy as punitive.

13 Noted in Liebling, A and Maruna, S The Effects of Imprisonment (Eds)(2005)

13.4.3 Recommendations

Key Recommendation 3: A bespoke suicide and self-harm strategy should be developed by the Scottish Prison Service and NHS Forth Valley for young people that builds on the strengths of the existing framework.

13.4.3.1 SPS recommendations

- The greatly increased risk during the first three months in custody should be emphasised in the TTM Strategy and staff training;
- a bespoke suicide and self-harm strategy for young people should draw on the evidence and good practice;
- recognition of the acute points of vulnerability; remand, social isolation and accessing available history and information, needs to be addressed in the bespoke strategy;
- when designing the revised suicide and self-harm strategy for young people, consideration should also be given to developing a more gradual reduction in care process for those being removed from it;
- the SPS, the NHS and community partners should develop multi-disciplinary team approaches for management plans specifically for those considered at risk or vulnerable, e.g. those young people on remand or in early custody;
- embedding trauma informed practice, knowledge of child development and age, and gender specific training for all staff working with children and young people is essential;
- more research is needed on the provision of effective and responsive emotional support for staff, families and children and young people following a suicide in custody;
- young people withhold distress from staff and fellow prisoners, so auditable processes must be in place to respond effectively when family, friends, peers or contacts in the community raise concerns;
- there is a need to create more dedicated time for SPS personal officers to build nurturing relationships that are not compromised by population fluctuations or operational pressures;
- staff confidence in dealing with distress and building nurturing relationships should be enhanced by regular and refresher training, and awareness in Child and Adolescent health and wellbeing; and
- the agreed recommendations from the Dr Briege Nugent review of TTM should be implemented.

13.4.3.2 The Scottish Government and SPS recommendations

- There should be a change in the legislation and organisational practice which seeks to minimise re-traumatisation and stigma, e.g. body searching should be intelligence-led only;
- The Scottish Government and SPS should consider introducing in-cell telephony and technology to improve non-stigmatising access to self-help and mental health professionals when locked in cell;
- The Scottish Government and SPS should consider the development of a softer, more normalised environment, for those in acute distress to be supported; and
- The Scottish Government and SPS should review the evidence for multisensory rooms for young people in distress and consider implementing in HMP YOI Polmont.

13.5 Health and wellbeing

13.5.1 Findings

There is recognition that interventions and services are needed for young people in any setting to proactively support positive wellbeing, and that these are important for the prevention of mental ill health. HMP YOI Polmont has focused on developing a whole establishment approach to learning, which encompasses many aspects of health and wellbeing to tackle the widespread presenting issues of low mood, anxiety and self-isolating behaviours. Whilst many young people are suffering from psychological distress, few are diagnosed clinically, and as a result practitioners share the view that much of the service provision should focus more broadly on strategies to improve wellbeing. The Draft TTM evaluation, commissioned by the SPS, also commented that:

> *"There is growing recognition that suicide prevention sits within a wider agenda about health and wellbeing".*

A number of sources stress the need for a more strategic approach to prison healthcare, addressing service issues with national implications and tackling continuing issues of staff recruitment and retention. Further, they argue that we should question the principle of health 'equivalence' with the community, (where prisoners have access to the same quality and range of services as the general public). The well evidenced background of young people in custody (who are generally from marginalised communities with poor access to primary healthcare) suggest that services should instead be based on levels of assessed need, which often exceed those within the general population. The Scottish Parliament's Health and Sport Committee Report (2017), concluded that providing prisoners with the best possible healthcare has advantages for the individual, the community, and the NHS, and represents:

> *"A unique opportunity to tackle health inequalities within a discrete section of the population".*

The joint response should not be one of medicalising or overt focus on individual risk, because our ability to predict risk is limited and clinical services and responses are only part of the answer. Rather we should understand that an environment supportive of wellbeing is essential, and a broader preventative whole establishment approach to health and wellbeing is needed, which places equal emphasis on care planning and the quality and consistency of delivery. In this regard, the Self-Harm And Suicide Prevention Competence Framework: Children And Young People highlights that:

> *"Research suggests that moving away from prediction to focusing on the needs of the person and seeing assessment as informing management rather than as a stand-alone activity".*

The Scottish Parliament's Health and Sport Committee Report (2017) on Healthcare in Prisons 2017 made two recommendations:

132. *The overriding impression we have received from our evidence is of a population which has been very much underserved by the change in responsibilities. The promised improvements have not materialised and we do not accept the suggestion or expectation that progress and change within the health service takes a long period of time. It does not need to if the will is there and sadly within prison healthcare this has been conspicuous by its absence at senior management levels.*
133. *We are disappointed to discover the unique opportunity to address health inequalities within the prison environment is not being taken. We recommend the extent to which this is tackled should be a key performance indicator for all of those involved.*

In HMP YOI Polmont, staff were found to be compassionate and caring for the young people in their care, and had empathy for the difficulties they faced. A number of areas of best practice were noted and welcomed, and in particular the initial screening assessment and subsequent continuity of care along with the rapid referral to psychiatry. The short waiting times for referral experienced in HMP YOI Polmont compare well with access in the community. We recognise that this is subject to change given the national picture of an inability to recruit and retain key specialist staff.

However, a range of clinical concerns were raised both during the inspection in 2018 and as part of this review, and were escalated to NHS Forth Valley. We are pleased to note the responsiveness to the concerns and look forward to seeing the new ways of working being embedded in the near future.

Concerns raised within the CEO of NHS Forth Valley included the lack of clear pathways and processes, agreed assessments and risk tools exacerbated by limited multi-disciplinary working, staff capacity to manage their clinical workload given the onerous medication administration, and inconsistent recording. The Review was surprised to learn that there were no adolescent trained NHS staff, and none of the staff had undergone the Essential CAMHS competency training.

Many of the concerns raised are experienced nationally including the inability to recruit and retain staff, lack of a national formulary, non-standardised pathways and processes. These issues will be raised with the Health and Justice Collaboration Board.

13.5.2 Conclusions

Many of our conclusions, like the capacity to share information electronically between agencies and the difficulties facing healthcare in prison, are long standing issues. Nonetheless, this review provides the opportunity for a step change in prisoner healthcare and wellbeing, and highlights some excellent examples of good practice.

The whole establishment approach has brought about a welcome culture shift, but this continues to be a work in progress, with different staff groups engaging to varying degrees. There is recognition that transitions take time, but the establishment appeared to be on a progressive path in the care and support of its young people.

The holistic wellbeing and healthcare approach in HMP YOI Polmont is to be commended and will be more effective when the Review's recommendations have been fully implemented.

There are a number of gaps in the identification of mental health issues and needs. These include issues with the sharing of information from courts, secure care and the community to the prison, difficulties for prisoners in disclosing issues, problems with processes and operational issues, and problems with staff being able to identify issues. The lack of national standards being adopted across prisons results in inconsistent services, from assessment to intervention to discharge. **However, the biggest barrier to young people accessing mental health services was the opinion of the young people themselves who felt some aspects of the TTM Strategy were punitive**.

13.5.3 Recommendations

Key Recommendation 4: NHS Forth Valley should develop a more strategic and systematic approach to prison healthcare, with accompanying workforce capacity review and improved adolescent and young people specific training.

13.5.3.1 The Scottish Government and NHS recommendations

- A more strategic approach to healthcare, including alternatives to prescribing policy and availability is required to address significant identified shortfalls;
- the Scottish Government and the NHS should address the issue of the shortage of mental health staff experience across Scotland.

