Suicide attempts and self-injury in male prisons

Alison Liebling and Helen Krarup

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SUICIDE ATTEMPTS AND SELF-INJURY IN MALE PRISONS

Alison Liebling
Helen Krarup

Institute of Criminology, Cambridge

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"Man's real need, his most terrible need, is for someone to listen to him, not as a 'patient' (or prisoner) but as a human soul."

(Lake, 1986)

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List of Abbreviations

AA	Alcoholics Anoymous
ADP	Average Daily Population
App	Application Form
BOV	Board of Visitors
CG	Comparison Group
CNA	Certified Normal Accommodation
CSO	Community Service Order
DIA	Directorate of Inmate Administration
EDR	Earliest Date of Release
FAI	Fatal Accident Inquiry
GG	Governor Grade
GOAD	Good Order and Discipline
HO	Hospital Officer
HPO	Hospital Principal Officer
HSO	Hospital Senior Officer
JR	Judgement Respited
LIDS	Local Inmate Data System
MO	Medical Officer
MRB	Medical Review Board
NAPO	National Association of Probation Officers
NFA	No Fixed Abode
OP	Own Protection
PGA	Prison Governors' Association
PMS	Prison Medical Service
PO	Principal officer
POA	Prison Officers' Association
RSU	Regional Secure Unit
SG	Subject Group
SMO	Senior Medical Officer
SPMG	Suicide Prevention Management Group
SO	Senior Officer
SPS	Scottish Prison Service
TOIL	Time Off in Lieu
VIR	Viral Infectivity Regimes [virtually phased out]
VO	Visiting Order
YOI	Young Offender Institution
YP	Young Prisoner

CHAPTER ONE

INTRODUCTION

Young prisoners are vulnerable. They need contact all the time, not a £56 million prison. (Prison Officer)

...research into the problem of suicide has been almost stagnant for some time. This I believe has been due to the preoccupation of the majority of research workers, psychiatrists and sociologists alike, with a retrospective analysis of people who have committed suicide. But we can learn a great deal through the intensive study of those who have survived suicide attempts... (Stengel, 1952)

Introduction

This project is the result of two years of interviewing, discussion, observation and listening in more than twenty prisons in England between 1990 and 1992. It was preceded by a similar, three year study carried cut in young offender institutions between 1987 and 1990. The report is submitted in the knowledge that it will take considerable effort to read in full. It tries to bring together, in a reasonably digestible form, information, data and opinion, which are sometimes incompatible. However, to do justice to the team and to those who helped with the research, nc apology is made for its length or content.

This introductory chapter will outline the background to the research, its context, and the various policy changes which have coincided with the period of the fieldwork. It will present some recent data on suicide and self-injury, and will also discuss the scope of the research. As the fccus of the research is attempted suicide and self-injury in relation to suicide, this introductory chapter discusses how far such links can be drawn and what limitations there may be in such an endeavour.

Section I: Background to and Objectives of the Research

By 1989 it was being reported that the suicide rate in prison exceeded the rate of suicides in the general population by about four to one (Home Office 1984; 1986; McClure, 1987), and that this disparity was still significant when allowance was made for the socio-economic characteristics of the prison population. The prison suicide rate had increased faster than the suicide rate amongst the general population from a running average of 8.6 per 100,000 receptions in 1972-1975 to 15.5 per 100,00 receptions in 1984-1987. The equivalent rates using Average Daily Population as the tase were 31 per 100,000 prisoners 1972-5 and 56 per 100,000 prisoners in 1984-1987, an increase of 81 per cent. During the years 1988-1992, this increase continued (see below). Dooley (1990a) noted that some of this increase was probably due to the disproportionate increase in the size of the remand population, which is thought to have a higher rate of suicide than the sentenced population, but some of the increase may have been due to other factors. In any event, it appeared that there were many factors other than the purely individual which were playing a part in prison suicides (Tumim, 1991; Liebling, 1991; Dooley, 1990a).

Most of the available UK research on prison suicides and self-injury (Backett, 1987; Dooley, 1990a; 1990b; Griffiths, 1990; O'Mahony, 1990; Phillips, 1986; Wool and Dooley, 1987) had been based on prison and/or court records. The same was true of research abroad (Flaherty, 1983; Hayes, 1983; Orlowski, 1985; Correctional Services of Canada; Bernheim, 1987; Scott-Denoon, 1983; Hatty and Walker, 1986; Biles, 1990; Spielman, 1988 and Hammerlin and Bodal, 1988). These studies produced a great deal of useful statistical information about the problems, but suffered from a number of limitations. The most important are twofold:

(i) problems of definition.

There are still a number of problems concerning the definitions of suicide, attempted suicide and self-injury. For example, Dooley (1990b) argued that

because of the strict motivational criteria demanded by courts, a significant proportion (35 per cent) of those deaths in custody in England and Wales which were given open or misadventure verdicts during the period 1972-1987 were most probably suicides. Clearly, such a problem of definition had implications for any research which takes recorded comparative suicide rates as its starting point.

Even greater problems attend the definition and recording of incidents of attempted suicide and self-injury. Recent research, for example, found widespread differences both over time and between institutions in recording practices (see Liebling, 1991; 1992; also Tumim, 1991). Individual establishments differed in the extent to which they collected meaningful information on suicide attempts; distinctions between 'genuine' and 'non-genuine' attempts were (and continue to be) arbitrary and unreliable. A more systematic way of collecting such information is required.

(ii) focus on individual prediction.

The thrust of much of the existing research had been to identify characteristics or factors associated with prisoners who commit suicide, attempt suicide, or injure themselves in order to predict who might be at risk. This approach suffers from a number of limitations. The risk factors tend to be shared by large numbers of prisoners, resulting in large numbers of false positives (inmates considered to be at risk who do not subsequently kill themselves). Difficulties inherent in the risk identification process also result in large numbers of false negatives (inmates predicted as non-suicidal who subsequently kill themselves). Dooley (1990a) for example, found that only 16 per cent of those who committed suicide between 1972 and 1987 had been identified as being at risk by staff (a figure similar to that reported by Topp in 1979). He also noted that improved screening procedures introduced as a result of the Working Group into Suicide Prevention (Home Office 1986) had not been successful in reducing the suicide rate. The application of this type of detection/prediction theory to suicide risk is highly problematic for a number of other reasons. Quite apart from its inaccuracy, it may also be inappropriate and counter-productive. It is not known whether there has been a reduction in the number of prisoners considered to be at risk who do not kill themselves (the 'false positives').

These limitations led to greater emphasis being given to the possible situational and motivational components of suicide and self-injury. In this respect, Dooley (1990a) found factors relating to the prison situation were noted as possible motives for suicide in no fewer that 118 (40 per cent) of the 295 suicides recorded as such in prisons in England and Wales between 1972 and 1987. Liebling (1991) also found prison based factors to be important in motivating suicides and self-injury in young offenders institutions. The report of the Working Group on suicide precautions at Glenochil (Scottish Home and Health Department, 1985) also emphasised the importance of situational factors in the suicides that had occurred there during the 1981-1985 period.

In 1989 the Home Office Research and Planning Unit approached the Institute of Criminology with a request for a research project. It should be designed to explore some of these issues and provide information that would contribute to an improvement in policy. The research was to build upon and develop the work still being carried out at the time by Alison Liebling on

suicides and self-injury in young offenders institutions. The results of that research were made available to the Home Office in 1991. It was felt that a research approach focussing on the situational and motivational factors behind suicide and self-injury would be more likely to yield information of use to management in planning intervention strategies than the traditional prediction approach. It was hoped that a greater recognition of social and environmental factors, as well as a more thorough understanding of the suicidal thoughts and activities of prisoners, would aid in the recognition of the 'onset of a suicidal crisis' and that this information would be useful in prevention and training. This focus constitutes the basis of assessment in prisoners thought to be at risk of suicide. It would also have important implications for the development of improved regimes, suggesting areas where 'general preventive measures' might be most effective. Some improvement on current statistical data was also required.

In 1990 a proposal was submitted. While many important situational factors such as the extent of overcrowding, hours out of cell, staff-inmate ratio etc., were readily quantifiable (and available to the researcher from records, although not always accurately recorded), many were not. This was particularly true of factors relating to the regime and the organization of the prison, and to the prisoners' relationships with staff and other prisoners. As Wormith (1984) stated: ' "What goes on" in prison will be unavailable in any form of documentation'. Thus, there was a clear methodological requirement for the researchers to develop a close understanding of the life of an institution, and to create an atmosphere of trust between themselves and those involved in such incidents so that the latter felt free to talk frankly about the context and motivation of their behaviour. A project based on long semi-structured interviews with prisoners and staff was therefore proposed and approved. The project also incorporated an epidemiological prospective study of suicide attempts in a range of establishments, in order to improve on descriptive and predictive data on these problems. The research began on 1 April 1990.

Objectives of the Research

The primary aim of the research was to explore the incidence, nature and motivation of attempted suicide and self-injury in custody. The relationship between self-injury, attempted suicide and completed suicide was also be investigated. In addition to these general objectives, which were both descriptive and explanatory, a further aim of the research was to explore what steps were being taken in respect of the management and prevention of suicide and self-injury by establishments, and to make suggestions as to possible improvements. Under these general headings, a number of more detailed objectives were subsumed:

(i) To establish the frequency and type of different forms of self-injury and attempted suicide in a number of establishments; to describe the affinities and differences between these two forms of behaviour; and to assess their relationship with completed suicide.

(ii) To establish how much attention should be given to self-injury as an indicator of suicidal intent, as far as possible; and to investigate to what extent there was evidence of the 'attention-seeking' syndrome so often raised in discussion; to investigate the reasons why

attention-seeking has taken this form, and what its connection may be with the quality of the regime.

(iii) To establish whether certain factors and characteristics - individual and situational - were typically associated with suicide attempts in custody.

(iv) To establish the possible motivations and intentions governing such behaviour - this being the most important aim of the research.

v() To consider existing suicide prevention procedures, any problems of implementation in the fieldwork establishments, and how staff perceived problems of management and prevention.

The research does not cover suicide and suicide attempts in police cells, immigration detention centres, female establishments, secure psychiatric facilities or other institutions.

The report is divided into several chapters. This introduction outlines the background to and the context for the research. Chapter two describes how the research was carried out. Chapter three presents the results from the epidemiological study - a largely statistical exercise attempting to improve on existing data about suicide attempts and self-injury in a large number of establishments providing a representative sample of male prisoners (objective (i) above). Chapters four and five present the results from prisoner interviews in the intensive study, and address objectives (ii) to (iv). Chapter six presents the results of the interviews with staff in this part of the research, and addresses objective (v). Chapter seven considers the potential role of different 'specialists' groups working in prisons. Finally, Chapter eight tries to draw the results together.

Section II: Suicide and Self-Injury - The Nature and Extent of the Problem

The following table gives a breakdown of prison suicides the period 1987-1992.

Table 1

Prison suicides, 1987-1992

	Adult Males	Females	Males Under 21	Total
1987	38	1	7	46
1988	28	-	9	37
1989	35	2	11	48
1990	39	1	10	50
1991	37	-	5	42
1992	29	2	6	37

Source: Home Office Prison Service. Figures includes all self-inflicted deaths.

In each year, the majority of these suicides occurred in local and remand centres (56-78 per cent). Between 20 and 25 per cent of the suicides each year involved prisoners under the age of 21. (In 1990, prisoners under 21 made up 21 per cent of the male prison population and 31 per cent of male annual receptions - see Table 2.3 in Appendix 4). Almost half were under 25. Between 40 and 50 per cent of the prisoners were unsentenced at the time of their death - compared with some 20 per cent of the prison population. Most (56-69 per cent) were located on wings and on ordinary locations, in single cells. Most occurred at night, and within four weeks of arrival in custody (66-85 per cent). For further details, see Home Office, 1992c.

Figures for suicide attempts and self-injury are more difficult to provide. The following table, compiled from a survey by the Prison Service, gives figures for 1991 and is the most recent and comprehensive official estimate of self-injury (undifferentiated into suicide attempts and other forms of self-injury). It gives a breakdown of the age group and establishment type in which such incidents seem to occur most frequently.

Some of these incidents will have involved prisoners repeating injuries, so it would be misleading to compare these figures with the prison population to calculate rates. What this Table illustrates to some degree is the extent of the problem. Such figures cannot elaborate on the nature of the problem (the motivations and feelings associated with them) or its 'true extent' (the total number of prisoners involved and the type of injuries inflicted). The results in chapter three contribute to this picture.

Table 2

Self-injury by age and type of establishment, 1991

Type of establishment	Age Group				
	15	16	17-21	Over 21	Total
Open	-	-	-	13	13
Cat C	-	-	49	174	223
Cat B (non-dispersal)	-	-	-	95	95
Dispersal	-	-	-	79	79
Local	-	2	289	660	951
Remand Centre	3	10	175	77	265
YOI	7	15	222	23	267
YOI/Remand Centre	1	21	285	2	309
Female (closed)	-	-	147	487	634
Female (open)	-	-	-	3	3
YOI (open)	-	-	21	-	21
Total	11	48	1182	1615	2856

Source: Home Office Prison Service.

Describing The Problem

Part of this research endeavour is to quantify and describe the problems being studied, so far as is possible. Some of the figures are given above. Alone, they indicate the urgency of the problem: that 50 prisoners can end their own lives in one year is tragic. That almost three thousand incidents of self-injury can be recorded in one year in one sense speaks for itself, although this figure incorporates a large variation in the type of behaviour described. There are several other ways of describing the problem. The following account documents the events of the last two years as they emerged in the press, in reports, from establishments themselves and from Prison Service sources. Improvements brought about in response to some of the events described below are outlined in the next section. At the end of this account, some figures from recent community studies are given, illustrating the important point that any explanation of suicides in prison must take account of the social world from which prisoners come, and to which they return.

At the beginning of the research in April 1990, a spate of suicide attempts at Hindley remand centre, near Wigan, was linked to the arrival of large numbers of young prisoners from Strangeways, evacuated at the time of the riot. Two suicides by 19 year olds in adjacent cells in the centre's segregation unit preceded an unprecedented increase in the number of prisoners attempting suicide at Hindley. Several other suicides were narrowly averted. Protest at the move, felt to have destabilised an already difficult population, was voiced by the POA and representatives from NAPO. The influx of transfers had increased overcrowding to unmanageable proportions and led to an increase in bullying, particularly of prisoners on Rule 43. Both of the young prisoners who committed suicide were charged with sex offences. This may have been significant in relation to the events at Strangeways (and their portrayal in the media), as prisoners' fears of attack by other prisoners increased.

Between 1990 and 1992, Brixton prison in South London received the most pronounced media attention; 16 suicides occurred there between January 1990 and May 1992. Most of these suicides took place on F wing, the large and poorly resourced medical and psychiatric wing. A television documentary was made, newspaper coverage was persistent and detailed, and staff began to speak out about the pressures they were working under. They felt they were being blamed for lack of care verdicts, the responsibility for which lay with doctors and prison managers. The problems being faced by Brixton mirrored those emerging elsewhere: understaffing, inadequate facilities, poor communication (particularly between eight different doctors) lack of information and overcrowding. In addition, an increasing population of difficult remand prisoners awaiting psychiatric reports or transfer to psychiatric hospitals was accumulating at Brixton.

Four young prisoner deaths at Feltham Young Offenders' Institution between September 1991 and March 1992 lent additional weight to a campaign already underway by the Howard League for Penal Reform to end the detention of 15 year olds in prison. A suicide at Swansea prison in 1990 had highlighted the acute problem of a lack of local authority secure accommodation for juvenile offenders, particularly in certain areas of the country. In March 1992, the Howard League set up an inquiry into the deaths at Feltham under the chairmanship of Anthony Scrivener, QC. Problems of bullying were acute

at Feltham. Lee Waite, aged 18, hanged himself after he had been robbed and sexually assaulted by other inmates. Poor regimes, long distances from home areas, staff shortages and excessive court commitments were all thought to contribute to the problems at Feltham. The Board of Visitors expressed considerable concern over the numbers of young prisoners attempting suicide and called for new initiatives in their treatment. Articles in The Observer (22 March 1992) and The Independent (22 March 1992) made gruesome reading.

Another suicide occurred after a doctor disagreed with a hospital officer's initial assessment of a young remand prisoner received into Feltham the day before. The hospital officer thought the inmate needed special care. He was of no fixed abode, and had been sniffing glue prior to his remand. The doctor did not think the inmate was likely to hang himself. He did not present any 'behavioural abnormalities'. Such disagreements highlight the difficulties inherent in 'risk assessment' and the subjective and fragile nature of decisions seen as 'clinical' and reliable. It also illustrates the confusion of psychiatric illness with suicide risk. These themes will emerge in the report as most important areas of concern. The question of the assessment of suicide risk (and its consequences for the prisoner concerned) remains poorly researched and weakly supported in terms of any treatment benefits for those identified. The prediction of suicide constitutes at present the crux of suicide prevention procedures in prison, despite the failure of such an approach to reduce the suicide rate in prison, and despite calls from many directions for a complete change of emphasis. This point is addressed later in the report.

At Lewes prison, a Board of Visitors member resigned over the issue of suicide prevention after a proposal put forward by the Governor, medical staff and prison officers that a special ward be provided where prisoners thought to be at risk of suicide could be located with others and supervised on a 24 hour basis by prison staff, was turned down by the Home Office on the grounds that funds were not available (Martin, 1992).

At Moorlands Young Offender Institution, one hundred and seventeen self-inflicted injuries were recorded in 1991. Bullying and depression were reported as major problems; 'attention-seeking' - or self-injury to secure removal from particular wings - was an established type of behaviour at many establishments housing young prisoners. A young prisoner's death at Deerbolt Young Offenders Institution added further confirmation of the link between vulnerability, lack of family contact and situational triggers: "no cigarettes and no future" propelled 16 year old Patrick Murphy to hang himself in April 1992. This was the first self-inflicted death at this establishment since it opened 21 years before. The staff were shocked: Deerbolt prided itself on its active regime and modern facilities. A suicide by a 23 year old remand prisoner in Hull days later gave the local papers a second major story.

