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Learning from self-inflicted deaths in prison: mental health

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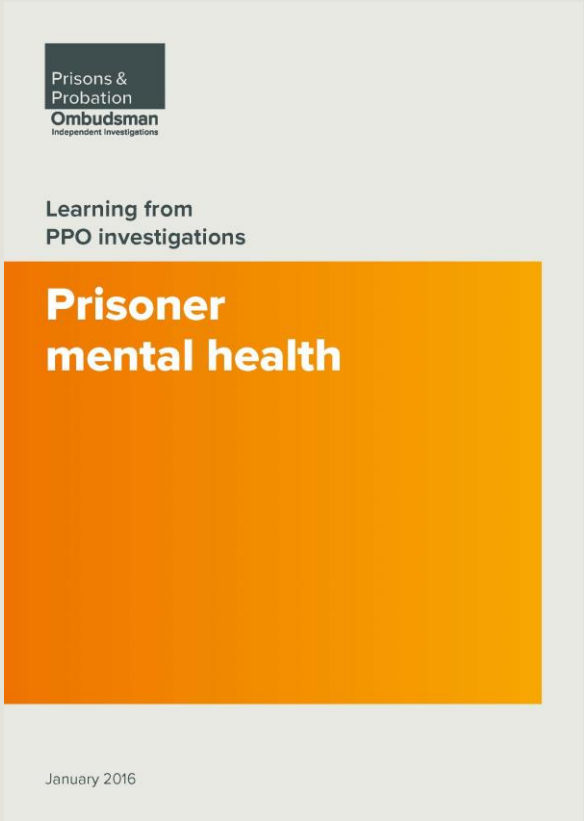
PPO thematic: prisoner mental health



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Review of the identification of mental health needs and the provision of mental health care for prisoners, based on the learning from our fatal incident investigations

Available online:
http://www.ppo.gov.uk/?p=6737

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Background

- Research has suggested that nine out of ten prisoners have one or more psychiatric disorders
- The prevalence of mental health issues in the prison population is considerably higher than in the general population
- A high proportion of the prison population need appropriate care and support for mental health problems
- The prison environment can be particularly tough for those with mental health problems

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PPO thematic: Prisoner mental health

- The report considered the deaths of 557 prisoners who died in prison custody between 2012 and 2014
- Updated to consider 347 self-inflicted deaths to March 2016
- 69% of those who died from self-inflicted means had been identified with mental health needs
- At least 13% had been identified with a severe and enduring mental illness
- 42% had been identified with two or more mental health issues

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Early identification

- Early identification of mental health issues when prisoners arrive can be vital to ensuring appropriate care and support is put in place
- The documentation that a prisoner arrives with may include important information about their mental health needs
- At the initial health screen this is often an over-reliance on the prisoners demeanour and presentation - documented risk factors should always be considered
- Information needs to be shared between community GPs and prisons, and from prison to prison

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Mental Health Awareness

- Difficult or challenging behaviour might sometimes be the only way that distressed people with mental health problems are able to communicate when they need help
- This can easily be misinterpreted, and can lead to punishment, when what is required is care and treatment
- Prison and healthcare staff need to be aware of the warning signs of mental distress
- But staff often do not receive any training in mental health awareness

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Treatment

- When mental health needs are identified, a referral should be made to the appropriate healthcare professional
- In 21% of self-inflicted deaths in the sample, a mental health referral was not made when it should have been
- When referrals are made, they often take too long or don't happen at all
- 26% of prisoners in the sample who had been diagnosed with a mental health problem had received no mental health care from a health professional while in prison
- 62% were prescribed drug treatments, but nearly 1 in 3 were not fully compliant at taking their medication

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ACCT

- 27% of the sample of prisoners who died from self-inflicted means were being monitored under ACCT procedures at the time of their death
- More than 4 in 5 of these prisoners had identified mental health problems
- Active participation in ACCT procedures by prison and healthcare staff is often an integral part of a prisoner's mental health care.
- Prison and healthcare staff should work together to develop an effective Care and Management Plan (care map), and to conduct reviews
- Too often there is not a multi-disciplinary approach and the opinions of healthcare staff are overlooked

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Recommendations

- Our most common recommendation is to improve the assessment of risk of suicide or self-harm and the management of that risk, including multidisciplinary working;
- More than half of our recommendations about mental health (77) are to strengthen the referral and assessment process;

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Lessons

- Reception staff should review all the documentation that a prisoner arrives with, and pass on all relevant information as appropriate
- The health professional responsible for the reception health screen should give due consideration to all of the information they receive about a prisoner when making an assessment, including SystmOne records.
- Mental health awareness training should be mandatory for all prison officers and prison healthcare staff, to provide them with necessary guidance for the identification of signs of mental illness and vulnerability.

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More lessons

- All prisoners should have access to the same care they would expect to receive in the community, including psychological and talking therapies
- Compliance with medication should be monitored and encouraged as part of an up-to-date care plan for prisoners with mental health problems.
- The mental health team should attend or contribute to all ACCT reviews for prisoners under their care, and should be fully involved in any important decisions about location, observations, and risk.

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Case study 1: Ms A, HMP Peterborough

- History of mental health problems, suicide attempts and self-harm. Several inpatient hospital stays and lived in supported housing.
- 12 May 2014 – remanded to prison for first time, charged with arson and criminal damage. ACCT opened in reception. Over four days several suicide/self-harm incidents.
- Had MH assessment but not allocated a MH care coordinator and not referred to psychiatrist – despite imminent assessment for transfer to hospital.
- 16 May – segregated for assaulting officer. Found unresponsive with bag over head at 11.50am.

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Findings:

- Lack of MH expertise in prison inpatient unit considering complex needs of women patients.
- No urgent referral to psychiatrist or care coordinator and no care plan. Lack of access to MH staff.
- No MH input into ACCT process.
- MH care not equivalent to community.
- Decision to segregate flawed.
- Failures in ACCT process.

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Case study 2 Mr B, HMP The Mount

- Sudden deterioration after no history of mental health problems during six years in prison;
- Self-harmed so suicide prevention measures started on Friday morning, but no mental health assessment;
- Very challenging and violent behaviour continued; segregated and went to unfurnished cell twice;
- Mental health nurse only attended one of four case reviews;
- Mr B died on Monday, four days after he was segregated, without a mental health assessment.

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Findings:

- No mandatory 24 hour mental health assessment for segregated at-risk prisoners and those in unfurnished cells;
- Nurses were told too dangerous to assess Mr B;
- Despite exceptionally violent behaviour, segregation officers did not try to get mental health input because it was a weekend;
- Mental health team did not participate in ACCT case reviews or segregation reviews, despite acute concern about Mr B's mental health.