13.5.3.2 NHS Forth Valley recommendations

- NHS Forth Valley should consider joining the Quality Network for Prison Mental Health supported by the Royal College of Psychiatrists. Arrangements could then be made by NHS Forth Valley for regular audit and examination of service delivery, enhanced by following the process and standards of the Royal College of Psychiatrists for prisoner mental health;
- NHS Forth Valley and HIS should ensure the development and implementation of workforce planning tools specific to prisoner healthcare;
- NHS Forth Valley must ensure that safe staffing legislation is applied to prisoner healthcare;
- A workforce capacity model should be undertaken to enable appropriate staffing levels and caseloads;
- NHS Forth Valley should consider addressing the retention issues through a proactive recruitment campaign including considering improving terms and conditions and bandings for nurses;
- There should be a rolling programme of Continued Professional Development for NHS staff to include topics relevant to adolescent mental health, such as ASD, ADHD and other developmental disorders;
- the competency framework and Essential CAMHS training should be considered for staff;
- clinical and caseload supervision should continue to be offered and the barriers to lack of attendance examined and overcome;
- NHS Forth Valley should review prescribing policy and availability of prescribers to try and reduce delays in access to medication;
- NHS Forth Valley should work with the Scottish Patient Safety Programme to help implement the recommendations regarding medication made during the HMIPS inspection;
- other options for medication dispensing should be considered to free-up mental health nursing time and to enable further and enhanced therapeutic interventions to be delivered;
- NHS Forth Valley should develop equitable access to services for all young people, and it should not be

dependent on remand or sentenced status. This would need the development of brief interventions to be made available;
- NHS Forth Valley should work closely with the Excellence in Care programme leads to ensure that the national assurance and quality framework for nursing is implemented in this setting; and
- all other recommendations from the HMIPS review of HMP YOI Polmont must be implemented and embedded, including in particular;
  - recommendations regarding mandatory training and appraisals of staff;
  - standardised assessments;
  - detailed and accurate clinical recording;
  - multi-disciplinary decision making, which is rights-based and person-centred; and
  - clarifying pathways, processes and agreed assessment and risk tools.

13.5.3.3 The SPS and NHS recommendations

- Staff absence is impacting services and this should be addressed by both the SPS and NHS Forth Valley;
- access to health should be co-designed with young people to overcome barriers and stigma;
- there should be improved links between NHS Forth Valley and the SPS at all levels of seniority to improve leadership of the health and wellbeing approach and accountability;
- adolescent Mental Health training should be adopted and delivered in a phased manner to SPS staff in HMP YOI Polmont;
- a systemic framework should be developed to embed the newly created multi-disciplinary team meetings and clinical and caseload supervision;
- the SPS and should work together to ensure the provision and sustainable resourcing of therapeutic supports and services, which address the underlying trauma behind the desire to self-harm, not just the presenting behaviours;
- the SPS and NHS Forth Valley should consider developing a joint information pack for families about how the system works, with details of mental health support; and
- a discharge checklist for both the SPS and NHS would help to standardise the process when people are being managed by the mental health team and are released from HMP YOI Polmont.

13.5.3.4. The Scottish Government recommendations

- Some aspects of delivery are under financial threat and some early services dealing with key issues such as domestic and sexual abuse have been lost;
- the Scottish Government should consider long-term sustainable funding for key aspects of service provision;
- a National Drug Formulary for prison healthcare should be developed; and
- consideration should be given by the Justice and Health Collaboration Board to repeating the work originally completed in 2013 by the SPS on evaluating the prevalence of Mental Health problems in prisons.

13.6 The SPS TTM Strategy

13.6.1 Findings

The TTM Strategy builds on the previous Act2Care Suicide Risk Management policy. The changes take account of the legislation and also some of the other changes specific to the prison environment. The emphasis is placed on the care plans being person-centered and individualised, agencies being involved and also making it clear that anyone can initiate a concern.

The TTM Strategy was developed following a consultation exercise and applies to every cohort of prisoners in the SPS. The TTM Strategy was generally followed well, and staff of all agencies were aware of their responsibilities. In addition, the TTM Strategy was found to be well audited by the SPS, though it was unclear where the clinical governance for the NHS part of the TTM Strategy was located.

At the time the review was conducted, there were increasing numbers of young people on TTM.

The increased number of young people on TTM limited staff (both NHS and SPS) time to undertake clinical or other interventions. Nursing staff were struggling to deliver interventions that would enable a reduction in TTM observation levels due to medication dispensing and attending case conferences. SPS staff were similarly involved in TTM case conferences, reducing the time required to build nurturing relationships with other prisoners.

Despite the best of intentions, the TTM Strategy was capable of being used in quite a mechanistic way by staff, potentially undermining the Strategy's intent. Young people reported that they found the questioning regarding self-harm and suicide very repetitive and like a 'tick box' exercise.

There were a number of repeat young people on TTM and the reasons behind it were not made clear, nor was it clear what progress had been made against their plan objectives.

Evidence from the SPS indicates that the majority of young people come off TTM relatively rapidly (within three days) and that 71% of the total deaths in custody in the last three years were at some point on TTM.

13.6.2 Conclusions

The relationship between self-harm and suicide is complicated, especially in a prison context, and the approach to this may require further consideration given the particular complexities of this age cohort.

There is a disproportionate number of young people being held on remand committing suicide or self-harm. Issues of information sharing and access to wellbeing activities have been explored, but further work will need to be done.

The review team and staff at HMP YOI Polmont felt that the TTM Strategy was not specific to the needs of adolescents.

The TTM process has a distinct constraint, inhibiting the praiseworthy intent. Although the emphasis is on individualised planning, application can appear mechanised and not age-specific.

Staff training in associated disciplines is an essential component in building staff confidence in dealing with mental health, challenging behaviour and helping young people to co-regulate emotions.

There is insufficient focus and understanding on the reasons behind repeat placements on TTM.

The process for access to hospital facilities in Scotland for acute mental illness is slow. There has been a recently commissioned review of the forensic mental health review by the Scottish Government. This is welcomed.

Dr Briege Nugent's robust and comprehensive evaluation of TTM has a number of recommendations that are endorsed by this Review.

13.6.3 Recommendations

Key Recommendation 5: An enhanced approach should be developed, by the Scottish Prison Service, for the Talk to Me Strategy suicide prevention work, with more intensive multi-disciplinary training and a more gradual phased removal for those placed on Talk to Me.

13.6.3.1 SPS recommendations

- Refresher training in TTM for all staff in contact with young people should be regularly undertaken and adaptations made for specific populations such as adolescents. This training should not just include the processes and paper work of TTM but broader aspects of trauma informed behaviour, child and adolescent development, self-harm and suicide;
- the SPS could consider replicating the good practice in the secure unit system, where each young persons' case notes identified and highlighted potential triggers and escalation routes for staff, should these occur;
- the data on young people who committed suicide that had previously been on TTM suggests the need for a more gradual phased removal from TTM, with appropriate supports and followup checks in place.

13.6.3.2 SPS and NHS Forth Valley recommendations

- NHS Forth Valley and the SPS should consider more intensive multi-disciplinary training on mental health issues, led by mental health specialists with an understanding of the prison context. Multi-disciplinary training is essential to build the relationships and respect required for shared practice and learning, but individual disciplines will also require specialist input; and
- repeat placements on TTM should be subject to a focused analysis to identify the causes and a multi-disciplinary approach, with support from the mental health team, engaged to provide help for staff in managing distress and challenging behaviour issue.

13.6.3.3 The Scottish Government recommendations

- The extent, efficacy and use of safer cells and their softer more normalised alternatives should be subject to a separate review and more in depth review looking at existing secure care research;
- young people on remand are particularly at risk and although this review has highlighted some of the underlying causes, further work needs to be undertaken to identify the root causes and develop protective factors; and
- a further piece of work to look at the comparison statistics of young people in Scotland with age cohorts under supervision or licence, or in residential care is recommended.

13.7 Death in Prison Learning, Audit and Review (DIPLAR)

Dr Briege Nugent's evaluation of TTM (2018) concluded that:

> *"A review of the documentation shows that this [DIPLAR] is an effective way of preserving evidence, communicating with appropriate parties and recording learning and identifying actions".*

13.7.1 Findings

The DIPLAR arrangements were approved by both the SPS Executive Management Group and NHS Health Board Leads and form a joint process for reviewing all deaths in custody, designed to promote partnership working and the identification of areas for learning and improvement.

The National SPS multi-agency Prevention of Suicide Management Group (NPSMG) is the strategic delivery group which collates learning across the prison estate, and monitors progress against actions which have been identified in the DIPLAR process.

The DIPLAR process may also, in some circumstances under legislation, be supplemented by a Significant Case Review (led by local authority social work), and a Health and Safety Executive investigation may also be requested by the Procurator Fiscal, so the collation of review outcomes can sometimes be complex.

Prison Governors and NHS staff from the prison in question usually chair the DIPLAR when deaths occur. At times it is chaired by the NPSMG lead. The review identified that this led to inconsistencies in the subsequent reports. The FAI recommendations are not correlated against the DIPLAR findings.

HMP Kilmarnock has its own supplementary investigation process conducted under legal privilege.