One of the complications of the field of prison suicide has been the tendency to conceptualise 'suicide, suicide attempts and self-injury' as one problem. They are inextricably linked, as this research enterprise reflects, but within rather than between each, there are important distinctions to be made. Suicide, suicide attempts and self-injury are related, not mutually exclusive, and they are complex, multi-dimensional categories. Importantly, the links between self-injury and suicide may be different for different 'types' of suicide. As a preface to the study, three types of prison suicide are briefly looked at. These are derived from

the literature and Prison Service data which was available prior to the study.

Prison Suicides: One Problem or Many?

A common mistake in prison suicide research (and therefore in training) has been to see prison suicide as a single problem with one 'profile' and a single explanation. This is highly unlikely and unsupported by evidence. At least three reasonably distinct types of prison suicide can be identified. The offenders involved differ not only in their profiles (especially age) but also their histories, their motivation, and the types of situational factors which appear to contribute to their action. (The typology is based on detailed current Prison Service data now collected on self-inflicted deaths - see Appendix 1). It is also informed by recent research (Dooley, 1990a and Liebling, 1991).

A Typology of Prison Suicide

	1.POOR COPERS/ SITUATIONAL	2.LONG SENTENCE PRISONERS (eg intimate homicide or sex offenders)	3.MENTALLY DISORDERED
MOTIVATION	fear/ helplessness distress/ isolation	guilt/no future	alienation loss of (self) control fear/helplessness
AGE	16-25	30+ (av 35)1	30+
PROPORTION OF TOTAL SUICIDES	30-45%+	5-20%*	10-22%**
SITUATION	acute	chronic	varied
HISTORY OF PREVIOUS SELF-INJURY	high	low	medium
FEATURES	often more typical prison pop. ie, acquisative offences, precons, etc	often (76%***) on remand, after midnight Some well into sentence	psych. history present; single NFA

* recent increase in 1991
** 13% for YP's (Dooley, 1990; Liebling, 1992)
*** Dooley, 1990a
1. In 1990, the average age of lifer suicides was 38 (range 20-59), 8/12 were over 30 years. In 1991, the average age of life suicides was 35 (range 21-52), 11/14 were over 30.

It is possible to see from the above, rather crude but conceptually important typology, that situational and motivational factors may be different for different types of prison suicide. In the case of long-sentence prisoners for example, situational factors relating to their imprisonment may be highly significant because of their chronic or long-term nature. For 'poor copers' these situational factors may be more acute. The typology is introduced at this stage in order to illustrate the point that the research has been asked to consider 'suicide, attempted suicide and self-injury'; relationships between these behaviours are complex, and the results will not be uniformly informative in every respect. It was obviously not possible to speak to those completed suicides who had not injured themselves before, and who might be found in greater numbers in 'types' 2 and 3. This typology and its relation to the results is discussed in the conclusions.

A final point must be illustrated at the outset. There is a community dimension to the prison suicide problem. Prison suicides are increasing in a context of significantly increased levels of suicide and attempted suicid amongst particular ('prison-prone') groups in the community and this could have significant implications for the research.

Possible Explanations for High Rates of Suicide and Suicide Attempts in Prison

It is indisputable that rates of suicide and attempted suicide have been increasing in prison both in the UK (Dooley, 1990a; Liebling, 1991, 1992); and elsewhere (Biles, 1990; Hammerlin and Bodal, 1988; Bernheim, 1987; Correctional Service of Canada, 1981; Hatty and Walker, 1986) - despite a slow down in the overall rate of increase in England and Wales over the last two years. What is open to further investigation is the question of the relative increase of these phenomena compared to rates in the community. This question must be addressed in any search for an understanding of or explanation for prison suicide. The problems inherent in trying to compare rates in the (relatively static) community with the (relatively transitory) prison population have been discussed elsewhere (Liebling, 1991; 1992; O'Mahony, 1991; Winfree, 1985). This research project has not been asked to investigate rates of suicide. It is the apparent (in fact, real) increase in rates of suicide and attempted suicide in prison that led to its conception, however, and this context of increasing numbers of suicides and attempted suicides is pertinent. There are several possible 'explanations' for the increase in suicide and attempted suicide in prison, some of which are addressed in the research, but others of which have their original source in the community. 'Community' explanations (not mutually exclusive) are:

- the social and economic disadvantage characteristic of the prisoner population (see Prison Reform Trust, 1991)
- the increase in suicide and attempted suicide in the community (see below)
- increased sense of vulnerability and isolation among young people in modern society (Kinsey et al. 1991).

Other explanations are largely prison/prisoner-related:

- the so-called 'pathological' nature of the prison population (see Home Office, 1984; 1986; Gunn et al, 1992; Grounds et al, 1992)

- prison conditions, and problems inherent in the prison situation (such as lack of access to specialist help, lack of alternatives, sub-cultural transmission, or changes in the prison environment (eg. managerial; see Burtch and Ericson, 1979; Scott-Denoon, 1983; SHHD, 1985; Home Office, 1990)

- increased proportion of remands in the prison population (to 22 per cent for males in 1991/2).

All of these explanations have some validity to them. Perhaps the least documented explanation for the increase in prison suicides is the significance of the community.

Suicides in the Community

It is clear from recent research and reports that the suicide and suicide attempt rate in the community has been on the increase, but that this increase has been concentrated amongst particular sub-sections of the population. It is amongst those groups most likely to spend some time in prison (the young unemployed male from social classes IV and V) that these increases have been reported (see Kreitman et al, 1991; Liebling, 1992). Kreitman first described the 14-fold excess of social class 5 individuals over those from social classes 1 and 2 combined in his study of parasuicides in Edinburgh (Kreitman, 1977:24; see also Jack, 1992 and Wells, 1981; Paykel et al, 1974). In May 1992 the Samaritans reported that there had been a 74 per cent increase in suicides amongst young men in the past ten years (Samaritans 1992). Young men accounted for 80 per cent of suicides among the under 25 age group. The official figures, according to the Samaritans, were the 'tip of the iceberg' (The Independent 16 May 1992). If suicides are increasing amongst particular sections in the community - arguably the 'prison-prone' - it is less surprising that the prison population may be increasingly 'suicide-prone' (see Kinsey et al., 1991; Liebling, 1992). This has important implications for the Prison Service and the role it can (be expected to) play in the minimization of suicide.

Section III: The Context

> People and institutions do not stand still to be studied. They do not exist to suit the researchers desire for methodological rigour or theoretical elegance (DiIulio, 1987)

The attempt to document 'what goes on' in prisons regarding suicides, suicide attempts and their prevention during 1990-1992, presents itself as a single slice of history. It is not. It is a picture taken cautiously of a moving target. Staff disappeared and reappeared in unexpected places. Establishments closed and others opened, populations were relocated, practices and policy changed. The remainder of this introductory chapter attempts to document the more significant developments which occurred during the period of the research.

Prison Service Policy Initiatives

Throughout the period of the research, a number of important policy initiatives were developed and implemented. A number of significant events also took place. Between the start date and the completion of the research, Strangeways erupted into riot, followed by major disturbances in at least 30 other establishments, including the pilot prison. The Woolf report appeared, Judge Tumim carried out and published his review of suicide prevention procedures; Prison Service created a Suicide Awareness Support Unit, staff 'care teams' were developed and introduced; the Samaritans were encouraged to take a much more active role in establishments, an inmate listening scheme was successfully piloted and expanded to other prisons; suicide awareness training was increased and improved in places, and major redevelopment work in particular establishments was undertaken, enabling changes in local policy to be introduced and populations to be re-accommodated. New procedures were introduced regarding the treatment of prisoners' families following a death in custody and during the subsequent preparation of inquests. A 'Family Ties' package was expanded, telephones were installed in most establishments and imminent agency status for the Prison Service was announced. This section will outline some of the most significant of these developments, in particular those which are seen as relevant to the conclusions, in chapter eight.

A Review of Suicide and Self-Harm in Prisons in England and Wales

Under a provision in Section 5A of the Prison Act 1952, as amended by the Criminal Justice Act 1982, The Secretary of State requested in February 1990 that a specific report be prepared by the Chief Inspector of Prisons on suicides in prison. Judge Tumim's terms of reference were:

> To review the effectiveness of the current policy and procedures for the prevention of suicide and self-harm in Prison Service Establishments in England and Wales, with particular reference to the risks posed by mentally disturbed prisoners; and to make recommendations.

He was assisted by Colin Allen, a former Governor and a member of the Inspectorate, Stephen Handley, and Malcolm Faulk, a consultant forensic psychiatrist. The team visited 40 establishments and consulted widely amongst those felt to be in a position to contribute to the review, which was explicitly an evaluation of current policy and practice and not a research project looking at motivation. That task had been left to the Institute of Criminology team.

In his report, Tumim referred to the drastic increase in prison suicides since 1987, an increase which has remained stable. Possible explanations for this increase included 'the very introduction of the Circular Instructions and screening procedures' (Tumim, 1990:4) which may have focused minds on the problem. Fresh Start, and related staff shortages, particularly at evenings and weekends, and an emphasis on 'budgetary matters and organisation rather than on the basic duty of looking after inmates' were also thought to have played a part. The closure of long stay psychiatric hospitals without a corresponding increase in resources or

training for prison staff dealing with mentally disordered prisoners was another important factor.

The Circular Instructions on suicide prevention were 'too defensive' (Tumim, 1990:6), resulting in protection for staff, but not enough support for prisoners. Often they were not followed in spirit, and there was too little emphasis on environmental aspects of suicide prevention or the role of non-medical staff, visitors and prisoners themselves. Inadequate resources produced unacceptable reception conditions, and brief interviews were too often carried out by part-time visiting doctors, with too little information. Observation options were severely restricted, to the extent that this aspect of the procedures became meaningless. Suicide Prevention Management Groups were under-used in establishments, recording of incidents was poor and subjective and not enough time was given to social interaction or to understanding inmates.

Certain 'inadequacies in the provision of basic facilities and regimes in local prisons and remand centres' were also identified in the report as contributing to the dehumanising impact of imprisonment. The notion of minimum legitimate expectations of some fundamental standards was raised here - a notion which was to receive additional emphasis in the Woolf report - covering cleanliness, privacy, clothing, food, medical attention, communication and visiting arrangements, activity and assistance from staff. Responsibility, choice and opportunity were to be encouraged. Dining should take place in association. The young, a particularly vulnerable group, should receive 'personal attention from staff who can listen', meaningful activity and greater access to telephones, visits and letters. An Induction process should be introduced. Full and active regimes should be provided, with a minimum of eight hours out of cells each day.

Tumim drew some comparisons between the provision of medical services in NHS and in prison. He pointed out that substantial differences in the training, backgrounds and experience of careers in the two services exist; differences in manpower levels, physical conditions and specialist support also exist. Treatment in the Prison Medical Service must be voluntary (because a prison hospital is not regarded as a hospital under the terms of the Mental Health Act) resulting in what he conceded to be a necessary resort to seclusion in stripped conditions for sometimes long periods of time. Transfer to a psychiatric hospital was not sought frequently enough. In prison, withdrawal from drugs may be effected too quickly, without adequate support. The standard of care in prison hospitals is 'insufficient to deal with uncooperative patients or those whose illness fails to respond to simple treatments' (Tumim, 1990:27). Insufficient facilities exist in the community or within the NHS for these patients. Tumim concluded:

> It would be of considerable assistance if the prison hospital, wholly or in part...could be upgraded and staffed to a standard so that it could be designated a psychiatric hospital within the meaning of the Mental Health Act (Tumim, 1990:28).

The cost should be met by the District Health Authority, on a case by case basis. Hospital facilities should be 'clustered' within the service, and Hospital Officers should receive additional nursing training.

At present, 'an excessive number of defendants' are remanded into custody for medical reports'. Often, a hospital placement is not the outcome.

'Remand in custody represents a readily available storage facility to allow a psychiatric assessment' (Tumim, 1990:29). This mechanism is inefficient and unjust, Tumim argued. He also recommended that psychiatric assessment and liaison services should operate at courts (as at present at two inner London magistrates' courts). Bail Information Schemes should be expanded. Structured bail hostels with psychiatric support were needed. Certain features of the physical design and condition of establishments should be remedied to minimise suicide risk, including more spacious reception areas, better cell design, refurbishment to include sanitation and the installation of in-cell television.

Tumim suggested that in the event of a death, Area Managers should submit a report to headquarters. A Governor from another establishment should be involved. A member of the SPMG should inform the next of kin, who must be allowed to involve a doctor of their own choice in the post-mortem examination, if they wish. The next of kin 'should enter the inquest procedure with the same amount of information as the Prison Service' (Tumim, 1990:36):

> The Prison Service duty of care to those for whom it is responsible should, in some circumstances, extend to family and relatives (Tumim, 1990:36).

Proper counselling should be provided for staff and inmates, where necessary. Tumim concluded his report with the recognition that a combination of the particular population found in prison, and the environmental conditions peculiar to imprisonment, produced an especially vulnerable group:

> confinement in prison may emphasise not only lack of occupation but also lack of purpose in day to day living. It can equally emphasise the extremes of human feelings, in the form of acute periods of hope and despair...Efforts should be directed as much to the improvement of the general quality of life within prison as to the needs of individual prisoners who may display suicidal tendencies (Tumim, 1990:37).

After a period of reorganisation, the 'attention of staff can be redirected the central purpose of looking after the people it holds' (Ibid.)

Tumim made 123 recommendations. He included in his report the most detailed statistical information yet provided on suicides in prisons in England and Wales in recent years. The report was launched with a detailed statement by the Home Secretary and a press release in December 1990, emphasising the Service's clear commitment to reducing the number of suicides in prison, showing how they were responding promptly to research findings, and arguing that they were now developing an integrated and comprehensive set of policies that would allow all (types of) staff to react in a professional manner to suicide risk.

The Howard League and the Prison Reform Trust were critical of the report, calling it a 'wasted opportunity' (Howard League Letter to the Editor, The Guardian 20 December 1990) as it omitted to include any consultation with prisoners or their families in its remit - those 'most directly affected by suicides in prison'. To be fair, the research reported here was intended to fill that gap, at least as far as prisoners (and staff) were concerned. The Prison Reform Trust felt the report was 'anodyne and complacent', not

going far enough in its recommendations to bring about a change of ethos. As argued by the Howard League,

> a new ethos in prison is needed respecting the human dignity of the individual. An effective suicide prevention procedure can only be based on kindness and support. (The Guardian 20 December 1990)

Others welcomed the review, feeling that its pragmatic, straight-forward recommendations provided a substantial improvement on previous reports. It certainly signalled a change of style and priority for suicide prevention, recognising the crucial need to integrate the problem of prison suicide with other aspects and problems of imprisonment. It was also less medical in emphasis than much previous official comment.

The Woolf Report

Tumim's report was closely followed by Lord Justice Woolf's Inquiry into the Prison Disturbances of April 1990, on which Tumim sat as a team member for Part Two: examining the wider issues to arise out of the disturbances. His specific recommendations relating to suicide prevention were given additional backing by the recommendations drawn up by Woolf. The importance of balancing the requirements of security, control and justice, and of furthering the aims of the criminal justice system as a whole, became the focus of debate in the wake of the Woolf Report. These broad principles were to a large extent incorporated into a White Paper issued in 1991: Custody, Care and Justice (see below). Woolf identified several root causes of the dissatisfaction expressed in the form of the major disturbances of April 1990. It should be noted here that many of these problems may be of equal significance as part of any comprehensive explanation for the drastic increase in prison suicides witnessed over the last seven years. Certainly, as part of the context in which prisoners and staff were talking to the researchers about their problems and their distress, it is important to take into account some of the issues raised during the course of the Woolf inquiry. This will become clearer in later chapters, as the findings and conclusions of the study are presented.

First, a level of distrust between governors and uniformed staff in the field was identified:

> there is a remarkable dichotomy within the Prison Service. The dichotomy is between the high calibre, deep commitment and sense of loyalty on the part of most staff, and the dissension, division and distrust which exists between all levels of the service. Staff labour under a 'blanket of depression'. There is a profound desire for more visible leadership. (Woolf, 1991)

Some of the areas of dissatisfaction, and many of the recommendations put forward by the Woolf report will be referred to in later chapters. Amongst the most significant of the former were: the recognition of a deep level of staff disillusionment and despair, some of which was linked to Fresh Start; reductions in regimes (cp. King and McDermott, 1989); and feelings of alienation from management.

The most important areas of recommendation were the notions of accredited

standards and 'legitimate expectations'; compacts with Area Managers and with prisoners; the particular case of remand prisoners; staff training, known to improve staff performance, self-esteem and staff-inmate relationships; sentence planning, involving the systematic assessment of prisoners' needs: education, training, work, medical care, etc. and the extension of home leave and visits; telephones, and the notion of community prisons (a 'return to throughcare').

Woolf's aim in his report was to minimise the harm done by imprisonment. The research sheds important light on the nature of this harm, how it might be understood and who might be most vulnerable to it. If 'justice should extend to every aspect of prison life', a better, more grounded view of prison life is needed from those who are most susceptible to its pains.

The White Paper

The Government's White Paper, 'Custody, Care and Justice' outlined 'the way ahead' for the Prison Service. Its twelve main proposals included improved co-operation with other services, increased accountability, improved job quality for staff, a recognition of the needs of remand prisoners, the provision of active regimes, a code of standards, and improved relationships with prisoners - incorporating a statement of the facilities they can expect, more consultation and an independent appeal body (Woolf's doctrine of 'legitimate expectations'). The White Paper proposed 'a fundamental review of its response to suicide and self-harm' (Home Office, 1992:86). Specific proposals relating to the prevention of suicide included support for prison staff following incidents, reviewing training, providing decent physical conditions, reducing overcrowding, developing a code of standards, providing a high quality of health care, developing active regimes, reviewing reception and induction procedures, extending personal officer schemes and enabling prisoners to maintain their family links. The proposals aimed to reduce suicide risk by creating a more caring and positive climate.

