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Preventing self-harm and suicide in prisoners: job half done



Prison populations have grown worldwide, and now exceed 10 million people globally.¹ Although some countries have clear and independent mechanisms of inspection, scant information is available about the conditions in which many prisoners are held. By necessity, published work in prisons represents a skewed sample of those countries from which evidence is made available. We must bear this discrepancy in mind because we know so little.

What we do know is that prisoners have high levels of mental health morbidity.² Suicide is the prevailing cause of death in prison worldwide, with mortality rates more than three times higher than the general population.³ The risk of death is highest in the early period after prison reception.⁴ In male prisoners, deaths occur most typically in local adult prisons that take people directly from the courts, whereas self-harm happens widely in female prisons.⁵ Mental disorder, substance misuse, white ethnic origin, violent offending, awaiting trial, and having suicidal ideas are risk factors for death, many of which are common globally.⁶ Although most risk factors for suicide are also prevalent in the general population, their frequency in prison is alarming.²

Writing in *The Lancet*, Keith Hawton and colleagues⁷ provide important confirmation of risk factors for self-harm and suicide in prison. They did a 6-year epidemiological study in the prison population of England and Wales and recorded 139 195 self-harm

incidents among 26 510 prisoners over 5 years. High annual self-harm rates were noted, in 5–6% of male inmates and 20–24% of female prisoners. Self-harm incidents accumulated in younger people and those of white ethnic origin, and an association was noted with prison type, serving a life sentence, or being unsentenced. Violent offending behaviour raised the risk of self-harm in female prisoners, and recurrence was common. The reported clustering of self-harm in time and location (adjusted intra-class correlation 0.15, 95% CI 0.11–0.18) highlights the importance of the prison context in understanding self-harm.

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For more on the Independent Advisory Panel on Deaths in Custody see <http://iapdeathsincustody.independent.gov.uk/>

Hawton and colleagues showed a temporal link between self-harm and completed suicide; 109 suicides in prison were reported in individuals who self-harmed, and more than half the deaths occurred within a month of self-harm. These findings indicate the importance of swift intervention after an incident of self-harm, and this work has already had an effect on the way the Prison Service in England and Wales manages people at risk.⁸ The risk factors identified for self-harm are similar to those identified elsewhere for suicide, thereby challenging the notion that self-harming behaviour and suicide might represent different entities: instead, a direct link seems to exist for many prisoners. Hawton and colleagues make a vital contribution to answering the questions of who self-harms and how often does it happen, which complements previous work to address why people self-harm and what methods work to reduce self-harm and suicidal behaviour.^{9,10} However, additional work is now needed to address these questions, to reduce self-harm in prison further.⁵

Although this work by Hawton and colleagues will assist practice in prisons in England and Wales, a broad range of risk factors have been incorporated into assessment training and processes provided by the Prison Service for some years.⁸ To mitigate against diminishing returns through expansion, we need to understand why most prisoners do not self-harm and why some who harm themselves are propelled towards suicide whereas others are not. The answers to these questions do not necessarily sit with further examination of over-represented groups, but instead could be studied by focusing on process,³ including specific investigation of prisoners from groups with enhanced vulnerabilities—eg, inmates who are foreign nationals, or people with neurodevelopmental problems, including those with learning difficulties. For many individuals, including 102 female prisoners reported by Hawton and colleagues who accounted for around 17 000 self-harming incidents, an examination that goes beyond generalised risk factors is crucial.

In England and Wales, a welcome and sustained reduction in the overall number of self-inflicted prison deaths has been noted, from 96 in 2004 to 60 in 2012.⁴ This fall has happened after several initiatives were introduced, including safer custody measures through the ACCT (Assessment, Care in Custody, and Teamwork) process,⁸ enhanced mental health services, and piecemeal environmental improvements. Although disentangling

specific causal factors can be difficult from a pure research perspective, in view of confounders, the evaluative focus of the Independent Advisory Panel on Deaths in Custody allows cautious optimism. With attention now turning to self-harm management, available evidence indicates a key role for multi-agency collaboration, in which “suicide is everyone’s concern”,¹¹ rather than being the sole preserve of health-care staff. As such, collaboration between organisations—with responsibility held jointly—could be an important preventive measure, for both self-harm and suicide. Prison officers can provide practical support, which could calm distress and play a central part in identification and management of risk, and have a key role in recognition of undetected psychiatric morbidity.¹² To harness this potential and thereby avoid so-called silo working, a focus on effective joint systems and a widening of the scope of specialist training and supervision (currently only available to a few prison workers in the UK) is recommended.

Despite clear gains in the care of prisoners and prevention of self-harm and suicide in prisons in England and Wales, much work remains to be done. Linking epidemiological samples and ground-level improvements is not easy. A renewed approach is needed that seeks to understand better the connection between suicidal ideation and completed suicide. We need to invest in the wide inclusion of all people who, on the ground, can listen to prisoners who are experiencing distress, mobilise concern, and help to deliver joined-up care.

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Public health science: a call for abstracts

The London School of Hygiene and Tropical Medicine, University College London, the European Public Health Association, and *The Lancet* invite abstract submissions for Public Health Science: A National Conference Dedicated to New Research in UK Public Health, to be held on Nov 19, 2014. Now in its third year, this multidisciplinary event showcases exceptional talent in the UK public health research community from early career researchers through to senior academics. This year we are delighted to hold the event in association with the European Public Health Association in Glasgow, UK. Work completed outside the UK can be submitted to the conference; however, abstracts relevant to UK public health science will be prioritised.

The core of the event will consist of submitted papers, and will conclude with keynote presentations from leaders in public health. The peer-reviewed abstracts will be published by *The Lancet*, online and in a conference booklet. Abstracts can be submitted under any of the following three themes: creativity and innovation in public health science; new methodological approaches to public health science; and implementing public health science in policy and practice. Further details on the programme for the day and topics can be found on the conference website.

Abstracts should be a maximum of 300 words, be written in English, and contain no references, tables, or figures. Submissions should include the following

sections: background (including context and aim); methods; findings; and interpretation. Please also include a non-declamatory title (including a study descriptor—eg, randomised controlled trial); names, titles, highest degrees, and affiliations of authors; postal and email addresses for the corresponding author; any funding received (if none, please state this); and a brief summary of the contributions of each author and any competing interests. Guidelines are available on *The Lancet's* website. Reports of randomised trials should follow the CONSORT extension for abstracts.

Please submit your abstract as a Microsoft Word document to *The Lancet's* online submission system, stating in your covering letter that the submission is for the Public Health Science conference, no later than June 27, 2014. After the *Lancet* peer-review process, participants will be informed of acceptance of abstracts for oral or poster presentation by Aug 27, 2014.

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