DIPLAR processes currently tend to prioritise the immediate period pre-incident. This takes a relatively narrow view, even in circumstances where, as is often the case a young person has only recently been admitted and limits the opportunity to learn more about their offending pathway. The scope and remit of the review would not support undertaking research with families who had lost a relative in custody to assess their experience of the DIPLAR processes and accessibility of available supports. However, that would be a beneficial exercise for a future review.

13.7.2 Conclusions

- There are further opportunities to refresh the shared DIPLAR process and format, for information collation through comparison with other agency and jurisdiction processes;
- delays experienced by the current FAI process inhibits the comparative analysis of the DIPLAR and the FAI recommendations; and
- the DIPLAR process, while well-designed, is not fully independent.

13.7.3 Recommendations

Key Recommendation 6: Enhanced and more consistent Death in Prison Learning Audit and Review processes, by the Scottish Prison Service, are required to maximise learning from previous incidents.

13.7.3.1 SPS Recommendations

- Consideration should be given to the benefits of appointing an independent Chair for greater independence and consistency during the DIPLAR review;
- further consideration should be given to the Chair meeting with the family prior to the DIPLAR to understand their concerns;
- consistent processes should apply in all prisons both public and private;
- consideration should be given to further refreshing the shared DIPLAR process and format for information collation through comparison with other agency and jurisdiction processes;
- further work is required to analyse the FAI determinations and recommendations against the DIPLAR learning to enhance learning; and
- a Memorandum of Understanding is developed or expanded between relevant agencies on the appropriate methodology for enquiry and reporting, the sharing of lessons learned and the management information systems needed to support effective information capture and analysis.

13.7.3.2 Scottish Government and other agencies recommendations

- Consideration should be given to commissioning a small focused study contacting and following up with families who have experienced the self-inflicted death of a loved one in custody.

13.7.3.3 SPS and SFIU recommendations

- The SPS and SFIU should review the DIPLAR process to ensure information collated and shared does not impinge on the FAI process; and whether it could contribute to the FAI process.

13.8 Strategic development and coordination

13.8.1 Findings

Comparative analysis and interpretation of Scotland's suicide statistics with similar age cohorts and European institutions is complicated by differing definitions, delays in FAI determinations and the quality of the data.

It is not always helpful to scrutinise one part of a system in isolation from others. In addition to the difficulties of interpreting the suicide statistics within Scottish prisons, there was also little comparator information on levels of suicide and self-harm across the whole justice journey, including in the community on supervision and in the period following release.

Considerable information exists from other areas of the health and justice systems and from reviews that are either completed or currently being commissioned.

The review identified a wide range of reviews with potential synergies, but no evidence of coordination across government to ensure knowledge management, shared resources, reduced duplication and economics of scale.

There is an identified need of achievement of a greater staff therapeutic interaction with young people.

There is increasing evidence that young people need individualised age and stage appropriate services and supports. In this regard, the SAMH report recommends that:

> *"By 2020, let children and young people stay in specialist services till age 25".*

The WSA currently applies to children under the age of 18, although in some local authority areas this has been extended to young people aged under 21 or 26. This extension has been encouraged by the Scottish Government (2015) in recognition of the vulnerabilities of these young people and in keeping with other legislative provisions (for example, corporate parenting entitlements for care leavers).

13.8.2 Conclusions

The Evidence Review confirms multiple opinions that youth justice processes should be extended to a wider age group consistent with the evidence in respect of maturation.

The Scottish Government should consider funding a work-force capacity review to meet the identified need of greater staff therapeutic interaction with young people. An analysis of the statistics on suicide in Scottish prisons is constrained by the difficulties of finding comparative statistics from other jurisdictions or even within Scotland's Justice System, and the quantity of current reviews suggests value in examining the opportunities for improved centralised coordination, to ensure each review is fully aware of the work and emerging findings of other reviews.

13.8.3 Recommendations

Key Recommendation 7: Further work should be undertaken by the Scottish Government to provide a central coordination point for government reviews, use the existing analytical expertise to analyse comparative performance on suicides, and consider how the justice system can better respond to international evidence about maturation and alternative models of secure care.

13.8.3.1 The Scottish Government recommendations

- The Scottish Government should consider a further collection and analysis of the suicide and self-harm statistics to gain an in depth understanding of comparative performance across the Scottish justice system and the UK;
- consideration should be given to examination of the contention that an extension in age of the youth justice and WSA processes would be beneficial;
- the Scottish Government should consider funding a work-force capacity review to meet the identified need of greater staff therapeutic interaction with young people;
- the Scottish Government should consider the development of new models of secure care and custody provision, taking account of the maturation evidence, the findings of the HMIPS inspection and the findings of the Care Review; and
- to reduce the risk of duplication, the Scottish Government should improve the coordination of relevant information between related government reviews, including access to emerging recommendations.

APPENDIX A

Terms of Reference for the Review

The full scope and terms of reference for the review, as agreed with the Cabinet Secretary, were as follows:

To review arrangements for young people, both untried and convicted, with mental health and wellbeing needs, entering and in custody, including:

- The information available to the SPS prior to entering custody;
- reception, screening and assessment arrangements;
- health and wellbeing culture linked to ongoing support and supervision;
- treatment and interventions during their time in custody; and
- arrangements by SPS for their return to the community.

The review was to include the following:

- An evidence review of mental health and wellbeing support for young people in custody including any areas of best practice;
- identifying and reviewing the processes for the identification of wellbeing and mental health needs for young people at the point of reception to custody;
- an investigation of information sharing practices and flows to inform the provision of information to SPS (including from other agencies out with the justice system such as health, education, social work 3rd sector agencies; and including any relevant factors arising from their experience prior to entering the custodial system) and whether the information can be better utilised to assess and act upon identified risk factors or specific vulnerabilities whilst in custody;
- the views and lived experience of staff, young people and their families with identified mental health and wellbeing needs at HMP YOI Polmont both currently in custody and those with lived experience of custody;
- reviewing the processes for mental health and wellbeing assessment and referral processes in custody including the management of the risk of self-harm or suicide or other complex vulnerabilities;
- reviewing the governance and decision making arrangements for implementation of the Talk to Me process in custody including the evidence for its implementation, operational procedures, staff training and awareness;
- review of:
  - staff training and awareness of mental health and wellbeing needs,
  - the risk assessment process on reception,
  - the provision of wellbeing and mental health support in custody,
  - the treatment and interventions in custody, and
  - the arrangements for continuity of care post release;
- review of the DIPLAR process arrangements when it's an apparent suicide;
- make recommendations for changes or improvements to Scottish Ministers which they can pursue with other relevant agencies and bodies as required;
- should anything of immediate concern be identified, these should be escalated to the respective bodies via Scottish Ministers; and
- suggest any further reviews that arise out of the investigation.

The review was to focus on young females and males in custody. It was made clear that the review would not consider the specific circumstances or details of recent cases which were the subject of current or future mandatory Fatal Accident Inquiries.

APPENDIX B

Letter from Cabinet Secretary for Justice to HMIPS

23 November 2018

Dear Wendy,

REVIEW OF THE PROVISION OF MENTAL HEALTH SERVICES FOR YOUNG PEOPLE BEING CONSIDERED FOR AND IN CUSTODY

I am writing, in accordance with section 7(2)(d) of the Prisons (Scotland) Act 1989.

Following the recent deaths of Katie Allan and William Lindsay (Brown) at HMP YOI Polmont, I refer the provision of mental health services for young people entering and in custody at HMP YOI Polmont to you for investigation.

I would expect the review to look at the arrangements that exist within HMP YOI Polmont and at the information that is available when a young person is entering custody to inform the reception and management of that young person.

I appreciate that you have recently undertaken a formal inspection of HMP YOI Polmont and that the Health and Wellbeing of prisoners at the establishment will have been examined by Healthcare Improvement Scotland as part of the inspection process. I would anticipate that this review will complement the work that your inspection team have recently been doing.

Given the focus of this review is on mental health provision I would wish the consideration of the provision of mental health services to be led by a healthcare professional with relevant experience but with full input from the Inspectorate and other agencies, as appropriate. Officials will be in touch to discuss the appointment of an appropriate individual.

As with current inspections and independent monitoring, we would expect the review to include direct engagement with young people in HMP YOI Polmont about their experiences. It would be helpful if the findings of this review could be published either ahead of or alongside the report of the recent inspection of HMP YOI Polmont, which I understand is likely to publish in spring 2019.

I will ask Neil Rennick, Director for Justice, to contact you to discuss the full terms of reference for the review.