Prison Medical Service Efficiency Scrutiny, 1990

The final report that had to be taken into account concerned the Prison Medical Service.

> The provision of health care in prisons raises many difficult issues; and there are other aspects of imprisonment which cause great concern, such as the incidence of suicide...which, while not wholly a responsibility of the PMS, are matters on which it has a major role to play (1990:4.5).

In the words of its Director, Dr Rosemary Wool, a 'bright light' was shone on to the Prison Medical Service in 1990 in the form of a scrutiny of its management and services. The scrutiny came about as a result of high expenditure on drugs and dentistry services in prisons in addition to a fundamental concern for prisoners' health care expressed by the Chief Inspector of Prisons. The review opened the way for a fundamental rethink, and precipitated considerable discussion of changes and reforms to the provision of medical services in prison. In particular, the fact that the PMS was 'held in low esteem both within the Prison Service and outside'

(Review, 1990:1) was felt to be unhelpful to those who worked within it, and those who were dependent upon its services. The operation of medical and psychiatric services, prison hospitals and the medical facilities available in establishments was of crucial importance to the research. How far prison hospitals could operate as a support to prison staff working on wings dictated to some extent how well suicide prevention procedures could operate in practice, and importantly, how confident staff felt in their every day task of identifying and observing those felt to be at risk of suicide. Improvements suggested by the team included a change of emphasis towards the promotion of health, and a change of name to the 'Prison Health Service'. A health care policy should be integrated with objectives set at Prison Board level.

The main purpose of the scrutiny was:

> to examine the effectiveness and value for money of the Prison Service's arrangements for providing medical services for prisoners (1990:5)

The three terms of reference for the review team were:

- expenditure on medical and dental services (in terms of 'value for money')
- policy and practice regarding management, and the provision of facilities and training
- to make recommendations.

It was significant that the scrutineers were carrying out their work during the time of the riots. This coincidence underlined the very real security problems inherent in prison service life and emphasised the differences between providing a health care service in the community and in prison and the many difficulties raised by the latter. The crucial issue was the extent to which services should be bought in on contracts from the National Health Service (and elsewhere) or how far the resources existing within the Prison Medical Service should be developed and expanded to cope with the apparently growing number of prisoners requiring psychiatric reports, transfer to outside psychiatric hospitals and other services. The crucial issue was how well prisoners thought to be at risk of suicide were being looked after, in what sorts of conditions and by whom.

The main findings of the team were that there should be a closer alignment of the Prison Medical Service with the National Health Service, ending the isolation of prison medicine from the wider community. Lines of accountability for medical services in prison should be more clearly drawn; a clearer distinction between clinical and management roles should be made; there should be a closer matching of need and provision, a 'responsive management close to the point of delivery' and 'integration of the health care perspective into mainstream prison management at every level' (1990:2):

> Active health promotion is needed throughout the prison, not just in the prison hospital but in the design of regimes (1990 6.2.).

The 'promotion of health should extend to prison staff as well as prisoners' (para. 16.2.). The 'tension between control and care should be

recognised as healthy and should be used in a positive way to improve the prison culture' (1990:7.2.) and 'the management of the medical service should be closely aligned to that of the Prison Service to facilitate integration of care into the prison management structure' (Ibid.). The issue of where the medical services 'fitted' in terms of provision of support for prisoners within establishments was crucial.

Chapter four of the report - 'the Context of the Prison Medical Service' - contains an illuminating and relevant discussion of the medical and other needs of prisoners. This chapter is particularly relevant to the results o the research concerning hospital services and is worth quoting in some detail:

> A review of prisoners' physical health in 1984 concluded that the prison population was made up disproportionately of men who drank and smoked heavily; had more active health problems than the population at large; and showed evidence of self-neglect; amongst the older group there were large numbers of alcoholics serving sho sentences for drink related offences; and that men in prison were under stress and had violent tendencies.
>
> There is also a higher incidence of psychiatric disorders... The available evidence from prison statistics and general populatcn surveys suggests that prisoners seek medical attention 10 times more frequently than the comparison population group in the community as a whole. Reasons for this include health characteristics of prisoners, their lack of access to household remedies; high level of stress and anxiety, boredom, and requirements of the prison system, such as seeking medical endorsement for not working, special diets or special footwear... A quotation from Professor Norval Morris gives a picture of the dilemmas and challenge of providing care to a vulnerable populatior in prison:
>
> "The doctor and attendant medical staff occupy a particularly sensitive position in the prison community. It is always a mistake for one in a hurry to ask a prisoner "How are you?" He will tell you - at burdensome length. Hypochondria is chronic and endemic in prison. And so is malingering. And so also, I believe, age for age, is a higher than average incidence of most illnesses. Hence th task of the prison doctor is to meet genuine medical needs without himself becoming cynical, assuming that he is merely the constant butt of the prisoners' efforts improperly to manipulate him; this is no easy challenge. Pressures to debase the healing profession pervade prisons...
>
> "Conflict and hostility tend to replace medical trust, and this is true even when medical services are of high quality and facilities are adequate to medical needs. Where, as is not unusual, services are less ample, diligent and skilled, and facilities antique rather than sufficient, these conflicts are exacerbated."

This commentary serves as an important reminder about some of the issues raised by staff (discipline and hospital officers) and prisoners in relation to suicide prevention, and will be returned to later. On this specific issue, the scrutiny team identified special needs groups of

prisoners, including remands, the young and the suicidal as being in need of policy strategies with implications beyond the medical. They concluded, however:

> The increase in the numbers of suicides in prisons in recent years is a matter of deep concern. We believe our proposals for unitary management, for the use of community psychiatric nurses at receptions and extended counselling can be of value in addressing this problem (1990:11.10.).

Other Organisational Changes

Finally, it was significant that the research witnessed one of the largest organisational changes in the Prison Service at senior management level for some time, as the four regional head quarters were abolished and fifteen area managers were appointed, each responsible for approximately nine prisons. Policy and operations were integrated through the creation of three Directorates, each of which took on responsibility for one of three broad policy areas: Inmate Administration, Inmate Programmes and Custody. For the purposes of the study, the most important change was that suicide prevention came under the immediate responsibility of the Director of Inmate Administration, Ian Dunbar. In 1991, a Suicide Awareness Support Unit was set up by the Director of Inmate Administration, to develop a strategy for suicide prevention and support, to coordinate best practice and to work closely with governors and staff in responding to problems relating to suicide in prison. In a message to staff, Ian Dunbar argued that the Prison Service was working hard to create the best conditions for suicide prevention and care for inmates to flourish:

> We in headquarters need to take action to:
>
> - reduce overcrowding
> - improve facilities for both staff and prisoners
> - increase opportunities for staff training
> - improve staff development and job satisfaction (Prison Service News, October, 1990:5)

He also said:

> Above all we need to make sure that resources are being used in the right way and we need to recognise when existing resources do not allow staff to spend enough time working with prisoners as individuals...These are all crucial issues which will need care and time to get right (Ibid.)

The Unit, headed by David Neal, liaised closely with particular establishments during the period of the research offering support, advice and interest where possible, and developing training initiatives. These initiatives included an invitation to Joseph Rowan, an experienced American consultant with special expertise in suicide prevention, to lead a series of seminars on suicide prevention at prison service colleges for all types of staff.

Family Ties

Initiatives to increase the level of contact between prisoners and their families were expanded in 1991. These included the extension of telephone provision to all Cat B training prisons, and local and remand centres, a review of home leave provision, including revised guidelines on risk assessment; a review of correspondence and visiting privileges, arrangements and facilities, including the introduction of extended visits schemes at several establishments; the funding of new visitors' reception centres and the provision of children's play areas in visiting rooms; better publication of prison visitor schemes; an increase in prisoners' pay and financial support for the work of the Federation of Prisoners' Family Support Groups. It also included a doubling of the visits entitlement for convicted prisoners to two visits every 28 days and the abolition of censorship of correspondence except at maximum security establishments.

The Swansea Listener Scheme

In Swansea prison, a 'listener scheme' was pioneered by staff and prisoners, with the support of DIA 1, as part of an experiment using experienced prisoner volunteers to befriend vulnerable inmates. The scheme was adopted as part of a local strategy aiming to prevent any further suicides after the controversial and distressing death of Philip Knight, a 15 year old, in 1990. The scheme was felt to be successful in many ways and is being exported to other establishments through 'good practice' seminars, visits to other prisons and the wide dissemination of the scheme (Davies, 1992). There was 50 per cent reduction in self-injury in the first year of the scheme.

Prisoner-Led Research

Prisoners in the Special Unit at Hull spent a considerable amount of time examining some of the issues and problems posed by prison suicide. They organised a seminar on suicide and its prevention in January 1992. This seminar was attended by representatives of a number of agencies. It resulted in 49 recommendations which were subsequently incorporated into a report produced by two of the prisoners: One-Off (Felo de se) (Jakubczyk and Ross, 1992). The report provides valuable material about the prison experience, the nature and extent of the prison suicide problem, and a useful summary of their constructive and well-informed campaign. Its recommendations are similar to those reported in Tumim and Woolf, but they also address issues of the treatment of prisoners' families; attitudes to prisoners who self-injure, and the use of medication.

The Samaritans

A new post of Samaritan Liaison and Development Officer was created and funded (for two years) by the Home Office in 1991. As a group, the Samaritans were encouraged to play a proactive and supportive role through involvement in training courses (including the making of a training video), membership of Suicide Prevention Management Groups; debriefings in the event of a suicide or suicide attempt and the befriending of prisoners at

risk by visit or phone. The Liaison officer worked closely with DIA 1 on issues of staff training (for example in communication skills) and the co-ordination of support to establishments. She has also been involved in the training of prisoners and the provision of support groups in the Swansea listening scheme (above). By May 1992, the Samaritans were involved in 119 establishments.

Other Developments

In response to the growing recognition that bullying and self-injury were related, particularly in young offender establishments, and that on occasion it led to suicide, the Home Office initiated a Steering Group on Destructive Behaviour amongst young offenders in custody to look specifically at the problem of bullying in young offender establishments and to spread good practice. The group held its first meeting in April 1992.

Local initiatives were also taken throughout 1991 and 1992 to tackle problems experienced by particular establishments. For example, towards the end of 1991 and throughout 1992, significant improvements were introduced at Brixton. A new Governor with a reputation for his ability and willingness to manage difficult prisons was brought into post; a drastic reduction in numbers was achieved when Belmarsh prison opened in 1991, curtailing the number of London courts being serviced by Brixton. Court liaison schemes aiming to divert the severely disturbed away from prisons and into psychiatric hospitals were introduced, and a new, modern psychiatric unit and hospital facility was opened, enabling the transformed F wing to be renamed the Health Care Annex. Additional training was made available and staffing levels improved when two of the four wings holding psychiatric patients were refilled with ordinary remand prisoners. These quite dramatic changes were reflected in the reduction of suicides to one in 1991 and none in 1992.

The Role Of Inquests

The campaigning organisation Inquest became increasingly involved in prison suicide cases during the years 1990 - 1992, following the 'lack of care' verdict brought by a jury in 1990 and upheld despite judicial review in 1990/91. This controversial case signalled a change of mood: prisoners' families began, with some encouragement by Inquest, to question their treatment at the hands of establishments following a death (see Liebling, 1991). As acknowledged in Tumim's review, outlined above, information was sometimes withheld, a 'wall of silence' left bereaved relatives feeling confused, angry and suspicious. Experience at Leeds as a result of the five young remand prisoner suicides on B wing had shown that opening prison doors and co-operating sensitively with families was both a pragmatic response to media and public criticism, and a moral requirement (see Liebling, et al., 1991).

Circular Instruction 52/1990, issued in December 1990, was to some extent a response to Inquest's campaign. To this end, their campaign can be said to have been 'successful'. There were also dangerous side-effects to such a campaign, however: it was suggested that families taking an initially resigned approach to a self-inflicted death were being 'fired up' by a

campaigning organisation determined to uncover evidence of maltreatment at any cost. This resulted in additional distress for relatives, and for staf particularly where individuals had acted in earnest to prevent the deaths. Perhaps the most critical concern here is the pressure felt by staff to 'cover themselves' in the event of a possible suicide. Risks cannot be taken, suicidal inmates must be prevented from taking their own lives; a transfer to another establishment may be preferred, even at the cost of the prisoners' contacts with his family, on the grounds that 'full-time medica cover' is required. Adherence to a set of Circular Instructions not entirely consistent with the care and humane treatment of those at risk but designed to 'do the best thing in the circumstances', has to take precedence over what might be a calculated risk intended to help the inmate to recover from his crisis. A prison officer knows which option he should take: no-one wants to face criticism in the coroners' court, the questions asked in that setting are 'did you follow the instructions?'. It is only where instructions can be shown to have been ignored in some way that a lack of care verdict can be brought.

It is an ultimate irony in prison suicide prevention policy that making a decision to keep a potentially 'at risk' inmate on the wing, where he knows a few faces and can be found something to do or offered some support, may expose the officer who makes this decision to a damning accusation in a court of inquiry. What the activities of Inquest have exposed in recent years is the lack of understanding on both sides of the walls of exactly 'what goes on' in prison, of what might cause suicides, and what sorts of strategies might humanely prevent them.

* * * *

It was felt important to document some of the developments relating to suicide prevention policy and the context in which it is carried out at the beginning of the report. This is in part to 'offset' the data, much of which is depressing, negative and at times, horrific. Prison Service was concerned that the report should build upon positive work already being carried out both nationally and locally, and that it give up-to-date information on the extent and nature of the difficulties. Suicide, in or out of prison, is not a simple problem. It is also recognised that the results may have implications for some of these developments and proposals, if only in their provision of a strong empirically-based message of support for most of the proposals outlined in many of these reports. The aim is to contribute to understanding - and ultimately, to improvement.

Footnotes

1. Elsewhere in this report reservations are expressed about the predictive goal of prison suicide research. There are several reasons for this. They are best articulated in Liebling, 1992; Bottoms and Brownsword, 1982; and Maltsberger, 1986. The aim of prediction is not always compatible with the aims of understanding and/or treatment. As Maltsberger argues:

> Statistical studies are helpful, especially when special subpopulations are studied; diagnosis alerts us ... (But) Predicting suicide at present is an insuperable task. We cannot do it... Statistical methods will identify high risk groups readily enough, and that is a valuable aid. But they cannot do more: selecting the particular patient in the high risk group who is sure to commit suicide is beyond this approach. (Maltsberger, 1986: 50)

Poor prediction methods subject both those 'at risk' and those not 'at risk' to unjustifiable and restrictive 'detention'. This practice is subject to the same criticism articulated by Bottoms and Brownsword in relation to the 'dangerousness' debate (see Bottoms and Brownsword, passim). More important is understanding the special vulnerability that makes those at risk of suicide especially reliant on external sustaining resources (Maltsberger, 1986) (such as structure, activity and contact). This can only be understood from a 'psychodynamic' or biographical case formulation - or, talking to the prisoner:

> In a recent paper, I summarized and reviewed studies that had tried to identify ways of predicting which people are going to kill themselves. Patrick and Overall (1969) successfully used a brief psychiatric rating scale to differentiate suicidal from non-suicidal patients. They concluded, however, that the use of their scale could not approach the level of accuracy achieved by simply asking the patient about his suicidal concerns. (Beck et al., 1986: 71)

2. Women were not included in the research after some discussion of the original proposal, which had included females. It was felt by the Prison Service at that time that the research should concentrate on male prisoners. Three women prisoners committed suicide during the period of the research and its development, two in 1989 and one in 1990. The numbers reflect their proportion in the prison population. Women prisoners are significantly less likely to receive verdicts of suicide at inquests following a self-inflicted death (Dooley, 1990b). This may contribute to an assumption that female prisoner suicide is a less urgent problem (see Liebling, 1992). This limitation to the research was accepted because it was felt that a separate and properly supported study on women's suicide and self-injury in prison would be desirable (see Coid et al., 1990; Wilkins et al. 1990 and Liebling, 1991, 1992 for work carried out).

3. It was heard from one or two prisoners that the suicide attempts which they had made during this period were directly related to fears of violence from rioting prisoners:

> Not as a child, no. I did once try committing suicide. That were last year, at Armley. I strung meself up, put mesen on bars, because I were frightened. At the time there were 1800 lads in a prison build for 600 lads, and then Strangeways broke out and they tried it at Armley. They tried breaking out one night and I just got scared. I thought, I'm not going to them the opportunity of killing me, I'll do it myself. My pad-mate found me. I remembered putting it round my neck, and then I just remember waking up on a bed, in my cell, choking. I were put in a strip cell - that made me feel even worse. I didn't get the treatment I should have had. I weren't particularly bothered about getting treatment at the time. But why I did that, I'll never know anyway. Like I say, I've got a common law wife on the out and kids... there was really no need to do all that. I was just really scared, and you're enclosed in such a small place with three lads. You've no chance if 1800 lads come for you.

4. It was decided not to include Brixton in the sample of 16 Sample 1 establishments (see chapter two) partly because of this over-representatio of the psychiatrically ill amongst its remand population. Judge Tumim had concentrated much of his own time in Brixton during his review, and it was felt that there was potential overlap in concerns of the two studies. It was felt that Brixton may have had a particular and therefore unrepresentative problem, particularly relating to the nature of its remand population. Later discussions with the Governor, and a visit towards the end of the research project at his invitation (see Liebling, 1992b in Prison Service Journal), persuaded the team that Brixton was by no means unique and that many of its problems were shared by other local and remand centres.

