People in detention must be a key focus of national suicide prevention efforts, says independent advisory body

People in detention are significantly more likely to die by suicide and must be at the heart of the Government's new strategy to prevent self-inflicted deaths, states a new report published today. The report by the Independent Advisory Panel on Deaths in Custody (IAPDC) comes as the Government publishes its new five-year suicide prevention strategy. While the IAPDC welcomes the strategy as a "step in the right direction", it raises concerns over the lack of focus and ambition needed to ensure that people in detention, who are particularly vulnerable, are properly protected. You can read the IAPDC's response here.

The IAPDC's report forms advice given to the Government earlier this year to help inform the development of the cross-sector suicide prevention strategy. It puts forward a series of recommendations to government departments, service leaders, and detention staff to reduce the alarmingly high rate of suicide among people under their care.

Recommendations include equipping staff with tools and confidence to support vulnerable individuals, improving multiagency working and information sharing processes, facilitating meaningful engagement with families, and providing detainees with access to purposeful activities. It also calls for an open approach to embedding and sharing learning following a suicide, and greater research in detention settings to inform effective interventions.

The report is the culmination of significant engagement by the IAPDC with current prisoners, Samaritans' volunteers in prisons, individuals with lived experience of detention, bereaved families, and experts representing all places of detention. It covers people in prison, police custody, immigration detention, individuals detained under the Mental Health Act, and residents of Approved Premises.

Lynn Emslie, Chair of the IAPDC, said:

"Every suicide in detention has a considerable and far-reaching impact on families, communities, and the staff who oversaw the individual's care. While we welcome publication of the Government's five-year suicide prevention strategy and the commitment it makes to continue to consider advice from the IAPDC, it must go further and faster to address the desperately high rate of suicide among people under the state's care.

"Factors which reduce the risk of suicide in the community – such as exercise, structured activity, and contact with loved ones – are considerably more difficult in places of detention. Our report puts forward practical recommendations to ensure detainees' rights to life are protected through policy and practice. We will continue to work with the Government, service leaders, and detention staff to ensure these recommendations are put into action to help prevent the tragedy of self-inflicted deaths."

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1. Contact: Lana Ghafoor, Ministerial Council on Deaths in Custody (lana.ghafoor@justice.gov.uk). Lynn Emslie, Chair of the IAPDC, is available for further comment and/or interview.

2. The role of the IAPDC, a non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials, and the Ministerial Board on Deaths in Custody. It assists Ministers to meet their human rights obligations to protect life. The IAPDC's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

3. In the 12 months to June 2023, there were 88 self-inflicted deaths in prison custody.[1] There were 50 deaths from 'unnatural causes', which includes self-inflicted deaths, of people detained under the Mental Health Act in 2021/22.[2] There were 52 apparent suicides following police custody in 2022/23.[3] There was one self-inflicted death in immigration detention in 2021 and zero in 2022.[4]

4. The IAPDC makes 42 recommendations addressed to government departments, service leaders, and detention staff, detailed in full below. The IAPDC submitted its report to the Government in February 2023.

5. Full list of report recommendations:

Staff culture, leadership, training, and capacity

1. Annual, mandatory training should be given to frontline staff to ensure they adopt a person-centred and trauma-informed approach to providing support to individuals under their care. Detention settings should adopt OHID's working definition of trauma-informed practice.
2. Staff training on responses to mental health crises should involve input from people with lived experience and families bereaved by suicide. Staff themselves should be given the opportunity to inform training content as well.
3. Detention settings should draw on learning from community postvention initiatives and the postvention initiative in prisons being developed in collaboration with the Samaritans to ensure people in detention and staff are supported when a death does occur.
4. Safety impact assessments should be introduced across detention settings to ensure that all policy proposals include assessment of their likely impact on the health and safety of detainees and the staff charged with their care.

Multiagency support and information sharing

[1] HM Prison and Probation Service and Ministry of Justice, 'Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2023 Assaults and Self-harm to March 2023', 27 July 2023, available here.
[2] Care Quality Commission, 'Monitoring the Mental Health Act in 2021/22', 1 December 2022, p. 71, available here.
[3] Independent Office for Police Conduct, 'IOPC publishes figures on deaths during or following police contact for 2022/23', 28 July 2023, available here.
[4] Home Office, 'Immigration system statistics, year ending June 2023', 24 August 2022, available here.

5. The transfer of information between different teams in individual custodial institutions, as well as with external agencies and organisations across the criminal justice system, needs to be improved. This should include the revision of robust memorandums of understanding between relevant teams and organisations.
6. Mental health services need to be universally available to individuals in detention and properly resourced.
7. Greater resource is required to ensure more hospital beds are available to ensure transfers from prisons or IRCs to hospital for individuals with severe mental health needs requiring hospital treatment are done within the 28-day limit proposed in the draft Mental Health Bill.
8. Tailored, multidisciplinary support is needed to address the often complex and diverse needs of female prisoners.
9. Release planning for detainees should be improved to prevent post-custody deaths. This should always involve input from core services, such as health, housing, and addiction treatment. Services should ensure each establishment has staff with clear responsibilities for making sure arrangements to support individuals ahead of release are taking place.
10. End-to-end systems of support should be put in place for people leaving all forms of detention. This is particularly important for individuals deemed at higher risk, such as those leaving police custody accused of child sex abuse and indecent image offences. Evaluation of interventions is needed to understand which are most successful and to ensure forces are not simply relying on signposting.
11. More health-based places of safety are needed to ensure individuals detained and transported under Section 135 and 136 of the Mental Health Act can be managed safely and in a timely manner.
12. DHSC should lead work with the Home Office to ensure targeted resources and improved systems are in place to make sure mental health professionals, not police officers, are the first responders to individuals experiencing a mental health crisis.