HUMZA YOUSAF

APPENDIX C

Glossary of Terms

ACE	Adverse Childhood Experience
ADHD	Attention deficit hyperactivity disorder
ANP	Advanced Nurse Practitioner
ASD	Autism spectrum disorder
CAMHS	Child and Adolescent Mental Health Services
CIRS	Critical Incident Response Support
CJSW	Criminal Justice Social Work
CJSWR	Criminal Justice Social Work Report
COPFS	Crown Office Procurator Fiscal Service
DBI	Distress Brief Intervention
DIC	Death in Custody
DIPLAR	Death in Prison, Learning Audit and Review
FAI	Fatal Accident Inquiry
GIRFEC	Getting it Right for Every Child
HIS	Healthcare Improvement Scotland
HMCIPS	Her Majesty's Chief Inspector of Prisons for Scotland
HMIPS	Her Majesty's Inspectorate of Prisons for Scotland
HMP YOI	Her Majesty's Young Offender's Institution
ISP	Information Sharing Protocol
LAAC	Looked after and accommodated children
MDMHT	Multi-disciplinary Mental Health Team
MHFA	Mental Health First Aid
NOMS	National Offender Management Service
NPHN	National Prisoner Healthcare Network
NPSMG	The National SPS multi-agency Prevention of Suicide Management Group
PRT	Prison Reform Trust
RCN	Royal College of Nursing
SAMH	Scottish Association for Mental Health
SFIU	Scottish Fatalities Investigation Unit
SIDCAAR	Self-Inflicted Death in Custody Audit, Analysis and Review
SIMD	Scottish Index of Multiple Deprivation
SPS	Scottish Prison Service
SPSP	Scottish Patient Safety Programme
TSO	Throughcare Support Officer
TTM	Talk to Me Strategy
UNCRC	UN Convention on the Rights of the Child
WSA	Whole Systems Approach

APPENDIX D

Wellbeing Activities at HMP YOI Polmont

'My life with others'

This approach recognises that many young people admitted to HMYOI Polmont need to address underlying trauma issues before they can begin to move forward in their lives. It is designed to facilitate 'readiness to learning' at a pace that each individual young person can cope with, and includes opportunities for personal planning, so that young people can help staff to understand their background and circumstances. Partnership working is extensive. A range of interventions and services were brought together under this umbrella to improve engagement of young people at the most appropriate time. These include:

- Bereavement counselling and 'Seasons for Growth' group work
- Chaplaincy
- Domestic abuse group work and counselling
- Sexual abuse counselling
- Mental health resources and CBT
- An inclusion area for those young people who need more intensive 1-1 support
- In-reach education and youth work services into the hall areas for young people who find it difficult to integrate and need to work towards learning in a phased way with more intensive support
- Speech and Language therapy
- Art therapy
- Offence related programmes specific to the needs of the population
- Mindfulness
- Restorative practices aimed to resolve conflict in acceptable ways
- Use of the 'Do it' profiler to assess inhibitors to learning and inform learning plans

Supporting inclusion

These activities are designed to further support young people in gaining the less tangible, but equally important, personal and social skills they will need on return to the community. Literacy, numeracy and communication skills are integrated within these learning opportunities:

- Regular and varied sports activity
- Working with animals (dogs) to develop personal responsibility
- Youth work and interventions which help young people to understand their rights
- Performance arts area
- Community safety approaches to recognise citizenship responsibilities to others (including delivery alongside Police Scotland of the leadership course)
- Life Skills areas to support self-care and independent living
- Parenting courses
- Arts and Crafts
- Media centre
- Library
- Hair and beauty
- Peer support hub to support a range of opportunities to contribute to the support of others
- Duke of Edinburgh award (Bronze and Silver)
- Fife college education provider (offering modules in communications, personal development, beliefs and values amongst others)

Skills for work

Many of the young people who are admitted to HMP YOI Polmont have been excluded from school and may find it difficult to engage in activity within a classroom setting, having previously opted out of formal education processes. Work related skills can bring a sense of achievement and purpose to young people, who may not previously have felt themselves capable. For these reasons, unlike adult establishments, HMP YOI Polmont offers a wide range of activities where qualifications from an introductory level onwards can be obtained:

- Employability area
- Joinery
- Bricklaying
- Engineering
- Fork lift truck driving
- Plumbing
- Waste management
- Horticulture
- Bike recycling
- Industrial cleaning
- Catering
- Painting and decorating
- Laundry

Support on admission and with transitions

Given the criticality of the period immediately following admission, the establishment places emphasis on getting to know each young person and providing them with information to help them settle in. Emphasis is placed on transition periods, both into and out of custody, since evidence suggests that young people often find these transitions difficult to navigate.

The establishment currently offers:

- Personal officer support
- Links area access to community agencies
- Throughcare officers and mentor organisations
- Family Contact Officers and information advice and guidance for families from partner organisations
- Induction programme
- Case management supports for both short and long-term sentences
- Positive Future plans built around the GIRFEC wellbeing indicators

APPENDIX E

Current policy, legislation and reviews

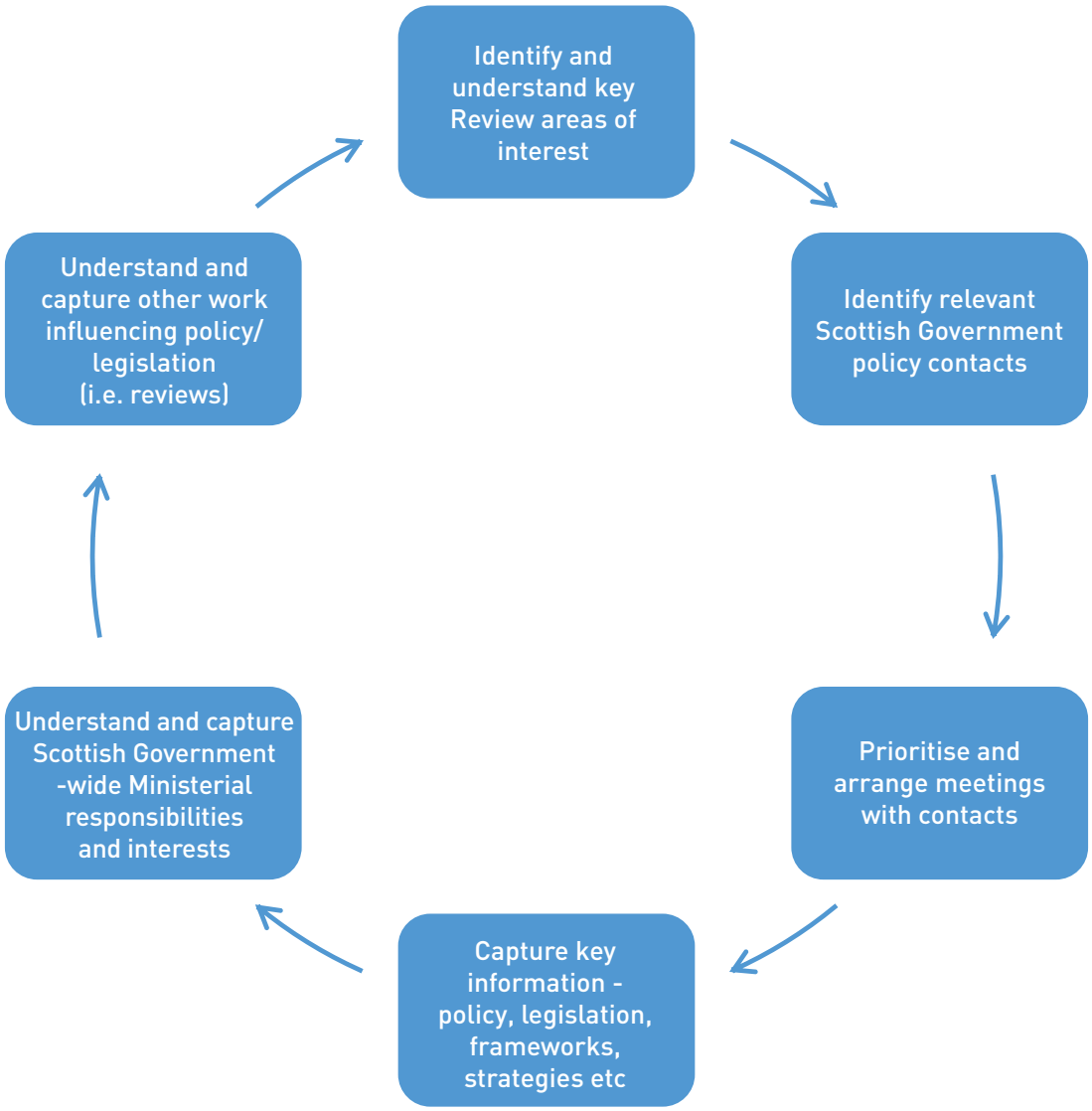
Rationale for policy mapping

The purpose of undertaking policy mapping is two-fold to ensure that:

- The Review is aware of current Scottish Government priorities and work in order to understand the current policy and legislative landscape as well as to avoid unnecessary duplication; and
- There is a collective understanding of the range of legislation, policy and relevant strategies etc informing wider work across Justice, Children and Young People and Mental Health policy. Ministers are thus in a position to quickly understand the potential implications of recommendations arising from the Review as relevant links have already been made.