5. Martin, C (1992) Boards of Visitors - Watchdog or Lapdog, in Howard League (1992) Criminal Justice 10(1):10-11; see also The Guardian - letters to the Editor 27 September 1991.

6. The definition of 'social class' in this study includes both occupational and social group (see Kreitman et al., 1991).

7. Families were not included in the research for two reasons. Firstly, ti did not permit, and it was not part of the study's remit. Secondly, the importance of visits to prisoners was recognised and it was not wished to interfere with them; there were also reservations about talking to families about suicide attempts and incidents about which interviewees had been promised confidentiality.

8. Full-time medical cover. This term usually means that the hospital is staffed 24 hours a day. In many cases, staffing is minimal, particularly at night. It does not guarantee increased levels of contact for the prisoner.

CHAPTER TWO

CARRYING OUT PRISON SUICIDE RESEARCH

Pioneers of research on inmate suicides invariably agree that only through a sustained, comprehensive exchange of information among clinicians, researchers, prison officials and inmates will our knowledge of prisoner suicide move beyond its present, nascent state.(Burtch and Ericson, 1978:1)

No. I'm refusing everything. I'm fed up, fed up with being pushed around. I know it's my own doing. They're not helping me. It's only since I left Grendon (a therapeutic prison) that I've acted up. Everything was just cut off for me (when I reached 22). If I saw them as even trying to help even; if they just came up now and again and had a chat with you. I'd be happy with that, but they don't even do that. It's hard to explain. I can understand why the doctors don't understand what you're trying to say. You don't get people coming and sitting in your cell like this and having a chat. You've got to put application after application in, and that's why people have to get attention the easy way. We're used to being punished all the time, being in 'care'. (Prisoner)

Introduction

The research summarised in this report consisted of two complementary but distinct phases carried out simultaneously, in different groups of establishments. The first, epidemiological study was designed as an attem to improve upon existing available data about the frequency and nature of self-injury and attempted suicide in custody. Its basis was quantitative, involving the prospective collection of information about suicide attempt and self-injury as they occurred over a period of one year in a 'representative sample' of sixteen male prisons.

The second, intensive study was based on the research carried out in youn offender institutions and aimed to gain a better understanding of the social, environmental and motivational factors involved in attempted suicide and self-injury in custody. Its basis was qualitative, involving long semi-structured interviews with prisoners and staff in four establishments: one training prison and three local and remand centres.

This chapter outlines the research methodology employed in these two phase of the project, starting with the first, quantitative study.

Section I: Research Design

A. The epidemiological study

In the previous study (Liebling 1991; 1992) it was demonstrated that recorded data on self injury and attempted suicide, at both the local and national level, was of doubtful reliability. Most of the previous research available on suicide and suicide attempts in custody (reviewed in the abov studies) had been based on this type of information. A similar point was made in the recent Report of an Efficiency Scrutiny of the Prison Medical Service:

> In the Prison Service a mass of data is collected, but it is not always collated or monitored in a consistent or systematic way; nor is the data collected always aligned to specific management needs or objectives, or available to those who need the information. (July 1990)

A separate quantitative prospective sample was therefore incorporated in the research, in order to collect systematic information on the frequency and nature of self-injury and attempted suicide occurring throughout a 12 month period. A specially designed form was used for this purpose (see below).

Selecting the sample and arranging access

Sixteen prisons were selected containing populations which were broadly representative of the male prison population as it existed at 31.12.89 (see Table 2.1 in appendix 4), whilst excluding those prisons which were to form the basis of the second, qualitative study. The first list of prisons was discussed with the Prison Service who requested two alterations. Table

1 (below) compares the sample and total remand and sentenced male prison populations as at 31.12.89.

Table 1

Comparison of sample and total remand and sentenced populations as at 31 December 1989

i. Adults

	Sample Population	Total Population
Remand	18.1%	18.5%
Sentenced	81.9%	81.5%
Remand: sentenced	1:4.5	1:4.4

ii. Under 21's

	Original Sample	Open Section* of Substitute YOI	All of* Substitute YOI Open & Closed	Total
Remand	27.1%	25.0%	22.7%	28.5%
Sentenced	72.9%	75.0%	77.3%	71.5%
Remand: sentenced	1:2.7	1:2.9	1:3.4	1:2.5

Source: Home Office: Occupation of Prisons, Remand Centres and Young Offender Institutions, and Police Cells on 31 December 1989.

* The columns refer to the substitution of one prison in the original sample by another similar establishment.

Collecting the information

The success or failure of this exercise depended upon the development of a form which could be used easily and quickly by staff in the establishments involved in the research to collect information about each incident that occurred. As both phases of the research were being run concurrently, it was necessary for the incident data to be collected for the researchers by hospital officers or medical officers locally. It was therefore necessary to design a form which could be:

a) used to collect useful and relevant data, sufficiently detailed to allow the team to achieve the research aim of improving on the quality of basic information available about the frequency and nature of attempted suicide and self-injury in custody, and

b) completed quickly, with a minimum disruption to staff's already busy routines and without the need to consult records additional to those already kept in the hospital.

The development of the draft form was informed by the experience already

gained on the young offender research, by knowledge of existing prison service and medical department forms relating to self-injury, and by discussions with prison hospital staff and with the project's Consultative Committee.

It was finally decided to collect information on the date and time of th incident; the location in which it occurred; the method(s) used; the typ of treatment any injury required (including number of stitches); the prisoner's reasons for the incident; action taken by staff; staff's understanding of reasons for the incident and their assessment of the le of risk it involved. The research also included background information o prisoners involved in these incidents: their age; status; their offences/charges; date of arrival in the currrent establishment; details any transfers and possible release dates; current and previous medical a psychiatric history and any previous involvement in self-harm or attempt suicide.

For most of these questions a considerable amount of time was spent devi check-list answers which staff could quickly tick (though always providi enough space on the form for them to add additional information if they wished). The officers were, after all, being expected to complete this an additional, voluntary task. They were asked to provide qualitative an to the two questions asking about reasons and risk assessment and to tho asking about relevant medical and psychiatric history.

Several versions of the form were discussed with prison staff during the day visits to the prisons (see below) and one establishment agreed to pil it. The development and refinement process resulted in a three-page form which collected sufficient information to provide a brief 'pen-picture' c each incident, which staff could complete by obtaining information from their colleagues, from the prisoner himself and from his Inmate Medical Record.

In addition to the incident form, a check-list (also used in the previous study), was taken to each establishment in order to provide a basic structure for the day-visits. It served as a reminder to collect as a minimum, sufficient information to provide a brief description of the location of and facilities at each establishment, average daily populatio and certified normal accommodation figures, information on receptions and discharges, the nature of the prisoner population and any particular features of the establishment or its population. Figures were also collected on staff numbers and on the numbers and types of specialist sta the establishment employed. It was also used to collect information abou the prison hospital, suicide prevention procedures, and establishment's recent history of suicides.

The data collection period for this phase of the research ran for twelve months, from 1 July 1990 until 30 June 1991.

B. The Intensive Study

This phase of the research provided an opportunity to extend the study already carried out amongst young sentenced prisoners to include a wider section of males in custody: adults and young offenders, both sentenced ar on remand. For a more detailed theoretical discussion of the choice of

methods employed, see Liebling, 1992.

Methods: an overview

Given the stated aims of the research: to study the social, environmental and situational aspects of attempted suicide and self-injury in prison, the intensive phase of the research was based around the long semi-structured interview, carried out within a context in which trust and openness were paramount. Interviews were carried out with two groups of prisoners: those who had recently injured themselves or attempted suicide and a comparison group selected at random from the prison roll. Separate interviews were also carried out with staff of all grades.

The team also held group discussions, attended prison meetings and discussed their research with as many people in the establishments as was possible. Long periods of time were spent observing and recording impressions of prison life; reading files, reports and documents, and collecting facts and figures about almost anything that seemed relevant!

Selecting the prisons

From the outset it had been anticipated that this part of the research would be conducted mainly in local and remand centres as they were known to experience the greatest number of attempted suicides and self-harm incidents and to have the highest turnover of prisoners. It was planned originally to carry out the research in four local and remand prisons, working in each for a period of up to six weeks. Four such establishments were selected, with one additional prison which could be used to pilot and develop the methodology and and schedules. The events of 1 April 1990 meant that one of these establishments could not be included. Moreover, Prison Service also asked for a training establishment to be included in the group. The establishments eventually selected are described in Table 2.

Table 2

Research establishments

Establishment	Type	Location	CNA	ADP
1	Category C training	East	584	520
2	Local + Remand	Midlands	391	565
3	Local + Remand	North	440	620
4	Local + Remand	North	642	900

1. Certified Normal Accommodation
2. Average Daily Population

Selecting the Samples

As indicated above, three groups of people were interviewed in this part of the study:

(i) prisoners referred to prison hospitals for treatment for self-inflicted injuries during the period of fieldwork, and those prisoners identified in prison records or by word of mouth as having injured themselves within one month of the team's arrival at prison (the subject group)

(ii) a comparison group drawn randomly from the general prison population, and

(iii) an 'opportunity' sample of all grades and types of staff.

The tables below show how these groups were distributed:

Table 3

Prisoners Interviewed

Establishment	CNA1	ADP2	Subject Group	Comparison Group	Total
1.	584	520	14	21	35
2.	391	565	21	24	45
3.	440	620	20	18	38
4.	642	900	8	16	24
Total	2056	2605	62	80	142

1. Certified Normal Accommodation
2. Average Daily Population

Table 4

Staff Interviewed

Institution	Total	Sample No. (%)	BGO	SO	PO	Hospital/ Nursing	Gov. Grades	Special-ists
1.	215	29 (13)	10	6	2	4	2	5
2.	275	33 (12)	9	5	2	8	2	7
3.	348	30 (9)	12	3	2	3	3	7
4.	540	38 (7)	10	7	2	7	4	8
Total	1378	130 (10)	41	21	8	22	11	27

1. Specialist staff included probation officers, chaplains, education staff, medical officers, instructors and a prison visitor.

The subject group was initially defined as comprising all those prisoners who had attempted suicide or injured themselves within a month of the researchers' arrival at an establishment, and all those who did so while fieldwork was being carried out in the prison. This group was identified by consulting wing and hospital staff and hospital records and by liaising

with the hospital on a regular basis. Occasionally, as the research became known in the prison, inmates would refer fellow prisoners or themselves.

This system worked well in the local and remand establishments. In the training prison (prison 1), fewer prisoners came into any of these categories. Consequently, the retrospective period was extended to include all inmates still in the prison who had attempted suicide or injured themselves within twelve months of the commencement of fieldwork.

Selecting the comparison group

The comparison group was selected randomly from the total prisoner population within each establishment. During the first week in each prison a print out of the daily roll was obtained from a staff member who had access to the LIDS (inmate data base) computer programme. This roll included details of the inmate's number, name, age, location, status, and where applicable, the length of sentence and release date.

In the light of estimates of the likely size of the subject group, it was decided to aim for 20 interviews in each prison with comparison group inmates. Different sampling fractions were therefore used to select prisoners in each establishment. In Prison A, for example, which had a roll of 541 prisoners, a 1/23 sampling fraction was used, in Prison C a sampling fraction of 1/50 on a roll of 625 prisoners.

Those who were likely to be released during the fieldwork period were deleted from the available population. A slightly larger sample than required was drawn in order to allow for 'loss': for example, members of this group might also have appeared in the subject group; some might have left the prison before the interview could be conducted, and so on. The sample was also checked for representativenes in terms of status, age and location within the prison making adjustments or re-sampling where the sample was skewed (for example, in terms of the proportion of remand to sentenced prisoners).

Prison 1, a training prison with a reasonably stable population, was sampled once only. In the other three prisons (the local and remand prisons, with rapidly changing populations), half the sample was selected at the beginning of the fieldwork placements and half at the mid-way point.

The resulting comparison groups are shown in Table 2.2 in Appendix 4, and Table 2.3 describes the general prisoner population.

Selecting the staff

In each establishment there were a number of key staff that had to be interviewed: the Governor, the (Senior) Medical Officer, the Hospital Governor or Hospital Principal Officer, the Chair of the Suicide Prevention Management Group, the Prison Chaplain and representatives from the probation and education departments. It was also necessary to carry out as many interviews as possible with uniformed officers: those in daily contact with prisoners on landings, wings and in the hospital. Given the complexity of shift patterns, day to day changes in staff deployment and staff absences due to holidays or sickness, it was not possible to select

staff on a completely random basis. They were therefore approached individually as they were encountered during the course of work in different areas of the prisons, making sure that all areas and grades were covered in a representative way. It was intended to complete between 30 an 40 staff interviews in each prison.

The interviews

a) The inmate interview

The adaptation of the inmate interview schedule from that used in the youn sentenced prisoner research was necessarily complex; it had to be appropriate for use with prisoners who ranged in age from the very young t 'pensioners' who would have had widely differing life experiences, and for people who could be at any stage in the custodial process: those remanded in custody for the first time to those coming to the end of a long life sentence. It also had to be retained in such a way that a prisoner's confidence and trust could be quickly gained and it had to be sufficiently flexible to allow a meaningful dialogue to develop.

The interview was divided into several sections, working chronologically through the prisoner's background and history, coming to the experience of custody, and focusing upon this experience and the prisoner's reflections upon it. It comprised:

1. Basic Demographic Details (age, ethnicity)
2. Criminal Justice History
3. Family History
4. Current Circumstances of Custody
5. Details of any Injury (for suicide attempt group only)
6. Coping in Prison and Any Thoughts of Suicide

The second section, separately designed for remand and sentenced prisoners, was used to collect information about the prisoner's current custodial history and experience. Those who were sentenced were asked to compare their experience of being on remand with that of being sentenced, where appropriate.

Those prisoners who had injured themselves or attempted suicide during their period of custody were asked about this in detail. Questions similar to those in the epidemiological study described above were asked, but in addition, this part of the research explored much more fully the prisoner's motivation, feelings and intentions; whether he had sought help for his problems before resorting to these actions, and whether help had been available to him. As much information as possible was collected regarding the circumstances surrounding the act, staff responses to it and his perceptions of those responses.

Finally, all prisoners were asked to complete a Hopelessness Scale, which had been found in previous research and in the young offender study to be a valuable indicator of suicidal ideation (See Beck et al., 1974; Beck et al., 1989, and Liebling, 1992)

b) the staff interview

This interview was again adapted from the previous study, and was intended to allow a meaningful dialogue to develop between researcher and staff member and to provide officers and others with an opportunity to discuss their experiences of and feelings about suicide and self-harm incidents in custody.

The interview began by asking staff about their career histories in the Prison Service, and moved on to ask about their current daily work; about which aspects they found most and least valuable and about their perceptions of a prisoner officer's role. They were asked whether they felt able to deal with suicide and self-injury, how they saw their own role in their prevention and management and whether they had received any suicide prevention training. They were asked to outline the procedures operating in their establishments for managing suicide risk, to discuss any problems in their operation and to suggest any improvements. They were also asked about the signs they thought might indicate that a prisoner was at risk of suicide and about their responses to such signs.

They were also asked questions about their own experience of suicide, suicide attempts and self-injury in custody, their feelings when they had to cope with these circumstances, and about the availability of and necessity for support for staff having to face these and other such incidents (see chapter six).

Section II: Carrying Out the Research

A. The Epidemiological Study

The Home Office Research and Planning Unit informed the Prison Officers' Association (POA), the Prison Governors' Association (PGA) and the Home Office Trade Unions (HOTUS) of the research, and arranged for a brief description of it to be included in Briefing No 28. They also contacted the governor of each prison included in the two studies, in order to explain the aims of the research and ask for their co-operation. All prisons agreed to participate and appointed a liaison officer to work with the researchers.

Throughout May and June 1990, each prison liaison officer was contacted and arrangements were made to spend a day in their establishment. Each day visit was organised (usually in advance) to allow a considerable amount of time in the hospital talking to staff about the research and about the management and prevention of suicide, gaining co-operation and discussing the best means of collecting the data. The draft versions of the incident form were shown to the staff and their comments were incorporated.

Each visit included a 'tour' around the establishment, meeting and chatting informally to as many staff and prisoners as possible about their experiences of suicide and about the research. During the course of these visits the information required to complete the check-list was obtained and the relevant departments were asked for copies of their regime monitoring figures throughout the research period.

After these visits, but prior to the data collection period, each liaison officer was sent a batch of incident forms, addressed envelopes for the return of completed forms and a letter confirming the research requirements.

Shortly after the data collection start date, one liaison officer enquired whether he should include in the sample a prisoner placed in the hospital because he was refusing to eat. It was then decided to collect information on prisoners who had been refusing food for more than three days and who were, therefore, located in the hospital for monitoring. The sixteen prisons were circulated accordingly.

Six weeks into the data collection period the Home Secretary announced that one of the sample prisons was to be scheduled for imminent closure. It was arranged with Prison Service for a substitute prison of a similar type to be contacted, visited and included in the research (See Table 1).1 An incident form was completed retrospectively for the one incident that had occurred in the substitute establishment during the initial six week period.

Each prison was subsequently contacted at regular intervals throughout the research year by a member of the team, either to thank the liaison officer for returned forms, to send further supplies or to check on nil returns. During the course of the research year, revisits were made to five of the establishments, in some cases because liaison officers had left and it was important to talk to their replacements, in others because it was clear that they were having difficulties collecting all the information. The researchers were also contacted by a number of establishments who wanted the team to talk to them about the research, about their suicide prevention procedures and, in one or two cases, about recent suicides which had taken place in their prisons. In one case it was possible to attend the inquest and in another the prison concerned sent full information on the prisoner and the circumstances of his death.