<u>Self-harm and suicide prevention processes</u>

13. Detention staff involved in care planning processes should make sure that non-clinical risks, such as negative parole outcomes and a lack of social visits, form part of self-harm and suicide prevention conversations and actively inform interventions.
14. Safety interviews and assessments should always take place in private to encourage detainees to share information about their mental health, wellbeing, and any concerns they may have openly and honestly.
15. Risks should be recorded in one place to enable easy and quick access to up-to-date information on detainees' vulnerabilities and needs. This should include healthcare information. Plans contained within the Prisons Strategy White Paper to create a single digital prisoner record should be fast tracked.
16. Detention settings should review processes to ensure a multidisciplinary approach is taken to supporting the mental health needs of detainees. Healthcare staff should be involved in self-harm and suicide prevention processes to ensure support is not fragmented.

17. Information on the Rule 35 process should be translated into a variety of languages and be readily available for detainees in immigration detention. An independent review of Rule 35 should be commissioned with the importance of protecting those at risk of suicide and self-harm, as recommended by the ICIBI. This review should involve health partners.
18. Individuals in immigration detention placed on an ACDT should be automatically referred for a mental health assessment.
19. Self-harm and suicide prevention processes should be used at an earlier stage than when the detainee is at the point of crisis in order to maximise the efficacy of interventions.
20. Leadership in individual prisons should take responsibility to ensure peer support programmes, particularly the Samaritans Listener scheme, are in place, supported, and prioritised.

Family involvement

21. Where appropriate and with consent, families should routinely be involved in ACCT reviews and care planning processes for individuals identified at risk of self-harm or suicide. Staff must facilitate this and respond promptly to issues raised.
22. Consent to contact families about mental healthcare concerns should be sought from individuals early on during their detention and kept under review.
23. Places of detention must have working, adequately resourced phone lines to ensure families can promptly escalate concerns about prisoners' wellbeing. A dedicated phone line for families should be introduced across all detention settings.
24. In-cell telephony should be rolled out across the prison estate. In the interim, a flexible approach should be taken by staff to ensure vulnerable prisoners can contact their families as a means of support.
25. Individuals in IRCs without close family ties should be empowered to access support provided by charities supporting detainees.
26. Where possible, individuals should be detained close to their homes, families, and communities to ensure they have access to support. Where this is not possible, schemes to facilitate visits, such as help with travel costs and accumulated visits, should be amplified as well as video-calling facilities offered as an alternative.

The custodial landscape and the untherapeutic nature of detention

27. Proactive steps should be taken to review and remove ligature points in accommodation across all detention settings.
28. Physical conditions across detention settings should be improved to benefit good mental health. For instance, examples of good practice are already taking place across several police forces which should be shared with and embedded across all forces as well as other detention settings where appropriate.
29. Alternative provision is needed to ensure custodial settings can reduce inappropriate use of segregation. Its use should not be a means to prevent self-harm and suicide.
30. The provision of care suites for individuals in crisis should be rolled out across the immigration detention estate.

31. Out of area placements for individuals detained under the Mental Health Act should be eliminated, as outlined in the *Five Year Forward View for Mental Health*, to enable patients to receive care closer to their support networks.

A lack of certainty, hope, and purpose

32. Alternatives to remand and non-custodial sentences should be prioritised, where possible. Sentencing decisions should be informed by high-quality pre-sentence reports. Training for staff is needed to improve the quality of, and thereby increase judicial confidence in, pre-sentence reports.
33. Indeterminacy for patients detained under the Mental Health Act should be minimised. Where possible, they should be given a clear timetable for their discharge. Similarly, information should be given to detainees in IRCs on the process of their release in a language they can understand.
34. Detention settings should invest in interpretation services to ensure detainees are able to access information and support and can communicate their emotions and concerns.
35. Prisoners should be given access to daily activities which promote their sense of purpose and wellbeing. Staff recruitment and retention, to facilitate purposeful regimes, is a key aspect of this.

Learning and accountability

36. An independent body with an investigative function, similar to that carried out by the PPO and IOPC, should be established to investigate deaths under the Mental Health Act.
37. Departments should consider the establishment of a function to monitor Article 2 compliance to ensure learning from investigations and inquiries is fully acted on and shared.
38. Staff shadowing opportunities should be made available across detention settings to facilitate sharing and embedding of learning and good practice.

Facilitating research in custody

39. Places of detention must be open to and facilitate research on self-inflicted deaths to develop an evidence base for interventions.
40. Research should focus on diversity within detention settings, factoring in the different experiences of, for example, women, young people, and ethnic minority groups.
41. Research in detention settings which have a lower incidence of completed suicides should focus on ‘near misses’ and attempted suicides.
42. DHSC should produce high-quality, disaggregated data on deaths of people detained under the Mental Health Act to enable an in-depth understanding of deaths across different population groups.