Methodology

The following cycle has been established to continually review and capture relevant knowledge as the Review and Government work progress and is consistent with the approach to policy mapping taken by other ongoing reviews.



The Review of Mental Health and Wellbeing Services for Young People in Custody is cognisant of and makes its recommendations with regard to Scottish Government commitments set out in the current strategies and legislation:

Legislation

Children (Scotland) Act 1995 – This Act is based on the UN Convention on the Rights of the Child. The three over-arching principles of the Act are:

- The welfare of the child is the paramount consideration when his or her needs are being considered by courts, Children's Hearings and local authorities;
- no court should make an order relating to a child and no Children's Hearing should make a supervision order unless a court or hearing considers that to do so would be better than making no order;
- the child's views should be taken into account where major decisions are to be made about his or her future and must be taken into account where the child is 12 years or older.

Criminal Procedure (Scotland) Act 1995

The Criminal Procedure (Scotland) Act 1995 consolidates certain enactments relating to criminal procedure in Scotland. It has a specific focus on children and young people in Part V and outlines:

- Age of criminal responsibility
- The prosecution of children
- Arrangements where children are arrested
- Detention of children
- Reference or remit to Children's Hearing
- Remand and committal of children and young persons
- Punishment for murder
- Detention of young offenders
- Detention of children convicted on indictment

Section 207 includes a presumption against custodial sentences for those aged under 21. Scottish Ministers have discretion on the placement of all children and young people (under the age of 18) detained under the Act.

Human Rights Act 1998 gives further effect to rights and freedoms guaranteed under the European Convention on Human Rights.

The Anti-social Behaviour etc (Scotland) Act 2004 gives local authorities and the Police new powers to tackle antisocial behaviour.

Criminal Justice and Licensing (Scotland) Act 2010. This legislation relates to a wide range of distinct policy proposals including those relating to sentencing, criminal offences, criminal procedure, disclosure of evidence, protection of victims and witnesses, and licensing. It deals with issues ranging from combating alcohol misuse, to the creation of a Sentencing Council, community payback orders and the presumption against short prison sentences of three months or less.

Children's Hearing (Scotland) Act 2011 strengthens, streamlines and modernises the Children's Hearing System.

Children and Young People (Scotland) Act 2014 places a definition of child wellbeing in legislation; provides a clear definition of corporate parenting, and defines the bodies to which it will apply; and places a duty on local authorities to assess a care leaver's request for assistance up to and including the age of 25. It also creates a new right to appeal a local authority decision to place a child in secure accommodation, and makes procedural changes in the areas of Children's Hearings support arrangements.

Criminal Justice (Scotland) Act 2016

The Act sets out changes to Police exercise of power. Police officers are now able to make arrests without warrant and can arrest an individual several times for the same offence should further evidence come to light. The Act also clearly indicates the timescales for detaining an individual in police custody and sets out the specific duties of the police in relation to all under 16s and under 18s subject to a compulsory supervision order in police custody.

Planned Legislation

The following **planned legislation** currently going through the Scottish Parliament will impact on the justice and youth justice system in Scotland:

Bill Title	Purpose	Progress	Lead Policy Area
Management of Offenders Bill	Makes provision for electronic monitoring of offenders and other restrictive measures imposable on offenders; to make provision about periods and processes as regards disclosure of convictions by offenders. The Bill also changes the wording regarding release on parole from "immediate" to "without undue delay" in order to ensure that there is time for throughcare arrangements including medical requirements to be put in place.	The Bill completed Stage 1 on 7 February 2019	Justice
Age of Criminal Responsibility (Scotland) Bill	Proposes to raise the age of criminal responsibility to 12 years.	Introduced on 13 March 2018. The Bill is currently at Stage 1	Youth Justice
The extension of the Presumption against short-term sentences in the Criminal Justice and Licensing (Scotland) Act 2010	Extends the presumption against short term sentences from 3 months to 1 year. Note that under the Criminal Procedure (Scotland) Act 1995, there is already a presumption against custodial sentences of any length for under 21s.	Order to be laid by Summer 2019	Justice

Scottish Government Strategies and Approaches

Strategy	Lead Policy Area	Ministerial Responsibility
Mental Health Strategy 2017 – 2027 This wide ranging strategy aims to realise the Scottish Government's guiding ambition for mental health – that we must prevent and treat mental health problems with the same commitment, passion and drive as we do physical health problems. The strategy includes a commitment (Action 15) to increase the mental health workforce by 800 additional mental health workers in our hospitals, GP surgeries, prisons and police stations.	Mental Health	Clare Haughey MSP Minister for Mental Health
Suicide Prevention Strategy: Every Life Matters The Scottish Government believes that no death by suicide should be regarded as either acceptable or inevitable. This Action Plan sets out an ambitious target to reduce the rate of suicide by 20% by 2022 (from a 2017 baseline) and established the National Suicide Prevention Leadership Group chaired by Rose Fitzpatrick.	Mental Health	Clare Haughey MSP Minister for Mental Health
Justice In Scotland: Vision and Priorities This identifies improving health and wellbeing in justice settings as a priority (among others) for the justice system in Scotland. Progress report (Oct 2018). https://www.gov.scot/publications/justice-vision-priorities-delivery-plan-overview-progress-2017-18-new/pages/5/	Justice	Humza Yousaf MSP Cabinet Secretary for Justice
Getting It Right for Every Child (GIRFEC) is the Scottish Government's approach to supporting children and young people. It is intended as a framework that will allow organisations who work on behalf of the country's children and their families to provide a consistent, supportive approach for all.	Children and Families	Maree Todd MSP Minister for Children and Young People

Strategy	Lead Policy Area	Ministerial Responsibility
Preventing offending: getting it right for children and young people Youth Justice Strategy 2015 – 2020 The national youth justice strategy was published in June 2015. It builds on the impact of a shift to prevention in 2008 which has seen numbers of children and young people in the justice system reduce substantially. This focus on early intervention laid the foundations for a whole system approach (WSA) to offending by young people which was rolled out in 2011. A progress report was published in June 2017, highlighting areas of impact and influence through the Board and the three Implementation Groups leading priority work streams on: **Advancing the Whole System Approach** – to ensure young people get the right help at the right time; **Improving Life Chances** – in areas where outcomes are poor; and **Developing Capacity and Improvement** – to support the workforce and improve systems.	Children and Families	Humza Yousaf MSP Cabinet Secretary for Justice Maree Todd Minister for Children and Young People
Whole Systems Approach Whole System Approach: aims to reduce youth offending by putting children – and their family – at the centre, delivering early and effective (multi-disciplinary) interventions, and diverting young people from prosecution wherever possible.	Children and Families	Humza Yousaf MSP Cabinet Secretary for Justice Maree Todd Minister for Children and Young People
Rights, Respect and Recovery: alcohol and drug treatment strategy 2018 This strategy recognises the high prevalence of problematic alcohol and drug use of people involved in the criminal justice system and the links between this and poor mental health.	Health	Joe FitzPatrick MSP Minister for Public Health, Sport and Wellbeing

Independent bodies work – Scottish Sentencing Council

The Sentencing Council has a body of work underway to prepare guidelines on various matters. One of the guidelines currently under development is the sentencing of young people.

Further information can be found in the minutes of a recent Council meeting below:
https://www.scottishsentencingcouncil.org.uk/media/1957/20190301-01-march-ssc-draft-minutes.pdf

Current reviews and relevant Boards

At the time of writing, the following Reviews were underway across Government which touch on the experience of young people in custody and/or mental health services for young people.