At the end of the data collection year return visits were made to each establishment. These visits enabled a number of tasks to be performed. Firstly, they provided an opportunity to thank all those who had helped the researchers during the year and discuss with them their experience of carrying out the research. Secondly, the opportunity was taken to check on the completeness of the information, as far as this was possible. The research had made heavy demands on the participating prisons and it had become clear as the year progressed that whilst some were doing all and more that could be asked of them, the team were not receiving all possible forms from some prisons.

There were a number of reasons for this. Some liaison officers had moved on to other jobs or prisons and it was often some time before it was possible to meet the new liaison officer. Liaison officers were not always aware of incidents that had occurred while they were off duty or on holiday. Staff shortages, and/or high workloads meant that staff were not always able to spare the time to complete the forms. Occasionally conflicts amongst different members of staff meant that information was not always passed on. Some prisons were simply poor at all record-keeping.

On revisits these problems were discussed with members of staff and checks were made in hospital occurrence books, ward registers, treatment books,

statistical returns and any other possible sources to try to ascertain how many cases had been missed. Where possible, incident forms were also completed retrospectively. These accounted for eight per cent of the total sample of incidents (see Table 3.4). Since the inmate had often left the establishment by this time, these were usually only partially complete.

It is clear that despite considerable time, resources and effort expended, by the team and by establishments, the information was not always complete, nor was it possible to say with certainty where the gaps were (see discussion in conclusions).

The information obtained on the initial and subsequent visits has been used to compile a brief description of each prison. These profiles, impressionistic as they are, provide an important context in which the problems posed by the requirements of the research can be seen. (see Appendix 3 and below).

B. The Intensive Study

(i) The Pilot Study

The draft interview schedules and methods of working were piloted during the first three weeks of July 1990 at the pilot prison, a large local and remand centre. Significantly, as it turned out, this establishment was still suffering from the aftermath of the riots referred to earlier.

The liaison officer had been asked to arrange an initial three-day induction programme for the team as this had proved in the earlier research to be the most useful way of familiarizing the researchers with the organization and layout of the prison, and of introducing themselves to staff and groups of inmates. This period was used to explain the research, how it was to be carried out and the help which would be needed. During this first week, arrangements were also made for information about the research to be included in the weekly 'in-house' newsheet, welcoming comments and suggestions from anyone who had them to make.

During this period three group discussions were held with prisoners, arranged via the education department. These sessions were particularly valuable for a number of reasons. First, they provided an opportunity to explain the research to numbers of prisoners at one time and to develop relationships with them. Working on the wings became a more comfortable experience when it was possible to recognize and acknowledge particular people. It also meant that group members could share with others on the wing their information about the research. Secondly, the team were able to discuss with prisoners some of the problems they faced (particularly as remand and adult prisoners by contrast with the previous research in YCIs).

The groups provided a wide range of information as they included first-time remanded prisoners and lifers who had spent many years in the system. Thirdly, they allowed the exploration with group members of their own experiences of suicide in prison. The results of these discussions were used to check that relevant and appropriate topics were being included in the interview schedule, and that the ideas were being expressed in the right language. Similar discussions were held in each fieldwork prison.

During this pilot exercise nine interviews were carried out with inmates, amending and adapting the schedules so to make them more suitable for use with adults. Ten members of staff were interviewed including specialists. The court escort team were also accompanied to the local Crown Court which provided the researchers with a valuable opportunity to observe prisoners' initial contacts with the custodial process and to learn more about the role of a prison officer and the (sometimes deplorable!) conditions under which they were expected to work and relate to prisoners (at that time).

(ii) The Sample 2 Study

Initial access to establishments had already been arranged by the Research and Planning Unit through the relevant prison governor who had, as discussed above, appointed a liaison officer for the research project. The liaison officers were usually involved in suicide prevention training or management in some way. The liaison officers were contacted in order to negotiate convenient fieldwork dates and to explain that the team planned to work for up to six weeks in each prison from Monday through to Thursday. (It was necessary to spend a day in the office each week so as to maintain progress on the epidemiological study.)

The fieldwork attachments were as follows:

Prison 1	November	-	December 1990
Prison 2	April	-	May 1991
Prison 3	July	-	August 1991
Prison 4	September	-	October 1991

Between each fieldwork placement contacts were renewed with the sixteen prisons involved in the epidemiological study (and with friends and families!), follow-up and final visits were made, and coding frames developed for the interview schedules and transcribed interviews.

In each prison the team were provided with office space, in different locations in each case: in the administration block sharing with a governo grade, in the hospital, in the visits block and on a wing. Each location provided different and valuable insights into prison life, and each had it own advantages and problems.

As in the pilot prison, each liaison officer was asked to arrange a three-day induction programme for the first week. They were also asked to announce the research through their local communication channels and to organize office accommodation and filing space for the researchers.

During the induction programme the team spent many hours talking to staff and prisoners, observing aspects of the regime and finding out about the facilities and special features of each prison. This informal stage allowed staff to get to know the team and allowed them to 'test out' their prison knowledge. Some saw the researchers initially as threatening outsiders who had little appreciation of the nature of their jobs, who were potentially hostile, and who were there to check up on them on behalf of the Prison Service. The induction programme provided an opportunity to dispel these misapprehensions.

Interviewing prisoners

Each interview with a prisoner was conducted on a one-to-one basis behind a closed door, and began with an explanation of the research and its aims. Prisoners' questions were answered and they were assured of the voluntary and confidential nature of the research. They were told that the researchers were unable to do anything for them as individuals, apart from listen. It was also explained that their conversations would be tape-recorded so that their views and experiences could be reflected accurately. Interviewing did not start until the team were happy that the prisoner felt relaxed and able to talk with some freedom. Each inmate was assured that if at any stage he wanted the tape-recorder turned off, or not to answer any question, he was welcome to do so.

Each prisoner was asked to complete the very simple 'Hopelessness Scale', (reading it out to him if necessary). Their reactions to and comments about this scale often provided an opportunity to answer other questions and develop rapport with the researchers. The researchers then moved on to asking the questions in the interview schedule itself. (The content of this schedule has been discussed above). Considerable attention had been paid to its order and structure; starting with less sensitive issues, moving forward gradually to the most sensitive and potentially distressing items, relaxing the tension again as the dialogue moved to a close. The structure was not adhered to rigidly, but followed where the prisoner led, providing him with the opportunity to expand and develop the interview as he wished. However, care was taken to ensure that all items were covered.

At the end of each interview, the prisoner was again asked if there were any questions he wanted to ask. At this stage many prisoners said how much they appreciated being able to talk to someone who was prepared to listen, who was interested in their problems and who treated them as individuals having something valuable to say, often shaking hands and thanking the researchers as they left.

Interviewing staff

Interviews with staff followed the same procedure as that outlined for prisoners above: the team explained the research, answered questions, assured respondents of the confidentiality of their replies and adopted the same methods of tape-recording and note-taking. As indicated above, particular attention had been paid to the structure and order of the questions in the staff interview schedule, but the interviewers were again happy to follow where staff led if this seemed more appropriate or more likely to encourage a meaningful dialogue.

Other data collection procedures

In each prison the team arranged discussions with inmates, attended meetings of the Suicide Prevention Management Group, and talked to members of the Board of Visitors. They also took advantage of any opportunity provided to talk to staff and inmates about suicide, suicide prevention, and prison life in general, or about the research in particular. They took part in many different activities and were able in two prisons to join the court escort teams for a day. All these experiences have informed the

descriptions in Appendix 3.

The use of records

It had been planned to consult prisoners' F2050 files and Inmate Medical Records (with the permission of individual Medical Officers). The latter were frequently consulted, but using the F2050s was much more problematic for a number of reasons. In the case of remand prisoners, they rarely contained any useful information. Those of sentenced prisoners were often little better. They were often located in a part of the establishment it was difficult to get to (particularly without keys). When they were used, they were often found to have inconsistencies in the information contained. When particular details were cross-checked with prisoners, it was not infrequent for them to turn out to be inaccurate. It was also found that the files of prisoners remanded or sentenced for serious and unpleasant crimes contained material that made quite a dramatic and unwelcome impact the researchers - importantly, an impact which was not borne out during the interview process. This 'disjunction' between the recorded impression of a prisoner and his or her appearance in interaction has been referred to in the earlier study (Liebling, 1991/1992). This point was even more relevant at the 'hard end' of the prison world. As a result of these problems, records were rarely consulted before interviewing. The time invested rarely paid off.

Organising and analysing the data

At the end of the fieldwork phase, coding frames were developed for the incident form and the interview schedules used in both pieces of research. The inmate and staff interview schedules were transcribed (in some cases, selectively). Quotations and examples of the kinds of responses given to each question were collected together thematically, and were used to inform and direct the material presented in the following chapters.

The interviews were coded and the data loaded onto a computer data base ready for analysis using SPSS-X.

The fieldwork and data analysis process took twenty-three months - slightly longer than had been anticipated. Two months were left in which to write everything up.

Section III: The Fieldwork Experience

The pilot exercise reaffirmed previous experience that both prisoners and staff were happy to talk to researchers, had a lot of information to share, and were often grateful to be given an opportunity to do so. As soon as the team started talking to staff, they found that they were particularly anxious to discuss their experiences during the recent riot that had taken place in the prison, during which a whole wing had been destroyed. Indeed, many of them had an urgent need to do so. They often asked how they could be expected to care for prisoners when so recently prisoners had been trying to kill them. Many staff felt that relationships between them and prisoners before the disturbances had been very positive, and that much had been done in the recent past to improve regimes and provide help and

support for prisoners both at an individual level and through the development of group work. Staff were now finding it extremely difficult to carry on working positively in the aftermath of what was by all accounts a major series of disturbances. They expressed some resentment about what they saw as a lack of support from the Prison Service and they were cynical about the outcome of the inquiry which had recently been set up under the chairmanship of Lord Justice Woolf. Staff made a point of showing the debris of their destroyed wing, and the team were encouraged to visit a neighbouring establishment which had suffered even more extensive damage. The impact of these sights will always be unforgettable.

Following these discussions and as a result of similar conversations which had taken place during visits to the sixteen prisons in the epidemiological study, the staff interview schedules were amended to explore in more detail the issues of staff problems, staff stress, and support for staff. It was clearly inappropriate to expect staff to discuss prisoners' problems and prisoner suicides without also providing them with an opportunity to express their own concerns.

At the conclusion of the pilot study the team had a much clearer idea of the problems of working in a busy, local establishment and what it would be feasible to plan to achieve. Equally importantly, they had learned to work together as a team and to rely on each other for support.

The second phase of the research - the intensive study - absorbed most of the available time and energy throughout the two years devoted to the project. In every establishment the team were received with great courtesy by most of the staff and prisoners. It was appreciated that it was not always easy for establishments to accommodate the needs of researchers. All five of the prisons were able to meet the team's requests for interviews, to facilitate integration into the establishment and to answer questions ungrudgingly.

Fieldwork experiences in each prison were very different. In one, the training establishment, the team were issued with keys and were able to move about freely. In the three local and remand establishments it was necessary to rely on prison officers for escort, and the best times to ask for this help were quickly learned. The advantage of having keys was being able to move around the prison at convenience and arrange interview appointments easily. The advantage of not having keys was the ability to chat to staff informally as they accompanied the team and to prisoners as they waited for an officer with a key to arrive. The shared situations were helpful in breaking down barriers.

Those who have worked or carried out research in prisons know only too well that talking to prisoners about their relationships, their lives and their problems can be a difficult and sometimes distressing task for both interviewee and interviewer; this was especially true of the present research, which set out explicitly to 'uncover' some of the most distressing moments of life in prison. It was important for the success of the research and for the well-being of all concerned that this task was carried out with sensitivity.

On a number of occasions the team saw for themselves the kind of abuse that prisoners on Rule 43 have to cope with. During interviews carried out within view of others (eg in offices with glass partitions), or when

walking with prisoners on Rule 43 through crowded landings and corridors, (accompanied by staff), the prisoners were often taunted and occasionally threatened. Sometimes prisoners would return from exercise, banging on the glass windows of the small interview room that was being used, shouting abuse at the prisoners being interviewed. This was difficult and raised questions about the relative legitimacy of inviting such prisoners to participate in the research. They were often especially pleased to do so, having few opportunities to communicate elsewhere, but the discomfort this exposure put them through was unpleasant for the researchers. It was also difficult to maintain equilibrium and professional detachment on the not infrequent occasions when a prisoner would pull up his shirt sleeve to show a gaping wound several inches long, or when an elderly recidivist might open his shirt and roll up his trouser legs to reveal a criss-crossed mass of scar tissue: the result of many years of self-harm. Neither was it easy to carry out a meaningful dialogue with an inmate who had been fetched straight from a protected room and was dressed only in a towel or an ill-fitting dressing gown. Despite these sorts of difficulties, most of the interviews were successful.

Although some of the staff were initially hesitant about being interviewed, often using lack of time as their reason, it was usually found that once they had become involved they were prepared to discuss issues freely and frankly, often devoting much more time than they had originally intended. A few members of staff shared details of their own attempts at suicide or those of close family members and some became quite distressed when talking about these events, as did others when describing their stress-related and other experiences (see chapter six). Every effort was made to allow time for staff to recover from these feelings before they returned to their daily routines. At the end of the interview most staff commented on how useful and interesting they had found the experience, often thanking the researchers in the same way as prisoners. Several commented on the fact that the 'macho' prison culture normally inhibited the expression of the kind of thoughts and feelings which they had shared with the team.

The team emerged from the research with a strong commitment to the staff and prisoners who had opened so many doors for them, who had poured out their life histories and shared their most private and individual inner worlds with them. The researchers began to share their concerns, and to develop a stake in seeing a future more in line with mission statements than had been seen in places during the course of the research. It was satisfying to notice that since the early days of the first study - back in 1987 - the atmosphere was different. It did not escape notice that a very real and imaginative commitment to suicide prevention was filtering out of Prison Service headquarters, and beginning to make its presence felt on the ground.

Footnotes

1. The substitute YOI had both an open and a closed facility. No incident forms were received from the open facility, but it was decided to include the closed facility in the sample, as prisoners thought to be at risk of suicide were occasionally transfered there.

2. Two prisoners chose not to be interviewed. Three prefered not to be tape-recorded, and full and detailed notes were taken instead.

CHAPTER THREE

SUICIDE ATTEMPTS AND SELF-INJURY IN SIXTEEN PRISONS

A good grasp of the statistical background is indispensible; it will not show whether a given patient is dangerously suicidal or not, but it will inform clinical judgement as one weighs the importance and availability of sustaining resources for each case that comes for evaluation. (Maltsberger, 1986: 99)

Introduction

As outlined in the previous chapter, a major aim of the research project was to provide epidemiological data on the nature and extent of suicide attempts and self-injury occurring in prison establishments. Such data has been poorly and haphazardly recorded in the past. The first phase of the research aimed to improve upon existing data and to provide a statistical and descriptive picture of incidents occurring over a period of one year in a large sample of prisons. A description of the establishments included in this phase can be found at Appendix 2.

Altogether, 343 completed incident forms were received from the 16 prisons taking part in the Sample 1 phase of the research between 1 July 1990 and 30 June 1991. Thirty eight of these incident forms involved apparent threats of self-harm or suicide rather than injuries and were therefore removed from the analysis.

The remaining 305 incidents were distributed as shown in Table 3.1 (Appendix 4). In 19 per cent of cases (n=57) an incident form was received following a repeat incident involving a prisoner already in the sample (see Table 3.2). Two sets of data were therefore available for analysis, the first looking at incidents (n=305), the second at prisoners (n=248).

Table 3.3 shows the distribution of incidents by type of prison; no incident forms were received from either the Adult or YP Open prisons included in the sample.

Incident forms were normally completed by a member of the hospital staff (Table 3.4), but in eight per cent of cases (n=25) they were completed by a member of the research team on one of their follow up visits to establishments. The information required was extracted from files and hospital occurrence books, often a considerable length of time after the incident had occurred. This time delay inevitably reduced the availability of relevant data, as records were not always complete, and the prisoner had usually moved on.

Half of the incident forms were completed within two days; almost two thirds within a week of the incident (see Table 3.5)

The Prisoners

(i) Age

It was possible to calculate age at date of incident for 242 of the 248 prisoners. Some 43 per cent of those involved in acts of self-harm were under the age of 21 (See Table 3.6). (The youngest prisoner was 14, the oldest 65). There was clearly an over-representation of young prisoners in the self-harm group, who made up 17 per cent of the average daily population of male prisoners and 31 per cent of annual receptions.

(ii) Status

The data also confirmed the great over-representation of remand prisoners in the self-harm population. Forty per cent (n=98) of the sample were on

remand compared with only some 20 per cent of the prison population (see Table 3.7).

(iii) Length of sentence

Information on length of sentence was available for 128 of the 130 sentenced men. Most were serving between four months and four years. There was some over-representation of those serving less than eighteen months and those serving over 4 years but this was not statistically significant. (Table 3.8). Eight prisoners were serving life sentences.

(iv) Offences and charges

Table 3.9 shows the main offences which the sample had been convicted of, or charged with. A breakdown of the distribution of offences for the general sentenced population as of 30 June 1990 is included, which enables comparisons to be made with the sentenced part of the sample population. The distribution of offences is broadly similar. However, it is possible that the general population of the sample prisons is not truly representative of the general prison population. Technically, the sample of establishments provided a representative sample of prisoners (see Table 2.1). In reality, however, prisons differ so markedly even within type and security category, that these comparisons should be treated cautiously.

The Incidents

This section mostly refers to incidents rather than prisoners, as the location, method and timing of self-inflicted injuries is of primary interest.

(i) Method

Table 3.13 shows that cutting wrists (across) was the most frequently used method of self-harm (38 per cent, n=117). Cutting of all types (including cutting wrists lengthways and cuts to other parts of the body) was a method used in 77 per cent (n=234) of the incidents. Hanging or self-strangulation was used in 18 per cent (n=54) cases. Other methods included setting fire, overdosing, swallowing razor blades, food refusal and placing a plastic bag over the head. A number of prisoners had used several methods in a single incident.

