Stakeholder Engagement 9
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From University of Manchester

Background on Professor Louis Appleby

Louis Appleby (LA) is Professor of Psychiatry at the University of Manchester and chairs the National Suicide Prevention Strategy Advisory Group. He has worked in the field of suicide prevention for many years, and leads the cross-government strategy for suicide prevention.

SELF-INFLICTED DEATHS

Until fifteen years ago there was a dramatic rise in deaths of those under 35 years of age and LA examined these in detail looking at the route people took to suicide. The following features were found:

- Risk factors are numerous and will be dependent on the individual;
- A model of cumulative risk was developed, i.e. multiple factors, each one making the next one more likely;
- Troubled lives with psychological harm were a characteristic;
- Social problems and early adversity were common factors;
- A whole series of interlinked issues with an entry point such as losing one's job, heavy drinking and or relationship issues;
- This would lead to a terminal event that objectively may seem trivial but adds to everything that has gone before.

This means a broad strategy to manage risk is need and issues can't be tackled in isolation. There is now the lowest rate of suicide in under 35 years than there has been for many years.

Contact with the Criminal Justice System (CJS), although not necessarily causal, is a specific risk; the recency of contact with the CJS, the nature of the charge and imprisonment itself are factors, even contact in the form of a caution can be a risk.

By the time a person is embedded in the CJS and needs a custodial sentence their life has been damaged. From a suicide prevention point of view, you shouldn't put most of these people in a custodial setting.

The CJS must not add to the cumulative risks already present:

- Keep high risk individuals out of custody where possible and where this is not possible, custody must be integrated into an individual therapeutic approach so that it does not add to the risk.

- There should be a therapeutic purpose to custody, with prisoners living in small units, in more personal settings to include education and rehabilitation and a goal of return to their families.
- Care shouldn't focus only on the final issue, it should focus on not adding to the cumulative risk factors through events such as bullying or a cancelled visit.

Immediately after arrival in prison is where the highest number of self-inflicted deaths happen. The figures for self-inflicted deaths are going down during this period and prisons have got the message about this risk and are doing better at keeping people safe at this time.

Most people who commit suicide in a custodial setting have been identified as low risk, so there is a need to focus on the perceived low risk group; they are only low risk in a high risk setting. It may not be possible to distinguish imminent risk from background risk.

LA is sympathetic towards prison officers; sometimes they just don't know what to do. In the early 1990s the suicide rate was at its highest in prisons and this was a serious problem. The Prison Service and government agencies really tried to do something about it and this led to early identification and prison In-Reach services. Following this, the self-inflicted death rate fell sharply by around 40% in a few years. Then the fall stopped and it hasn't gone down again. No one has looked at why; the MoJ have said that it is because there are more prisoners, which is a defensive response. It would be better not to be defensive about this.

Early days care, safer cells and information sharing have all changed. However the nature of the prison service response to personality disorder in the prison setting hasn't made any difference to managing the mood swings, disruptive behaviour and 'blow ups' that are often expressions of vulnerability; prison culture needs to change to deal with this group.

Outside custody, safer wards have been introduced in mental health units. All high level ligature points have been removed and this has led to a significant reduction in the number of deaths. A more interesting outcome is that this has had a broader effect and led to an eventual reduction in the number of self-inflicted deaths overall. This is because a more safety conscious environment has meant that all aspects of safety have improved.

In Mental Health units, physical safety has been a spearhead for safety more generally. This does have a cost but the legal costs to the system of a death are high. Making the means of death less accessible has most evidence behind it for reducing the number of deaths in all settings.

ALTERNATIVES TO CUSTODY

Liaison and Diversion is not being done as intensively as LA would like for those with vulnerabilities and is only used for low level offenders. The Youth Offending Teams (YOTs) divert under 18 year old offenders for mental health reasons. The same system could be applied to under 24 year olds, not just to divert them but also to address their needs. Imprisonment should be recognised as a causal factor.

Diversion was originally intended to provide disposal for people with criminality who are severely mentally ill. Over time the model changed to include those who were recidivist and

those less severely ill, whose health and social care needs were not being met, such as drug use and homelessness.

The current liaison and diversion service takes into account the level of risk and the nature of the offence. If there is a very high risk a disposal under the Mental Health Act is considered.

ACCT

ACCT was originally envisaged as a universal care planning system, so embedding safety into the system is crucial. All prisoners need to be covered by a care plan. Most people who die by suicide are not saying that they have any intention to take their lives. Almost all prisoners have a mental disorder of some kind.

There are no good tools for risk assessment. Staff can become de-sensitised if they are using these tools every day.

Safety needs to be built into the system, so that the cumulative risk factors can be addressed even when imminent high risk isn't apparent.

INFORMATION SHARING

Information sharing about health and mental health can be very poor although it is much better within prisons now and better from outside, with GPs for example, but it is not uncommon for prisoners to arrive with no information on Mental Health.

Information sharing would improve if mental health and physical health are seen as a priority, if all staff know who the prisoner is, and how they got into prison in the first place.

STAFF AND CULTURE IN PRISONS

Budgetary challenges for the Service mean that staff will find it harder to use a preventative approach when they are under pressure and there is an unproven but logical connection that when a system is under pressure the more subtle things are lost.

It is often said that people may be more vulnerable when they have nothing to do. It may be that staff cuts and, if there is a corresponding reduction in purposeful activity, could contribute to self-inflicted deaths.

More established prison training would be a good thing for managing people with mental health needs who present as 'difficult'.

HEALTH AND MENTAL HEALTH

The need for mental health services in prisons is huge, this affects risk of suicide and re-offending.

The CQC could influence mental health services in prisons by not being a minor part of the HMIP visits and seeing prison health as what happens in the prison more broadly, not just in healthcare. It needs to be recognised that the problems for those with personality disorder

will escalate if they are dealt with harshly and that a more therapeutic, socially concerned model of prison is needed.

Medication in prisons will reduce risk if properly used. When someone presents with multiple problems medication may be prescribed as a therapeutic option - this happens everywhere. LA is in favour of using psychological treatments for real social problems, which can be addressed during imprisonment. Recognising a multiplicity of need is crucial; there is not one therapeutic paradigm.

People who are severely mentally ill tend to be (or should be) taken out of the CJS on a different pathway, which applies to everyone including BME people. There is a higher level of psychosis among BME people and that would increase risk, especially if they are reluctant to ask for help. Prisons are now better at getting help for severe mental illness. This may be a partial explanation for the lower rates of self-inflicted death in the BME prison population.