Review/Advisory Group	Timescales	Chair
Children's Hearings Improvement Partnership (CHIP)	Nov 2010 – ongoing	Michael Chalmers, Scottish Government
Children and Young People's Mental Health Task Force	June 2018 – ongoing	Dame Denise Coia
EHRC Access to Criminal Justice Inquiry	February 2019 – ongoing	EHRC
Expert Group on Sexual Offending and Young People	Nov 2017 – Spring 2019	Catherine Dyer
Health and Justice Collaboration Improvement Board	ongoing	Paul Johnston (co-chair), Scottish Government Education, Communities & Justice Paul Gray (co-chair), Scottish Government Health and Social Care
Homelessness Prevention and Strategy Group	2017 – 2018	Kevin Stewart MSP (Co-Chair) Minister for Local Government and Housing Cllr Elena Whitham (Co-Chair) Community Wellbeing Spokesperson, COSLA
The Independent Care Review	February 2017 – ongoing	Fiona Duncan
Independent Inquiry in to Mental Health Services in Tayside	September 2018 – ongoing	David Strang
National Child Protection Leadership Group	June 2017 – ongoing	Maree Todd MSP, Minister for Children and Young People
National Suicide Prevention Leadership Group (NSPLG)	September 2018 – ongoing	Rose Fitzpatrick

Review/Advisory Group	Timescales	Chair
NICE Preventing suicide in community and custodial settings Guideline	September 2018	NICE
Scottish Adverse Childhood Experiences (ACEs) Hub	Dec 2016 – ongoing	Linda de Caestecker, NHS GGC
Review of the delivery of forensic mental health services	March 2019 – to be confirmed	Chair – to be confirmed
Secure Care Strategic Board	Oct 2017 – Dec 2018	Donald Henderson (Chair), Scottish Government, Deputy Director Care and Protection and Care and Justice
Thematic review of Fatal Accident Inquiries by the Inspectorate of Prosecution in Scotland	Published August 2016. Follow up to be published in 2019	Michelle Macleod, HM Chief Inspector of Prosecution
Transforming Parole in Scotland; consultation	Closed 27 March 2019	Scottish Government, Justice
Youth Justice Improvement Board	Oct 2015 – ongoing	Michael Chalmers, Scottish Government
Youth Commission on Mental Health	April 2018 – Summer 2019	SAMH and Young Scot

APPENDIX F

Summary of recommendations and suggested actions by agency

SPS recommendations

1. The SPS and NHS Forth Valley NHS should consider the use of holistic age appropriate risk assessment tools on induction, to inform the management of young people in their care who arrive with little significant information about any risk and arrange a 72-hour case conference once further information has been gathered.
2. Inter-agency review arrangements should be considered for all young people in readiness for their release.
3. The greatly increased risk during the first three months in custody should be emphasised in the TTM Strategy and staff training.
4. A bespoke suicide and self-harm strategy for young people should draw on the evidence and good practice.
5. Recognition of the acute points of vulnerability; remand, social isolation and accessing available history and information, needs to be addressed in the bespoke strategy.
6. When designing the revised suicide and self-harm strategy for young people, consideration should also be given to developing a more gradual reduction in the care process for those being removed from it.
7. The SPS, the NHS and community partners should develop multi-disciplinary team approaches for management plans specifically for those considered at risk or vulnerable e.g. those young people on remand or in early custody.
8. Embedding trauma informed practice, knowledge of child development and age, and gender specific training for all staff working with children and young people is essential.
9. More research is needed on the provision of effective and responsive emotional support for staff, families, and children and young people following a suicide in custody.
10. Young people withhold distress from staff and fellow prisoners, so auditable processes must be in place to respond effectively when family, friends, peers or contacts in the community raise concerns.
11. There is a need to create more dedicated time for SPS personal officers to build nurturing relationships that are not compromised by population fluctuations or operational pressures.
12. Staff confidence in dealing with distress and building nurturing relationships should be enhanced by regular and refresher training, and awareness in Child and Adolescent health and wellbeing.
13. The agreed recommendations from the Dr Briege Nugent review of TTM should be implemented.
14. Refresher training in TTM for all staff in contact with young people should be regularly undertaken and adaptations made for specific populations such as adolescents. This training should not just include the processes and paper work of TTM but broader aspects of trauma informed behaviour, child and adolescent development, self-harm and suicide.
15. The SPS could consider replicating the good practice in the secure unit system, where each young persons' case notes identified and highlighted potential triggers and escalation routes for staff, should these occur.
16. The data on young people who committed suicide that had previously been on TTM suggests the need for a more gradual phased removal from TTM, with appropriate supports and follow up checks in place.
17. Consideration should be given to the benefits of appointing an independent Chair for greater independence and consistency during the DIPLAR review.
18. Further consideration should be given to the Chair meeting with the family prior to the DIPLAR to understand their concerns.

19. Consistent processes should apply in all prisons both public and private.
20. Consideration should be given to further refreshing the shared DIPLAR process and format for information collation through comparison with other agency and jurisdiction processes.
21. Further work is required to analyse the FAI determinations and recommendations against the DIPLAR learning to enhance learning.
22. A Memorandum of Understanding is developed or expanded between relevant agencies on the appropriate methodology for enquiry and reporting, the sharing of lessons learned and the management information systems needed to support effective information capture and analysis.

The Scottish Government recommendations

23. Some aspects of delivery are under financial threat and some early services dealing with key issues such as domestic and sexual abuse have been lost. The Scottish Government should consider long-term sustainable funding for key aspects of service provision e.g. domestic and sexual abuse.
24. A National Drug Formulary for prison healthcare should be developed.
25. Consideration should be given by the Justice and Health collaboration Board to repeating the work originally completed in 2013 by the SPS on evaluating the prevalence of Mental Health problems in prisons.
26. The extent, efficacy and use of safer cells and their softer more normalised alternatives should be subject to a separate and more in depth review looking at existing secure care research.
27. Young people on remand are particularly at risk and although this review has highlighted some of the underlying causes, further work needs to be undertaken to identify the root causes and develop protective factors.
28. A further piece of work to look at the comparison statistics of young people in Scotland with age cohorts under supervision or licence, or in residential care is recommended.
29. The Scottish Government should consider a further collection and analysis of the suicide and self-harm statistics to gain an in depth understanding of comparative performance across the Scottish justice system and the UK.
30. Consideration should be given to examination of the contention that an extension in age of the youth justice and WSA processes would be beneficial.
31. The Scottish Government should consider funding a work-force capacity review to meet the identified need of greater staff therapeutic interaction with young people.
32. The Scottish Government should consider the development of new models of secure care and custody provision, taking account of the maturation evidence, the findings of the HMIPS inspection and the findings of the Care Review.
33. To reduce the risk of duplication, the Scottish Government should improve the coordination of relevant information between related government reviews including access to emerging recommendations.

The Scottish Government and SPS recommendations

34. There should be a change in the legislation and organisational practice which seeks to minimise re-traumatisation and stigma e.g. body searching should be intelligence led only.
35. The Scottish Government and SPS should consider introducing in-cell telephony and technology to improve non-stigmatising access to self-help and mental health professionals when locked in a cell.
36. The Scottish Government and SPS should consider the development of a softer, more normalised environment, for those in acute distress to be supported.
37. The Scottish Government and SPS should review the evidence for multisensory rooms for young people in distress and consider implementing in HMP YOI Polmont.

38. Some aspects of delivery are under financial threat and some early services dealing with key issues such as domestic and sexual abuse have been lost.
39. A National Drug Formulary for prison healthcare should be developed.
40. The Scottish Government should consider long-term sustainable funding for key aspects of service provision.
41. Consideration should be given by the Justice and Health collaboration Board to repeating the work originally completed in 2013 by the SPS on evaluating the prevalence of Mental Health problems in prisons.
42. The extent, efficacy and use of safer cells and their softer more normalised alternatives should be subject to a separate review and more in depth review looking at existing secure care research.
43. Young people on remand are particularly at risk and although this review has highlighted some of the underlying causes, further work needs to be undertaken to identify the root causes and develop protective factors.
44. A further piece of work to look at the comparison statistics of young people in Scotland with age cohorts under supervision or licence, or in residential care is recommended.