(ii) Timing of incident

Self-harm incidents were evenly distributed throughout the week but not over the course of a day (see Tables 3.14 and 3.15). Thirteen per cent of the incidents (n=39) occurred (or were reported) during the early hours of the morning (between midnight and 8 am); a further nine per cent (n=28) occurred (or were reported) during the morning (being discovered between 8 am and mid-day). Hourly rates were also at their lowest during these periods. Some 40 per cent occurred or were discovered between 5 pm and midnight, a quarter of all incidents occurring or being discovered after 8 pm. Hourly rates were at their highest during this period. Information on the timing of 16 incidents was unavailable or not applicable (eg. food refusals, or multiple injuries).

The highest number of incidents per month, 12 per cent each occurred in July and August respectively (see Table 3.16). The lowest figures of 6 per cent per month (17 incidents) were recorded for both February and March. Whilst this distribution has been found in related research (Dooley, 1990a) the pattern shown here may be related to changes in establishments' interest in recording information as time went on and as establishments were re-visited or phone calls were made to maintain contact.

For 124 of the 130 sentenced prisoners for whom incident forms were available, it was possible to calculate the time interval between the date of the (last) incident and the date the prisoner received his sentence, as shown in Table 3.17. From this table it can be seen that just less than a quarter of incidents among sentenced prisoners had taken place within one month of sentence, 36 per cent within two months and 44 per cent within three months. It confirms the general picture that self-harm episodes are likely to occur relatively early in sentence.

This result was confirmed by looking at EDR (Earliest Date of Release) information which was available for 105 of the sentenced cases. Over half (n=63) of these incidents occurred amongst prisoners who still had more than 6 months left to serve, and 30 per cent (n=30) occurred amongst those who had six months or less to serve. (Table 3.18)

To some extent, the tendency of prisoners to self-harm earlier, rather than later, during sentence might have been an artifact of the impact of the custodial experience itself, rather than the effect of the sentencing experience itself. For taking the sample as a whole (ie including remand as well as sentenced prisoners), 18 per cent of the incidents had occurred within one week of arrival at the establishment (which was largely equivalent to their custodial experience), 31 per cent within 3 weeks and two thirds within 12 weeks (see Table 3.20).

(iii) Location

Self-injuries and suicide attempts took place in all areas of the prisons: including cells, work areas, landings, recesses and unfurnished rooms. Most occurred on 'normal locations': a third in 'ordinary location' single cells and over a third in shared cells. Fifteen per cent of incidents (n=44) took place in the hospital (24 of these - over half - occurred in single or unfurnished rooms - see Table 3.21).

(iv) Risk and Type of treatment

A suicide risk referral form (F1997) had been completed in almost half of all cases (see Table 3.22). The range of treatment administered for the injuries inflicted was broad, suggesting that the sample of incidents reported to the researchers included a wide spectrum in terms of the degree of risk to life. In just under half the cases reported (48 per cent, n=139) little or no medical treatment had been given. On the other hand, 8 per cent (n=24) required transfer to outside hospitals, indicating urgent and grave injuries. In an additional five per cent of cases (n=14) transfer to a prison with full medical facilities was required (see Table 3.23).2 Cf those 37 prisoners needing stitches, three required between one and five , 11 received between six and 19 stitches, and nine had 20 or more, including one prisoner whose wounds required over 100 stitches. Steri-strip was applied in the remaining 18 per cent (52) cases. In a small number of cases

the prisoners concerned refused stitches.

(v) Action taken

Forty five per cent of the incidents of attempted suicide or self injury, were dealt with by placing the prisoner in 'seclusion/unfurnished' rooms; 23 per cent (n=67) were located in single rooms in the hospital and nine per cent (n=27) were accommodated in hospital wards or shared rooms (see Table 3.24).

In 16 per cent (46 cases) the prisoner was placed on 'special watch'. Information about the location of the special watch was provided for 44 cases; half of them (22 cases) were located in hospital rooms and a further 20 per cent (9 cases) were located in unfurnished hospital accommodation. In three cases a special watch was carried out in the segregation unit. Special watches appear to have been ordered on ordinary location in only eight cases.

Information on the use of shared accommodation was available for 296 of the incidents. In 10 per cent of these cases (n=28) the prisoner was placed in shared accommodation (see Table 3.24); in 12 of these cases he was accommodated on ordinary location; in the remaining cases for which we received information shared accommodation was provided in the hospital (three cases) and the segregation block (two cases).

In 29 per cent (n=87 cases) of the 296 cases for which information was available, the prisoner was referred to a psychiatrist. Other action taken included referrals to the Medical Officer (MO), referrals to counselling, welfare and social services, a change of job, a referral to Grendon, and in one case a 'bully' was removed from the wing; in another a prisoner's medication was changed.

(vi) Current and past psychiatric and related history

In this section, information relates to prisoners rather than to incidents.

Forty-five per cent of the prisoners in the sample had injured themselves or attempted suicide before (see Table 3.25). In almost half of these cases, this had happened on more than one occasion (see Table 3.26). Two thirds of those who had injured themselves before had done so in custody (see Table 3.27). Of those who had injured themselves in custody before, 14 per cent had done so within one week of the current incident reported to us (see Table 3.28). Over a quarter had injured themselves within four weeks of the current injury. Three of the previous incidents had occurred in police cells.

Over a third of prisoners were in receipt of medical or psychiatric treatment at the time of their self-injury (see Table 3.29). Some were current hospital patients. Almost a third had last seen the Medical Officer within the seven days preceding their injury (see Table 3.30).

(vii) Risk indicators

Respondents were asked to give brief details of any medical history they considered relevant to the current incident. The results for both prisoners and incidents can be seen in Table 3.31. In over a third of cases a

history of suicide attempts, self-injuries or threats was mentioned; in 15 per cent of cases there was a comment about the previous psychiatric history of the prisoners and in 14 per cent of cases there was a comment about possible or diagnosed psychiatric conditions - depression, claustrophobia, and 'thought disorders' etc. In 11 per cent of cases reference was made to personality disorders or characteristics, eg 'childhood history', 'temper tantrums' and 'residential care'. 'Other possible risk indicators' included comments such as 'death of mother', 'being bi-sexual', 'having been difficult in the past', 'not taking drugs' and 'being non-English speaking'.

Several questions were asked about the history and medical background of each incident, with particular reference to information which may have indicated a degree of risk to the staff on reception. On many forms a combination of factors were mentioned. Some of the information received was insightful, professional and valuable. Other comments were unprofessional and unhelpful. Direction and training in the selection of information to record might be helpful. Examples of the information recorded in this section are:

> Long history of mutilation. This is often prompted by his mother in letters. His mother also has a history of indulging in self-mutilation. (Case 65)
>
> Returned from psychiatric hospital as they were unable to cope with his behaviour. (Case 17)
>
> Twin brother cut wrists some months previously in HMP Frankland; claimed claustrophobic architecture affected him. Manipulative - wants transfer to Wakefield where his brother is. (Case 33)
>
> Claimed to have taken drugs, cannabis, hooch, LSD. (Case 34)
>
> No serious illnesses except appendectomy. Gunshot wound to head; stab wound to shoulder. Psychiatric report 1989 - Rochester Prison. Suffered depression - family problems. Seen by child psychiatrist for behavioural problems. (Case 58)
>
> Hearing problems. Low intelligence. Homosexual. (Case 59)
>
> Suffers from Kleinefelters syndrome and has moderate gynaecomastia. Many past attempts at suicide and self-injury. Has been on R43 and in hospital. Has been bullied, attacked and raped by other inmates. Has had surgery for above conditions. (Case 62)
>
> An inadequate personality very immature, possibly finds difficulty in coping. (Case 77)
>
> Long standing schizophrenic. Recent transfer under S47 MHA to NHS Secure Unit for 4 months. Cut wrists previously. (Case 147)
>
> He has a long history of mental illness. An inadequate young man who has no insight into his problems. (Case 143)
>
> Under considerable stress. Domestic/appeal/involved in Manchester Prison riot and its aftermath. (Case 174)

Very immature 14 year old. Very manipulative. Resorts to crying and tantrums to get his own way. (Case 197)

Reasons and intentions

Respondents were asked what reasons prisoners gave for their actions and what reasons and intentions they themselves attributed to the prisoners' actions (see Tables 3.32). (This analysis is limited, and 'reasons for suicide attempts and self-injury' are explored in more detail in the intensive study, reported in the chapters to follow).

Not surprisingly, staff were more much more likely than prisoners to try and explain prisoners' behaviour in 'strategic' terms: ie to describe it attention seeking, manipulative, an attempt to change location, to change job etc. Even less surprisingly, they were much more likely to mention th inmates' personal inadequacies as reasons. On the other hand, prisoners were much more likely to mention the role of depression in their behaviou Otherwise, both staff and prisoners were (both) most likely to mention 'situational' reasons as motivating self-harm behaviour - basically the impact of custody and the nature of the charge, coping problems (bullying victimization etc), and 'system frustrations' such as failure to get bail

Some examples follow of the kinds of reasons given by respondents on beha of prisoners and their own views about the incidents:

Case 273

Visits by girlfriend difficult because of location. Missing parents. Threatened by inmates. Panic response to get back to Hull. (prisoner)

Not a serious attempt. Means of getting back to Hull. (staff)

Case 279

Arranged marriage he does not want - he has a girlfriend he wants to marry. Family problems as well. (prisoner)

Quite a lot of family problems but they are beginning to be sorted out. I think after the visit next week he should be clearer in his mind about his own destiny (staff)

Case 002

Wants to prove his innocence. Protest against his conviction. (prisoner)

He is not clinically depressed. He is not expressing suicidal ideas. His hunger strike is a manipulative gesture. (staff)

Case 012

Depressed because his father died in May and also had his parole turned down. (prisoner)

Depressed because of his father's death and his parole being turned down. I felt as if he was seeking attention more than attempting suicide. (staff)

Case 013

States had no exercise for 6 days and is fed up with being in his cell (prisoner)

I do not think [this prisoner] intended to kill himself. In my opinion he was seeking attention as he is a known and persistent nuisance. He is very immature and his behaviour is generally intolerable. (staff)

Case 042

Refused toothbrush by night staff (prisoner)

Fit of pique. No risk. (staff)

Case 064

Says he cannot handle it on the wings being bullied (prisoner)

Superficial scratches to wrist and forearms. Says can't handle it on wings. Used to bully now being bullied (staff)

Case 061

Says this was done because he does not want to lose contact with his mother (prisoner)

This is the third time in two months that this inadequate lad has pretended that he is attempting suicide. These gestures are patently manipulative. He alleges that the discipline staff ignore his appeal for help. What he is trying to do is get back to [wing]. Not a medical problem - disciplinary. (staff)

Case 079

He had not seen his daughter who was turned away from the prison (prisoner)

Spur of the moment because his daughter was turned away from the prison. Risk of suicide - definite risk. (staff)

Case 112

Let down family and friends with offence. (prisoner)

Intended suicidal attempt because of offence committed. Feels depressed as he has let mother and family down. (staff)

Differences Between Adults and Young Prisoners

As is shown in later sections of the report, there are important differences between adults and young prisoners (and other types of prisone - see chapter eight) in relation to suicide risk and self injury. Data fc young prisoners (under 21) and adults were therefore analysed separately i order to see whether any consistent and significant differences emerged.

106 incident forms for young prisoners and 136 for adults were received. - an average of nine forms per month for young prisoners and 11 for adults. Half of the young prisoner incidents had occurred in single cells (compare with 27 per cent of adult incidents, $p<.002$),

Significantly fewer of the young prisoners required or received treatment (including hospitalization) for their injuries (34 per cent compared with 68 per cent of adults). This difference in degree of seriousness of injuries may explain why more adults than young offenders were located in hospital ward following the incident (15 per cent compared with 5 per cent).

Half of both groups had injured themselves before, two thirds of the youn prisoners and three quarters of the adults several times. Slightly but not significantly more of the adults had used overdosing (11 per cent), hangi (7 per cent) or several methods previously (30 per cent). Fifty seven per cent young prisoners and 46 per cent adults had cut themselves before. In three quarters of both groups, previous incidents had taken place in custody.

Rather more of the adults had received previous psychiatric treatment and had been in receipt of medical or psychiatric treatment at the time of th incident. Similarly, more of the adults were indicated as having a psychiatric illness or borderline psychiatric condition relevant to their suicide risk. Slightly (but not significantly) more of the adults were noted to be withdrawn or depressed on completion of the incident form.

As can be seen from the following table, adults were more likely than young offenders to be classified as immediate suicide risks.

Table 1

Risk assessment

Age group	Suicide Risk		Possible Risk		No Risk		Total
	No	%	No.	%	No.	%	
Young Prisoners	16	(16)	51	(50)	36	(35)	103
Adults	37	(28)	56	(43)	38	(29	131
Total	53	(23)	107	(46)	74	(32)	234

For adults, the break up or threatened break up of a relationship was indicated more frequently as the main reason for self-harm by both prisoners and staff. Bullying and victimization were more frequently indicated for young prisoners (see Table 2).

Table 2

Reasons given for incident

Reason	Adults				Young Prisoners			
	inmate		staff		inmate		staff	
	No	%	No	%	No	%	No	%
Break Up/Threat Break Up Rel.	20	(16)	16	(13)	6	(6)	3	(3)
Bullying/ Victimization	10	(8)	10	(8)	28	(27)	24	(24)

Inability to cope and personal inadequacies were more likely to be indicated by staff as reasons for young prisoners' incidents than adult incidents - confirming the findings of the earlier study (Liebling, 1992) that for young prisoners (both remand and sentenced), problems of bullying and coping are of major significance. Such problems are also significant for adults, but in smaller numbers. For adults, reasons relating to the offence, sentence length and domestic problems may be more significant, although placing all adults in one group may be masking important differences between them. These patterns will be explored in detail in the interview study (see especially chapter eight).

Summary

One of the limitations of the data presented in this chapter is its incomplete nature. Not all incident forms were received from all establishments: cross-checking with local sources of information and record-keeping (such as Hospital Occurrence Books) suggested that the data was more complete for some establishments than for others. In the case of

some of the larger local and remand prisons, it is estimated that less than a third of the expected number of incident forms were received (based on records compiled locally for the research year). The forms that were received were not always complete or the information was insufficient for analytical purposes. Consequently, despite considerable time and effort invested in the task, both by the team and by individuals in the establishments concerned, there is still no complete epidemiological picture of the nature and extent of self-injury in prison. Indeed, because of the very nature of self-harm behaviour - and the problems which people have in defining and reporting it - it is possible that no really complete epidemiological picture will ever emerge.

Two specific qualifications to the data presented in this chapter also need to made: firstly, those establishments failing to complete incident forms for all incidents were likely to be those with the highest number occurring in them. It was in these prisons that time, staffing and other resource constraints were most pressing. Secondly, while every effort was made to select a representative sample of prisoners from a representative sample of prisons, it is always possible that the final population was not fully typical of the larger system.

Nevertheless, given these caveats the following picture emerges:

- Just over half the prisoners (52 per cent) involved in the incidents were 21 or under (the youngest was 14 and the oldest 65), despite the fact that young offenders make up only about 18 per cent of the prison population

- 48 per cent of the sample were remand prisoners (compared with 21 per cent of the prison population) and 52 per cent were sentenced (79 per cent).

- Not surprisingly, most of the incidents (60 per cent) were reported from the local and remand centres amongst the 16 establishments, 20 per cent from the young offender establishments, and about 20 per cent from the training and dispersal prisons. No incidents were reported from the open prison establishment in the sample.

- There was no over-representation of short or medium sentence prisoners. Only very short sentence prisoners (4 months or less) appeared to be over-represented - possibly a reflection of the disproportionately large numbers of under-21s in the sample. Long sentence prisoners were slightly under-represented.

- The sample's pattern of offences (and charges) was not dissimilar from the prison population. Sex and violence and robbery offences were more or less in proportion to the prison population while only arson and criminal damage appeared to be significantly over-represented - although the overall number of such offenders in the prison population is small.

- Incidents tended to occur earlier, rather than later, during the sample's custodial experience.

- Only 26 per cent of the sample had been identified as being at some risk of suicide at the reception screening interview.

- Most self-injury involved wrist cutting, but a significant group used

hanging as a method.

- Almost half of the sample had injured themselves before - a quarter on more than one occasion. Two thirds of those who had injured themselves before had done so in custody - 14 per cent within one week of the current incident.

- About half of those prisoners who injured themselves in the sample were placed in seclusion (protective custody) as a result. Less than a third were referred to a psychiatrist.

- 32 per cent of the sample had seen the prison medical officer less than seven days before the incident.

- 34 per cent per cent of the sample had been receiving medical or psychiatric treatment at the time of the current incident.

- In many respects staff and prisoners shared the same views about the reasons and motivations why prisoners self-harm. Not surprisingly however, staff were more likely to mention attention seeking and manipulation as possible motives.

Footnotes

1. Or were recorded. It is likely that there is some time delay between the incident and its discovery. This may vary, both between establishments and according to staffing levels/time of day. It is likely that staff record time of discovery on incident form, rather than the time of incident - this will be difficult to know precisely. For the purposes of research the time the incident was carried out is actually the more valuable piece of information.

2. Type of treatment administered. It is important to note here that 'type of treatment administered' will not always reflect the nature or degree of injury. Stitches are not always given (or accepted) when medically required, and transfer to prison hospital with full-time medical facilities is not always on medical grounds (alone).

CHAPTER FOUR

TALKING TO PRISONERS: A DESCRIPTION OF THEIR LIVES AND AN ACCOUNT OF THEIR PRISON EXPERIENCE

> How life's experiences are perceived, coded, organised, and understood is the basic clue to the explanation of why a person acts to end his existence. (Jack, 1992: 44)

Introduction

This part of the report builds upon the results of the previous study of suicide and self-injury amongst sentenced young prisoners (Liebling, 1991; 1992). In that research it was shown that young prisoners showing a distinct vulnerability to suicidal thoughts and behaviour during a sentenc could be differentiated from other young prisoners by the extent of the background deprivation they reported, and by their inability to cope with or make constructive use of their sentence. It was shown that the most vulnerable inmates could often be found in the worst situations in prison, many having no job or activity, and many receiving little contact from their families. They made few friends, experienced more difficulties with other inmates, and described their prison experiences as particularly distressing. The research showed how the combined effects of hopelessness, their histories, their perceptions of the experience of imprisonment, and their inability to generate solutions to their problems, could propel them towards such behaviour. Situational triggers could be decisive in a suicide attempt at different thresholds, depending on the prisoner's vulnerability and the level of stress he or she experienced. Young prisoner suicide was shown to be much less of a psychiatric problem than is commonly supposed and more a problem of coping.

By emphasising the importance of coping behaviour, the research also emphasised the limitations of the medical/predictive model of suicidal behaviour (see Liebling, 1991; 1992; Jack, 1992; Neal, 1992 pers. comm.) which tried to predict such behaviour largely from a knowledge of the personal and behavioural characteristics of the prisoners themselves. The current research has confirmed the validity of that approach, despite the more complex population being studied. The 'poor coping' theory carries an important and dual message: firstly, that prisoners are - in many ways - a uniquely vulnerable group; and secondly, that staff hold the key to their safe and humane custody, and to the minimisation of suicide risk in this context.

The following chapter presents the findings of the research with regard to suicide risk: who may be susceptible, in what circumstances and why.

AN OVERVIEW OF THE RESULTS

A total of 142 interviews with prisoners in four establishments were carried out. 62 were in the 'suicide attempt' group and 80 were in the comparison group. Their ages ranged from 16 to 54.

As found in the earlier research on young sentenced prisoners, most of the socio-demographic characteristics investigated failed to distinguish significantly between the 'suicide attempt' group and the comparison group drawn randomly from the general prisoner population. On the other hand, questions about prison experience produced significant and consistent differences between these two groups, despite there being a wide variety of prisoners (remand, sentenced; young, adult; long sentence and short; etc.) in the sample, and despite the interviews having been carried out in different types of establishment.

The following table summarises the differences and similarities between the two groups (* $p<.05$; ** $p<.02$; *** $p<.01$; **** $p<.005$; ***** $p<.001$).

A Vulnerability Profile

Criminal Justice History

age****
adult sex offenders*
drugs related to offence*
remand for sentenced group*
number of cautions****
number of parole refusals*

Background

'Dear John' from girlfriend*
how long lived in same area*
why truanted from school***
reason for placement in local authority care***
bullied at school**
number of jobs in two years before prison*
family psychiatric history*
previous psychiatric treatment (and reason)*
child sexual abuse*****
previous self-injury (several)*****

Current Custody

location in shared accommodation*****
having a job in prison***
level of pay***
whether do PE*
how spend time in cell*****
whether 'Active' in cell****
bored at weekends*
what can do about being bored*****
how mix in prison (on own)*
difficulties with other inmates**
relationship with staff**
in what ways staff are helpful (personal ways)*****
in what ways staff could be more helpful***
use of protective custody*****
length of time spent in isolation (and how felt about)*
reason for isolation*****
use of Rule 43**
contact with/referred by wing to hospital/psychiatrist*****
views about hospital*****
current medical treatment*
previous self-injury in prison*****

Family and Outside Contacts

Few letters written/received*
Would like to receive/send more letters***
Would like more visits***

Thinking about outside makes custody harder****
Does not keep in touch with current events*
Does not read paper/watch news**
No release plans*****

Coping With Custody

whether using sentence constructively***
thinking about the past**
not hopeful about release***
persistent problems sleeping****
serious thoughts/attempts at suicide*****
how tell if others' attempts are serious*
experience custody as difficult (and reason)***
Main difficulties face***
Hopelessness Scale*****

It can be seen from the above summary table that the types of variables most able to distinguish between the subject and comparison groups relate to the current prison situation, rather than the criminal histories or background characteristics of the prisoners.

To a large extent, prisoners share the characteristics of multiple contact with criminal justice agencies and multiple family and educational deprivation. Once in prison, it is their perception of a whole range of aspects of custody that differentiates between the two groups. This division is neither absolute nor uncomplicated (see account below), but it is a useful place to start formulating an understanding of suicide risk.

THE CHARACTERISTICS OF THE SAMPLE

The following account looks in some detail at the characteristics of the sample.

Age

Young prisoners were significantly over-represented in the subject group (see Tables 4.1 and 4.2).

Ethnicity

85 per cent of the prisoners in the sample described themselves as 'white British', 5 per cent described themselves as 'other European' and 4 per cent described themselves as 'black British'. In line with other studies, (particularly American studies such as Hayes, 1983) the proportion of black offenders in the subject group was less than in the comparison group - but the overall number of black prisoners in the sample was too small for this difference to be statistically significant (see Table 4.3).

Psychological characteristics

The subject group scored significantly higher on the 'Hopelessness Scale' (an instrument for assessing likelihood of suicidal behaviour) than the comparison group: well over half scored more than nine - a score that has a well-established association with suicide risk. Perhaps equally significant however is the finding that a fifth of the comparison group also scored more than nine (see Table 4.103). Significantly more of the subject group also reported themselves having major problems sleeping:

> Yes, thinking about my family problems and other problems; things like that. (SG)

Offence

Adults charged with or convicted of sexual offences were significantly over-represented in the subject group (see Table 4.7). (The large number of adults in both groups, who were charged with or convicted of sexual offences, was in part due to the population of the (specialist) training prison. There were no differences in the types of pleas reported or in the type of court elected (see Tables 4.8, 4.9 and 4.10).

The Influence of Alcohol and Drugs

A significant proportion of both groups said that alcohol or drugs had affected their offending behaviour ('It lowered the threshold'; 'Yes, it boosts the system a bit'; 'the violence, yes'). However drugs (usually cannabis, cocaine and 'crack', but also heroin, and 'downers'), were significantly more likely to be reported as a contributory factor by the subject group than the comparison group, particularly by the young offenders in the sample (see Tables 4.11 and 4.12).

Experience of criminal justice system

(a) Police custody

Most prisoners had had some experience of police custody, the majority describing it in negative terms (Table 4.14 and 4.15). The cells were 'grim', 'depressing', 'rough', and 'dirty'; the experience was 'frightening', 'horrible' and 'shattering'. There were no significant differences between the two groups in the way they talked about their experiences:

> Hell, sheer hell. I tried to hang myself in the cells with a bootlace. I finished up with a sore neck and the bootlace broken. (SG)

> Horrible. You're in a cell by yourself and you're frightened. (SG)

> It's like having your whole life torn in shreds. I roared my eyes out. They won't spend an ounce of time with you, it's stupid. (SG)

> It was the first time I'd been behind the door for so many years, you know, since I was about 17 years old and that frit the life out of me to be honest with you. I've never been so scared in my life, didn't know what to expect, you know. (CG)

One or two reported that they had been well treated and that the food was better, or that visits were easier than in prison, but apart from these (localised) exceptions, the experience of police custody made grim reading.

(b) Remand on bail

Half of the prisoners had been granted bail at some stage. Most broke it - by re-offending or by breaching the conditions. One or two did not turn up at court ('the wife'd just had a child, you see, so I thought, well I'm not going to court, because I want to see that kid grow up.'). Table 4.17 shows why prisoners had been remanded in custody for some or all of the pre-sentence period. There were no significant differences between the two groups.

(c) Remand in custody

It is recognised that the disproportionate number of self-injuries and suicides which occur on remand are closely related to the uncertainties of the remand situation. The sample were therefore asked a number of questions about their experience of the remand situation.

Slightly more of the subject group had been remanded into custody before being sentenced (see Table 4.18). Almost all of the young prisoners had been remanded at some stage (see Table 4.19).

Most of those in both groups who were or had been remanded in custody had served their time in one establishment, although 16 and 13 per cent respectively had been in two or more. Many of these transfers had occurred as a result of a local arrangement between two prisons over court responsibilities, due to the 'locking out' procedures operating in two establishments and as a result of the riots which had occurred in Spring 1990. Others were transferred because of threats by other inmates or distance from home (Table 4.21).

There were no differences in the length of time spent on remand: well over half of both groups had spent over twelve weeks on remand, some spending considerably longer (see Table 4.22). Similarly, there were no differences in the way each group described this experience: over half of each group found it 'difficult' or 'devastating' (Table 4.23). Often, the experience varied, depending on the stage, the particular situation, and the level of support being sustained from outside:

> For the first four months, it wasn't too bad. I was hoping to get out on committal. Then I started to get worried, and between four and six months I started to get pressured, by being confined. It was the weather, and they [the family] stopped coming for us. (CG)

Importantly:

...then I got a job as A wing cleaner, so that was completely different. (CG)

Many of those experiencing remand for the first time reacted badly to the situation, particularly where serious charges were faced, or particular types of offences had been committed. As in the above example, a prisoner's ability to cope may be affected by staff sensitivity to his distress (or a chance resolution of his struggle to cope):

> It did me head in because of our lass being pregnant and we'd just got a house. (SG)
>
> I was on the R43 landing in prison X. But they give you a hard time, the other landings do: verbal abuse. They chuck buckets of urine under the cell doors and all sorts of things. It's quite rough. (CG)
>
> Well you get a lot of aggro and that, and with being on '43 you get shouting and everything like that. I didn't know this when I first went in, but the doctor explained it to me about 43 and what to expect. (SG)
>
> It was ok; I mean, I was in a state of shock still; I hadn't had time to work things out or become adjusted to what I'd done. I was quite surprised actually, despite the nature of the crime, to find one or two people who were - you can't say sympathetic, but...it helps you to calm..I was three'd up and you get to talking. I was quite lucky, each time you go out to court you normally get put back in a different cell and most of the time I was in the same cell with the same people...I look at other people and I think, they just wouldn't have coped. (SG)
>
> Well, I think I was still in a bit of a depressive state, but no, everybody was nice to me. I didn't have any trouble. I can say that now; I was treated well. (SG)

The remanded prisoners were asked about their contacts with probation, solicitors and police, and as shown in Table 4.24, nearly a quarter of the remanded prisoners had had no contact with any of the above. Of those who had had contact which they considered useful, most reported that this was in terms of practical and legal help and advice (see Table 4.25). Surprisingly perhaps, contact with solicitors was often seen as at least as valuable and supportive as contact with probation officers:

> Not really no [probation]. They like to know what you're doing and all this, but then when you've got problems, they can't help you out (CG).
>
> Yes [solicitor] because he took a load off my mind. (SG)
>
> My solicitor's a good solicitor. When he comes into police interviews, he knows things. He tells me whether I've got time to do this or that, he tries his best for me, and he really puts a lot of effort into speaking for me in court. He's pleasant and friendly to me. (CG)

> Yes, probation came down and gave me a special visit about four or five days ago to make a probation report out for court. The probation are very useful. To be perfectly honest, I'm the sort of person who seems to ignore them. Even on the outside, I was getting probation on the out, but I was going in there, saying I'm doing well for myself, I've got myself sorted out, I'm going straight and clean, when I knew for a fact it were a pack of lies. I weren't using the help they were offering properly. (CG)

Over two thirds were anticipating custody (Table 4.26). Most were expecting sentences of less than four years, but eight of the subject group and ten of the comparison group were expecting sentences of over four years, including life (see Table 4.27). Some expressed a detailed and and impressive understanding of their chances, but even if the sentence were expected, receiving it was difficult (Table 4.28). When asked how they would feel about receiving their expected sentence, over half of each group said they would be 'upset' or 'devastated':

> I think I'd be fairly upset. I don't know...it's always a shock when you stand in the dock and they, you don't get bail or you get a custodial. It's always a shock. (CG)

Well over a third of both groups reported having been completely shocked by the sentence (see Table 4.30):

> Gutted, gutted; I was gutted, but basically the reasons why were because I'd only just done a five year sentence and I was only out a month, so I was a bit down on my luck at the time. At the time as well I was hoping for less. My brief told me to expect more but I was hoping for less simply because I didn't feel it was justifiable to send me back into prison after just doing a five. I mean, I thought he could have been a bit more lenient on me. (SG)

> It was a reasonable sentence for what I went up for but like I said, you lose a lot and they don't seem to look at your circumstances. It's a bit out of order really. They just seem to look at the offence and what you've been in for before, and they just give a vague description of what you've been up to on the out. They don't know, they don't know what's happening on the out. (CG)

> Cold. I just felt numb. I felt as if me whole world was just destroyed and the bottom dropped out, you know what I mean? (SG)

Nevertheless, being sentenced reduced uncertainty:

> Since I've been sentenced I've been able to talk about what I'm in for (SG)

> You know what you've got; you know what you're doing, where you stand. When I was on remand I was all the time worried what was going to happen; what I was going to do. (SG)

Criminal justice history

There were few differences between the two groups in terms of criminal justice histories. However, a number of legal and administrative changes had taken place during the years preceeding the research (eg. in sentencing and cautioning practice) which made the data difficult to interpret. For example, more than half of both groups had more than eleven previous convictions (see Table 4.38) while few of either group had none. Most of both groups had been between 13 and 17 years of age when they were first convicted of an offence (Table 4.39). There were no differences between the two groups in type of previous offence either. An exception was prior custodial experience, the subject group being significantly more likely than the comparison group to be experiencing their first prison sentence (44 per cent compared with 29 per cent)

BACKGROUNDS AND FAMILY HISTORY

Education

One third of the adults, but nearly two thirds of the young prisoners, had been expelled from school (see Table 4.46). Three quarters of both groups had no qualifications from school. The only difference to emerge in relation to schooling and qualifications was the reason for truancy: almost half of the subject group reported having truanted from school because of specific problems they were having rather than because they were 'bored' or 'because their friends did' (see Table 4.46). Significantly more of the subject group - almost a third - said that they had been bullied at school (see Table 4.47).

Care history

Where young prisoners were concerned, the subject group were more likely to report a history of local authority care than the comparison group, but the overall numbers were too small to differentiate significantly. There were no differences between the adult subject and comparison groups in this respect (Table 4.48). However, the reasons given for being placed in local authority care did differentiate between the two groups (for both adults and young prisoners), the subject group being much more likely to have been put in care because of 'family problems'. The comparison group were more likely to have been in care as a result of their criminal behaviour.

Work and accommodation

Work history was difficult to describe, as many of the sample had either not been outside long enough to have had a clear employment history, or had had such a mixture of unemployment, part-time work and 'grey economy' work that finding codes to represent them was rather complicated (see Table 4.49). Only a fifth of the interviewees had not experienced some unemployment (between sentences or otherwise). More than half had been unemployed prior to custody. Most had had an assortment of manual, service and labouring jobs. Few had stable, regular or well paid jobs. There were no real differences between the two groups.

Similarly, there were no significant differences between the two groups in relation to living arrangements before custody (see Table 4.50). Four of each group were homeless, and a further six in each group had been living in temporary lodgings or in hostels:

> I was NFA. What happened was I got out of prison on the ninth of July and I didn't have any address to go to. That's part of the reason why I ended up coming back here [rearrested nine days after release]. Probation in here couldn't sort me out a place for when I got out, so I ended up having a few drinks and taking a car to keep warm in, to sleep in. (CG)

> Before I come in here, I was living on the streets at first, and then I went to the bail hostel. (SG)

> Numerous places; just moving around quite a bit, with friends.. (SC

More than a third of both groups did not have an address to go out to on release:

> I'm homeless. I'll have to go into a hostel for a couple of weeks and then I'm going to try and get back to me mam's house. [She won't have you back at the moment?] No because of me offending, that's why I want to stop when I get out for. (SG)

Many seemed to have unrealistic hopes about accommodation with girlfriends and parents, given their own descriptions of the instability of these relationships. More of the subject group were single, but this was accounted for by the high numbers of young prisoners in this group, most of whom were single (see Table 4.51). Seven of the subject group and nine of the comparison group reported that divorce proceedings had been started since coming into custody; two of the subject group had been widowed in that time (one lost his wife by suicide). Several of both groups had broker up with girlfriends or received 'Dear John' letters since coming into custody.