The Scottish Government and other agencies recommendations

45. The Scottish Government should consider developing and adopting a standardised approach, including developing minimum information data sets, conforming to the GIRFEC principle, across the justice system to ensure relevant history and information accompanies **all** young people entering custody.
46. The Scottish Government should re-energise its work to introduce the electronic transmission of information across the justice system and children's services.
47. Consideration should be given to risk alerts completed by a named person or lead profession being shared electronically across the justice system.
48. The template for risk alerts should be reviewed and consideration given to including information on identified needs and vulnerabilities, including wellbeing and welfare assessments e.g. risk of harm to self or others and health and wellbeing matters (including any physical and mental health concerns, medication, alcohol and substance use). This information should be shared with whoever is transporting the young person and included in the PER.
49. On the day a child or young person is remanded or sentenced, their Child's Plan and Criminal Justice Social Work Report (CJSWR) (where a CJSWR has been completed) should be shared electronically.
50. Once information requirements and minimum data sets have been agreed, consideration should be given to a sustainable quality assurance and scrutiny mechanism to ensure the systematic flow of information.
51. If a young person is at risk of a custodial sentence, where possible and without disturbing the court process, consideration should be given to their hearing being listed as early as possible in the court day, to support their transition into custody and ability to access appropriate support.
52. Similarly, where practical, liberations should be arranged for times when those with complex support needs can receive appropriate support.
53. Consideration should be given to commissioning a small focused study contacting and following up with families who have experienced the self-inflicted death of a loved one in custody.

NHS Forth Valley recommendations

54. NHS Forth Valley should consider joining the Quality Network for Prison Mental Health supported by the Royal College of Psychiatrists. Arrangements could then be made by NHS Forth Valley for regular audit and examination of service delivery, enhanced by following the process and standards of the Royal College of Psychiatrists for prisoner mental health.
55. NHS Forth Valley and HIS should ensure the development and implementation of workforce planning tools specific to prisoner healthcare.
56. NHS Forth Valley must ensure that safe staffing legislation is applied to prisoner healthcare.
57. A workforce capacity model should be undertaken to enable appropriate staffing levels and caseloads.
58. NHS Forth valley should consider addressing the retention issues through a proactive recruitment campaign including considering improving terms and conditions and bandings for nurses.
59. There should be a rolling programme of Continued Professional Development for NHS staff to include topics relevant to adolescent mental health, such as ASD, ADHD and other developmental disorders.
60. The competency framework and Essential CAMHS training should be considered for staff.
61. Clinical and caseload supervision should continue to be offered and the barriers to lack of attendance examined and overcome.
62. NHS Forth Valley should review prescribing policy and availability of prescribers to try and reduce delays in access to medication.
63. NHS Forth Valley should work with Scottish Patient Safety Programme to help implement the recommendations regarding medication made during the HMIPS inspection.
64. Other options for medication dispensing should be considered to free up mental health nursing time and to enable further and enhanced therapeutic interventions to be delivered.
65. NHS Forth Valley should develop equitable access to services for all young people, and it should not be dependent on remand or sentenced status. This would need the development of brief interventions to be made available.
66. NHS Forth Valley should work closely with the Excellence in Care programme leads to ensure that the national assurance and quality framework for nursing is implemented in this setting.
67. All other recommendations from the HMIPS review of HMP YOI Polmont must be implemented and embedded, including in particular:
    - recommendations regarding mandatory training and appraisals of staff;
    - standardised assessments;
    - detailed and accurate clinical recording;
    - multi-disciplinary decision making, which is rights-based and person-centred; and
    - clarifying pathways, processes and agreed assessment and risk tools.

The Scottish Government and NHS recommendations

68. A more strategic approach to healthcare, including alternatives to prescribing policy and availability is required to address significant identified shortfalls.
69. The Scottish Government and the NHS should address the issue of the shortage of mental health staff experience across Scotland.

The SPS and NHS Forth Valley recommendations

70. Staff absence is impacting services and this should be addressed by both the SPS and NHS Forth Valley.
71. Access to health should be co-designed with young people to overcome barriers and stigma.
72. There should be improved links between NHS Forth Valley and the SPS at all levels of seniority to improve leadership of the health and wellbeing approach and accountability.
73. Adolescent Mental Health training should be adopted and delivered in a phased manner to SPS staff in HMP YOI Polmont.
74. A systemic framework should be developed to embed the newly created multi-disciplinary team meetings and clinical and caseload supervision.
75. The SPS and should work together to ensure the provision and sustainable resourcing of therapeutic supports and services, which address the underlying trauma behind the desire to self-harm, not just the presenting behaviours.
76. The SPS and NHS Forth Valley should consider developing a joint information pack for families about how the system works, with details of mental health support.
77. A discharge checklist for both the SPS and NHS would help to standardise the process when people are being managed by the mental health team and are released from HMP YOI Polmont.
78. NHS Forth Valley and the SPS should consider more intensive multi-disciplinary training on mental health issues, led by mental health specialists with an understanding of the prison context. Multi-disciplinary training is essential to build the relationships and respect required for shared practice and learning, but individual disciplines will also require specialist input.
79. Repeat placements on TTM should be subject to a focused analysis to identify the causes and a multi-disciplinary approach, with support from the mental health team, engaged to provide help for staff in managing distress and challenging behaviour issue.

SPS and SFIU recommendations

80. The SPS and SFIU should review the DIPLAR process to ensure information collated and shared does not impinge on the FAI process; and whether it could contribute to the FAI process.

APPENDIX G

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ANNEX A

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

Annex A

SCCJR
The Scottish Centre for Crime & Justice Research

No. 02/2019

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

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University of Glasgow

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Contents

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).[1] 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 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.

[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.

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); 'tickbox' 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), 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 Chapter 9), 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. 'gray' 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: Changing Prisons, Saving Lives Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds (2015)

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.)

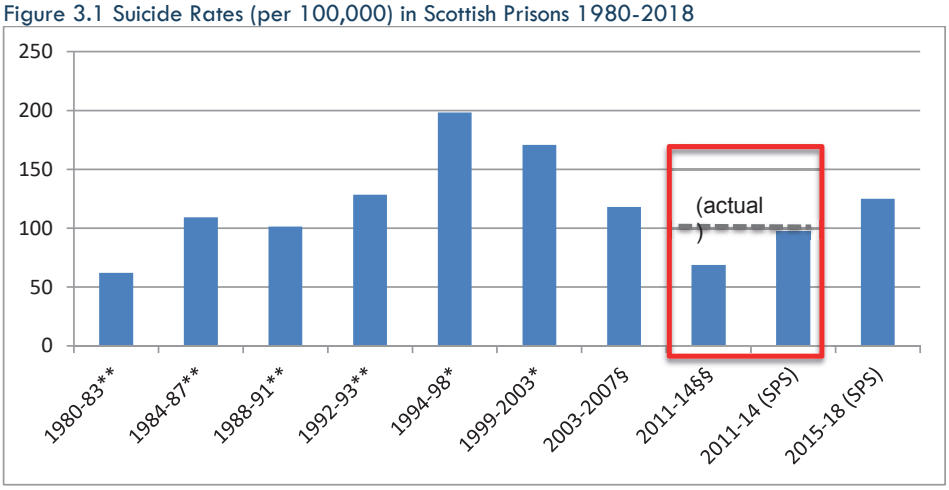
Faulty data underlie inaccurate findings that can fuel misleading claims. Fazel et al. (2017: 5) notes that 'prison suicide rates significantly decreased in Scotland' between 2003 and 2014, on the basis of his team's apparent undercount of suicide. The authors go on, referencing an un-tested and un-evidenced 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[2], **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).

[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.
**1980-1993 data from Liebling (1999)
§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.

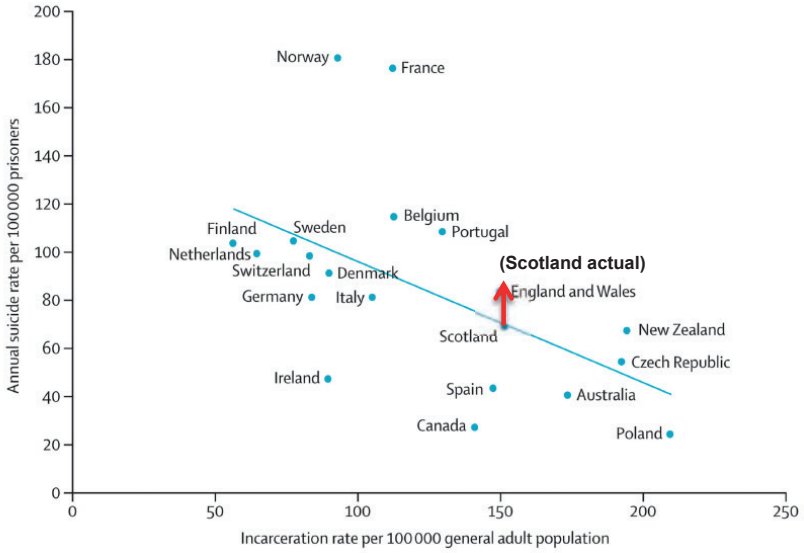
International comparisons

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.[3] 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**.

[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.

Figure 3.2 Prison suicide rate compared to imprisonment rate in 24 countries (2011-14)



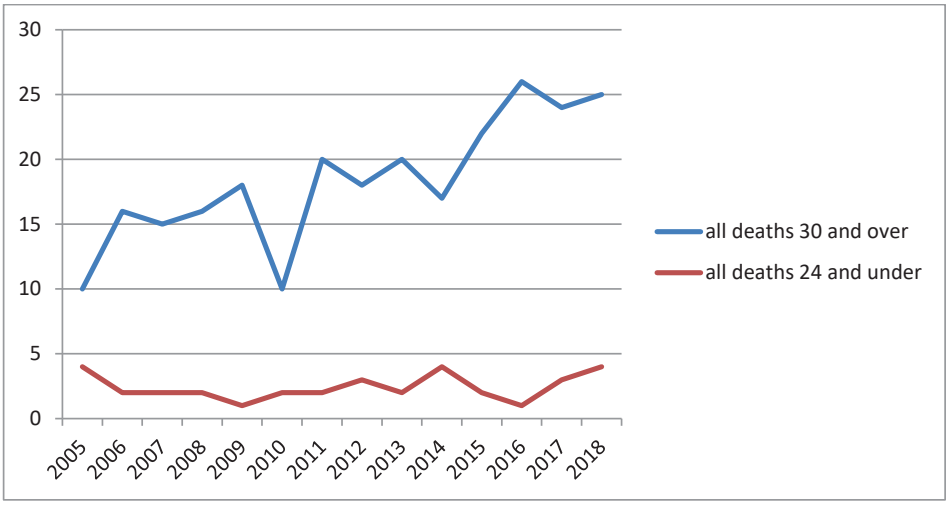
SOURCE: Fazel et al. (2017, p. 12); arrow signifies adjusted rate using SPS 2019 figures.

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

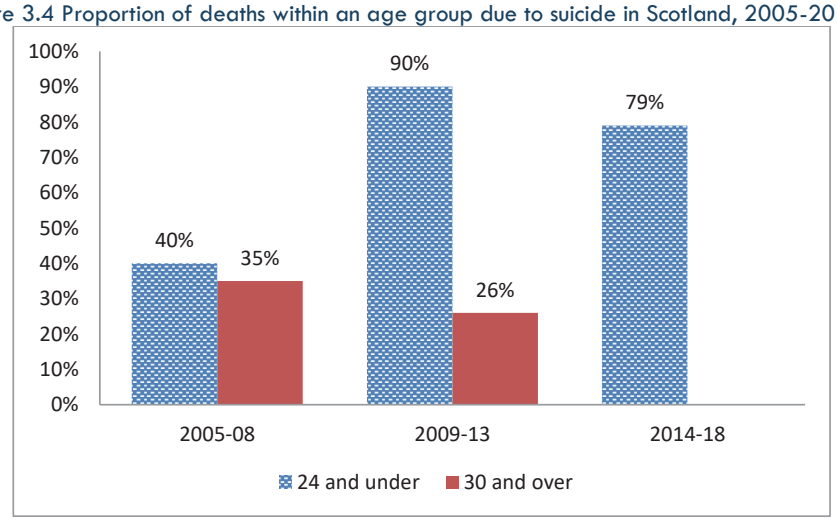
The death of a young person in prison remains a relatively rare phenomenon in Scotland, although there there has been **at least one and up to four deaths due to suicide in each year between 2005 and 2018 among young people (aged 24 or less)**. By contrast, deaths among older prisoners (30 years or more) for all causes is on the rise (Figure 3.3); this is not surprising given the increasing average 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

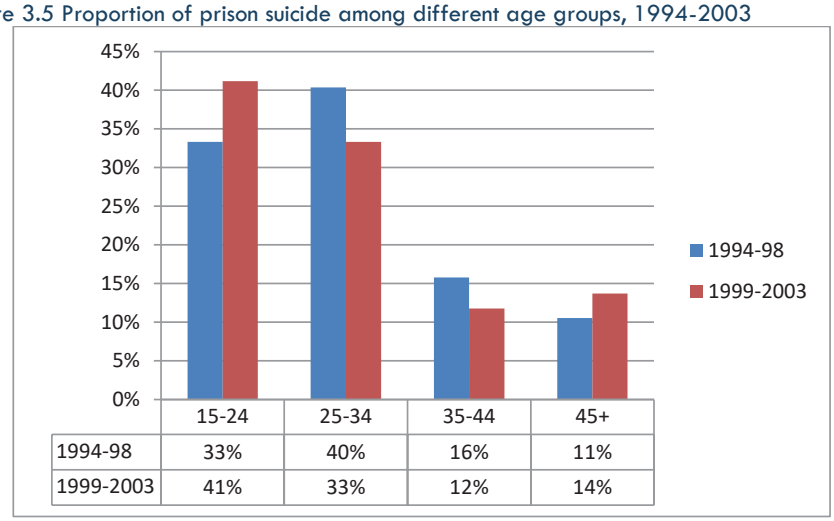
Figure 3.4 Proportion of deaths within an age group due to suicide in Scotland, 2005-2018



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.

Figure 3.5 Proportion of prison suicide among different age groups, 1994-2003

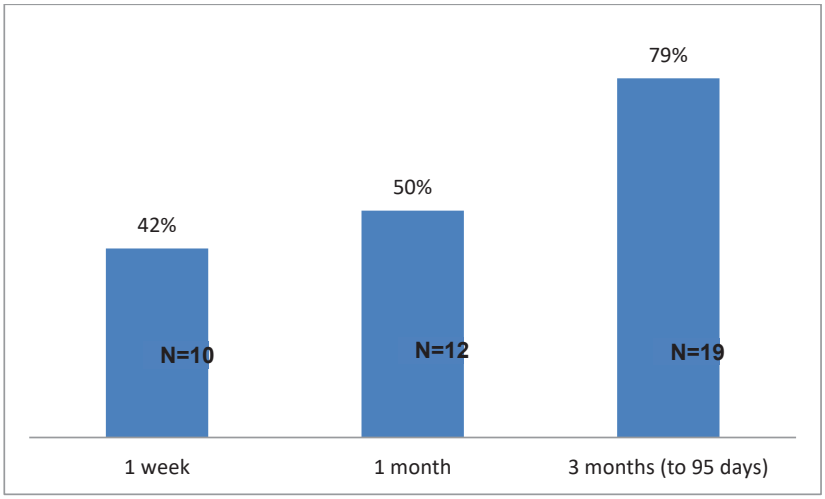


	15-24	25-34	35-44	45+
1994-98	33%	40%	16%	11%
1999-2003	41%	33%	12%	14%

SOURCE: Bird (2008)

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).

Figure 3.6 Time in custody at point of suicide among young people in prison in Scotland, 2005-2018



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

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.[4]

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.

[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; dying by hanging; recent contact with health services; recent experience of isolation; a change in circumstances (bereavement, sentence status, relationship breakdown).
- 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 were within a month of entering custody, and 10% were 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.[5] Being on remand in Scotland also 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 are both crucial opportunities of learning but also in easing the transition into the institutional environment**.

[5] Analysis by authors of SPS website data on all deaths in custody of young people up to age 24.

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 your 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 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.
- 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 unregulate**d (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 Forester, 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 of 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

Models and Examples: What does it take and what does it look like for things to work well?

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)

Slade, K. and Forrester A. (2015) Shifting the paradigm of prison suicide prevention through enhanced multi-agency integration and cultural change, The Journal of Forensic Psychiatry & Psychology Volume 26(6): 737-758:

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'

NHS Health Education England & National Collaborating Centre for Mental Health (2018) Self-harm and suicide prevention competence framework: Children and young people:

> 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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