Family situation

The family situation of both groups were surprisingly similar (except perhaps that the subject group were rather more likely to be single and tc be without a current girlfriend than the comparison group). For example, more than half of both groups had young children. Providing details about them could sometimes be painful:

> - How old are your children?
> - Same age as I was when I went in to care: eighteen months. (SG)

> I've no contact. I've wrote to them but I've had no reply. (CG)

> Well, there's ups and downs with my wife at the moment, so we don't know what's happening. She's gone into care, because my wife can't cope. (SG)

> This is going to sound daft, but I'm not sure. I know one is

living with her mother and she's got married again; the other one - I know where they are, but she won't let me see them. (CG)

The level of contact with parents and other relatives was often difficult to estimate because of the complex structure of their families and family histories. Many had been in care, had foster parents or step-parents. More than half (almost two thirds of the young prisoners) came from 'broken homes', and in most cases the separation had occurred before the age of eight. More than a third of the subject group ended up in care as a direct result of this (see Table 4.51). Questions were asked about families in an open way, only directing the interview in specific directions if this was necessary. Often, the questioning would begin with, 'what can you tell me about your family?'. The following response is a good example of the sort of answers received:

> I'll tell you what I know, yes. I have no contact with my mother. She doesn't know I'm here. My father? I've never known him, not even his name. I've got a half sister, living in Jamaica, from another marriage. I had foster parents at the very beginning. They said that they couldn't cope, and that I was emotionally unstable. This was two months to three years old. Maybe I was noisy and demanding. I remember them, and the home, but I can't remember being emotionally unstable. Then I went into a children's home - I think it was; I don't know what the place was. It might have been that mother and baby's home - I have a lot of confusing thoughts. (SG)

Tables 4.51 to 4.52 contain considerable detail about the sample's family situation, but even so, they only probably tell part of the story. The other part of the story is better told whole:

> Well, I lived at this place in Sheffield, with my three brothers and my mother and father. That's a rough area of Sheffield. We moved to another area and got a house, which he now owns, but we rented it at the time. And me mum found somebody else and left when I was five, never seen her since. My dad had a good job working for a company..he had to leave that to bring us up. So for ten years, my father was unemployed, but not through his own fault or because he couldn't be bothered to get a job. We went to school. My dad tried his best; I can't knock my father, in fact I'm proud of the things he tried to do with us. It's just me; I had a kind of grudge against society, from being little. Not a big grudge, it's just, if my dad told me to do something, I'd deliberately do the opposite, I don't know why. We had to wear education clothing. We used to get the odd bit of stick at school. Then when I was about 15 my dad got remarried, and I didn't like my step-mother from Day one, because she'd got a mentally handicapped son, who was me step-brother, and there was too much favouritism. Now it sounds silly, but we were all jealous. I weren't bothered because I was always out doing my own thing and I was earning money doing paper rounds and that, so I'd always got more money, and one day I were fed up with it, so I left home. I just packed me bags. My dad was in tears and asking me to stay, and why couldn't we start again, and my step-mother just piped up and said, 'why don't you let him go, if he wants to go?', and I felt like slapping her for that. It

was me and me dad, and I didn't want her interfering. From that point on, I was in the outside world and I met all the underworld people. (CG)

Parental violence

Slightly more of the subject group had witnessed parental violence, and in thirteen cases (and nine of the comparison group) this violence had led to hospitalisation (see Table 4.52).

> Yes, that's why I once stabbed him and he like grounded me. I couldn't go out. [You went for him because he was hitting your mother?] Yes, he started slashing her up once with he got drunk with a carving knife. He's a psycho. (SG)

> Yes, very much. I think me dad went once for stitches to his head after a stiletto heel hit it...I think they were as bad as each other really. I think they got married because she was single and he was single and he had four kids like. It were either that or we would have gone in care. I remember just after me mum died when somebody from the care authority came round and actually talked to him about it. I hid behind sofa. (CG)

Slightly more of the subject group had experienced violence at the hands of their parents than the comparison group, although the difference was not statistically significant. In more than a third of the subject group cases (43 per cent, cf 30 per cent of the comparison group) the violence had been repeated and serious. In nine subject group and six comparison group cases, this violence had resulted in hospitalisation. Usually, the parent concerned was the father or step-father.

> Me dad was, yes. [Did you ever need to go to hospital as a result?] Not so much hospital because if he'd done ought bad to me, he used to keep me in so nobody knew. Like, bust lips and black eyes and stuff like that. He didn't like me much because he's not me real dad. He's the father of the other three but not my father. (CG)

> Not my parents; one parent, my dad. I think what it was with him, he was a violent bastard anyway when he had a drink. He beat me mother and he beat the kids but he had something against me. I must have been different from the others. He must have seen something in me that he didn't fucking like. Because I used to get 'paid' more than the others. (CG)

> Me dad used to belt hell out of me every time I didn't go to school. [Did you need to go to hospital?] No, not quite that bad, but it got to a stage where I were in police station and I had to show him all marks and cuts on me and they, they warned him. (CG)

> He like batters me around when he's drunk...You see all those scars in me head, he used to hit me with a piece of furniture. [Did you ever need to go hospital?] Yes. NSPCC, me mum used to get in touch with them. They used to take me on day trips

to keep out of me dad's sight. (SG)

I used to get regular beatings. If anything went wrong it was my fault. I was the runt of the litter, it was always that way. I was the one that used to get into trouble the most, fight the most. I turned my parents and my family off when I was very young and I used to go sit in the garden on me own like and let them get on with it. [Why was that?] I suffered with a skin disease. I've had it for years, I look different from everybody else. I used to go to school and people would call me scabby and I'd have to hurt them...It got so bad that later on in life people used to be afraid, they used to walk the other side of the road, they wouldn't even talk to me. [Psoriasis?] Yes. I would have thought my parents would have took the time to get it cured and cleared up but they wasn't interested. (SG)

Child sexual abuse

If the two groups experience of physical violence failed to distinguish between them, their experience of childhood sexual abuse most certainly did. Indeed, it was - by far and away - the single most significant difference between them where their personal histories were concerned.

Thirty seven per cent of the subject group had been sexually abused as children compared with only six per cent of the comparison group. Three of the 27 young prisoners (all subject group members) had been sexually abused; 24 of the 114 adult prisoners (19 subject group members) had been sexually abused ($p<.0001$). Ten (4 per cent) of these cases were charged with or convicted of sexual offences:

This is confidential, isn't it? When I was seven these two lads - well, one of them did - I didn't know what you called it then, but they buggered me. They were about 16. There was another occasion when they made me play with them. No-one ever knew until I told this psychiatrist, and now you. My wife never knew anything about it. It might come out in court, so it might be best telling her before it goes to court. (SG)

Yes, at school, and me dad as well. I always thought me mother knew. At school, it was other pupils. It started right from the age of when I was five, right up to when I was 14. (CG)

Yes, the other person that was in my bedroom at the children's home. He was 15. It happened over a period of about three weeks. I think once again, although I was nine, I still didn't have the full understanding. Ignorance is a bliss, you know? (SG)

The subject group's history of child sexual abuse links to the theme of their more general vulnerability in many ways (eg. bullying at school and in prison) and has a significance far beyond the boundaries of this study.

Family Psychiatric History

There were few differences between the subject and comparison groups in relation to family psychiatric history - except perhaps that more of the subject group seemed to have difficulty in recalling their family history in sufficient detail to answer the question (see Table 4.53). A quarter o both groups reported a family member who had made a suicide attempt. Ofte (but not always) this was the mother:

> Yes. My mother. When she split up with my dad. She took pills and booze at the same time, and had to go into hospital. I was old enough to know what was going on (CG)

> A couple of 'em was overdoses and once she climbed up to the top and was going to throw herself off. We've all just learned to live with it, because she was, like, really bad. I don't help matters...She is a lot better now; she can cope with things a lot better (SG)

> My mother. She got me in the bathroom and tried to slit her throat. She got me a bit worried as well. (SG)

Three of each group reported a family suicide. In one case:

> Yes. My brother, my wife, her sister and my father in law. The wife and her sister did it within four months of each other. The father in law did it two years after. (SG)

Psychiatric and Other History

Both adult and young offender subject groups were more likely than their respective comparison groups to have received some form of psychiatric treatment before coming into custody. Reasons for treatment were slightly different: more of the subject group had been treated for depression (22 per cent) or addictions (8 per cent; see Table 4.54). Many had seen psychiatrists in institutions, either in care, or in previous custody:

> It was quite a few reasons really. In one case it was for a court report, and in another it was because my last prison thought I had slipped a few cogs, because I kept smashing cells up. I mean really, I was having great difficulty coming to terms with being detained until my 17th birthday, when I was 14. I couldn't cope with that. So I kept smashing cells up, and I had to see a few psychiatrists about that. [Did you get to talk about it? Did you work out at the time that this was what you were upset about?] Oh no - not at all! Like they say, it's a lot easier for them to stick the label 'subversive' on you, rather than help someone with their problems. It's a lot easier just to throw them in a strip cell. (SG)

Significantly more of the subject group had injured themselves before, either once (18 per cent) or several times (44 per cent). Twenty four per cent of the comparison group had also injured themselves, however; young

prisoners were more likely than adults to have done this (see Table 4.56). In over a third of these cases, the incident was described as a suicide attempt. The others were described as an expression of distress, a mixture, or (relatively few) a 'cry for help'. Some of the injuries had occurred outside, others in prison:

> The staff took me to the hospital and I stayed in the hospital landing for two weeks, on their ward. Nobody came to talk to me, just the doctor kept coming round 'you feeling any better?' and I used to say 'no'. So he said, 'you stay here until you feel better'. I got tablets to take the pain away and to clear up the spots on my face, and that were about it. What I tried doing that night were a suicide attempt, yes. I'll never do owt like that again. (CG)

> Only with stuff like medication that me mum was on, I just dropped it. I was unsure about what was going on, because the time I was taking it me mum and dad were covering up everything. There was no bond in the family; and I kept feeling it. It was mainly attention more than anything. [How old were you when this started?] 13 or 14. [What did you do?] Just taking tablets and things like that, paracetamol. The first time I had an argument with me mum about me dad, because me dad used to call me the shock absorber of the family. I used to take all the troubles to bed with me and let it brew in me head. And I went down one morning, me dad had gone to work, and I said to me mum, 'What's going on, in the family?' And she said, 'Nothing's going on'. And I said 'there is, there's no bond, everything's falling to bits', which it was, they just weren't admitting it. And she said 'It's nothing to do with you'. I said, 'Oh, is that how you feel?' and she went to the shops and I just threw a load of tablets down me and sat there. (SG)

> Yes, I cut my wrists in 86 in ... YC. [Why?] I don't know. It was my first time in prison and I was on a downer....Then I tried to hang myself in ... in 89.....I wanted to get back up here because I wasn't getting no visits or nothing. They weren't going to ship me out so I said if they didn't I'd do it properly next time. [Would you say it was a suicide attempt?] No...I set it up with me pad mate. It squeezes you, it passes you out anyway, you know what I mean. I had noose round me neck so it passed me out and that were it, he just banged on door. I wouldn't do it again though. I woke up and it was like hammers banging on me head, I felt right bad. I was in strip cells, I was there for four days. Bad news man, couldn't smoke or anything. I started kicking off, one of the night officers he used to let me have a few cigs like. Then they kept me down hospital for about a week and a half. Governor, man, he was going barmy. He says 'How dare you try to hang yourself in my prison'. He says It's on my record now that you tried to commit suicide. That's all he was bothered about, his reputation. (CG)

SUMMARY OF BACKGROUND CHARACTERISTICS

There were few differences between the two groups where most demographic and socio-economic variables were concerned - for example accommodation, employment histories, education (age left school, expulsion, qualifications etc). Nor were there any differences where family situation was concerned - both groups being similar in respect of siblings, parents, step parents and the extent of the contact they maintained with them. Similar proportions had divorced or separated parents. Nor were there significant differences between the groups in respect of parental violence.

Neither were there were significant differences between the two groups in terms of previous criminal history, ie number of preconvictions, age at first conviction, type of offence, period at liberty since last custodial sentence etc.

Nevertheless, a number of interesting differences emerged. For example, both groups were equally likely to have experienced local authority care at some time, but the subject group was much more likely to have been sent there as a result of family and behavioural problems than the comparison group (who were were more likely to be there as a result of offending behaviour).

However, the most striking difference between the two was the fact that the subject group were very much more likely to have been sexually abused as children (by a non-family person such as a neighbour, step father, older boys in care and supervisory adults in care), than the comparison group - suggesting the possibility that there is a powerful connection between childhood abuse and later self-injury and attempted suicide.

This theme of vulnerability was was further underlined by the fact that the subject group were more likely to have a history of depression and previous self-injury than the comparison group. Moreover, while the two groups had similar histories of truanting from school, their reasons for truanting were very different, the subject group being much more likely to have refused attendance because of problems such as bullying.

What does emerge from these results is a fairly clear picture of a type of prisoner who is not at all dissimilar from the mainstream prison population, but who comes to prison with a history of general 'vulnerability', which is going to make his experience of custody that much more difficult to manage than most other prisoners.

LIFE IN PRISON: COPING WITH CUSTODY

These differences emerged clearly from the next set of questions which related to their experience of life in prison, the subject group describing many more difficulties in coping with custody than the control group.

General

Well over half of the subject group (but almost half of the comparison group) described the prison experience as difficult (see Tables 4.98 to

4.101). The reasons given were varied, but included boredom and inactivity; conditions, pressure from other inmates (reported more frequently by the subject group); other types of pressure; too many rules and regulations governing every day life, and uncertainty.

When asked the question in a slightly different way ('and what has the experience of imprisonment been like for you?'), three quarters of the subject group described it as difficult, compared to less than half of the comparison group. The experience was often made more distressing by particular problems the inmates were facing: either domestic worries, bullying, anxieties and boredom. These problems were reported more frequently by the subject group (see Table 4.102):

> Hell. I live a hell every time I close my eyes and go to sleep. I live a hell every time I get up in the morning and have to face this lot. I live a hell every time I look at people in here shouting nonce and beast and every time I go for me meal and find that it's, you know. Every time I see somebody sitting here crying because his wife's left him and he can't have contact with his kids, or he wrote a letter and the letter's got lost, or nobody writes to him, or somebody stands there and slits his face open because of what he's in for. Bleak isn't it, whether it be open, semi open, closed. The point is that we love people outside. We're not bad people, we make mistakes the same as everybody else does, we don't have to pay for it for the rest of our lives. But we do pay, we pay because we lose our families, we lose our children, we lose everything, we end up with nothing whatsoever. We end up with a life that's not even worth living, because we know as soon as we step outside the gates it's going to take them a few weeks to fit us up with something else. They might even have something else to arrest you with when you walk out the gates anyway. (SG)

Current and preferred location in Prison

At the time of interview, a large proportion of the subject group were in hospital accommodation. However, the nature of accommodation is obviously one of the most important aspects of prison regime and the sample were asked a number of questions about their experience and preferences in this respect.

Slightly more of the subject group said they preferred to share a cell, rather than be on their own, although they often qualified this to say that they would like to share if they could choose a cell mate, or if they found this cell mate acceptable. This difference was not as marked as that found amongst young sentenced prisoners in the earlier study. More of the remand and adult prisoners seemed unsure (Table 4.57) (sometimes because of bullying, or the pressure of sharing with others they didn't get on with), or only marginally preferred to share:

> I'm on the YP landing and I share with two. I don't like it, because there's people in there that keep starting on me and taking things off me and that. The people who I'm in with, they said if I asked for a pad change they'd give me a

good kicking. They keep using me to do all their work and that. (SG)

I prefer to be in a single cell. When I feel emotionally under pressure...a single cell is like a retreat. (SG)

There is no way whatsoever that I can cope with being alone. After talking to you, I feel so much better. I asked if I can share a cell with another guy who's been charged with murder; we've like trusted each other, we can understand each other. We're both afraid. The doctor said he'd look at it but he can't promise. (SG)

It's diabolical. I share with two others. I'm under a lot of pressure because it's only me what gets a visit. It's only me what gets tobacco sent in off my wife; I get stamps sent in. They want to borrow stamps, tobacco...you have to give it to them to keep them quiet. (CG)

Sharing is excellent, because you're both inside and you get depressed from time to time; you go a walk round the compound. You can be happy one minute and depressed the next. If you've got a decent, sensible pad-mate you can talk things out. I've got a pad-mate that's from ... He knows a lot of my friends. It's good 'cause you can have normal conversations. (CG)

The hospital was an alternative location for those struggling on the wings, but this had its disadvantages:

It's alright in the ward; better than in a two man cell on here because if you're in with a nonce, you get associated and then when you go back on the wing, you get sliced up. (SG)

No, what I want to do is...I've been told that being on the hospital ward makes it look bad for me; makes it look like I'm not the sort of person you can let outside, so I want to get off the hospital ward and on a normal wing so I can get stuck in, do some work. I'd like to do something just to pass the time; I don't like sitting around. (SG)

Work in Prison

Work was apparently very important to both groups. Despite reservations about its quality, most prisoners in both groups wanted to work, feeling that it would 'take the pressure off', 'relieve boredom', and 'keep you busy'.

I can't really answer that one straight-forwardly [Do you prefer to be working?]. I prefer to be working just because it gets me out of my cell to do something, but I don't enjoy the work. It's only cleaning and it's very mundane; well, most of the work in prison is. (CG)

Ninety four per cent of the subject group and three quarters of the

comparison group who were working felt that the job they had helped them to do their time. Half of the subject group and a third of the comparison group who were working said they did not spend enough time doing so, they often commented that many would like more 'appropriate' work. Many inmates said they derived satisfaction, experience and company from working, in addition to 'passing the time' ('You can walk around and talk to people'; 'you get to meet other inmates, and make friends'; 'This might sound strange, but I'm beginning to get some sort of job satisfaction out of it').

However, significantly less of the subject group had a job in prison (a third, compared to well over half of the comparison group; see Table 4.58).

> No, I'm banged up all day. That's what I want to go back on the wing for, so I can get a cleaner's job so I can get out of me cell most of day so I'm not depressed. That officer's trying to do that for me now. (SG)

> No. I was in the workshops but they don't want me there no more (CG)

One or two had irregular work of some kind:

> Ocassionally they get me out to do the work here. (CG)

The subject group were surviving on less money than the comparison group - not least because of their lack of work opportunities (and their younger age?). Those not working were given £1.75 per week with which to buy stamps, tobacco and any other canteen items. Some did not want to work at all, particularly if they had other things to do:

> No, I prefer it in my cell, because I'm relaxed; I'm drawing, doing envelopes, doing pictures for the kids. Cheers them up. (CG)

Education in Prison

Eight subject group and three comparison group members were on full-time education (Table 4.59). Others were either doing education part-time, or did evening classes. Many more wanted to do education, but could not, because of their remand status, the need for security clearance, the uncertain length of time they would be in custody, or because there were waiting lists. Over three quarters of those who did classes in both groups enjoyed them and thought they helped pass the time. 80 per cent of the subject group and 60 per cent of the comparison group thought they got other things (as for work, above) out of their classes too. Significantly more of the subject group wanted to spend more time in classes than the comparison group. Those who had any qualifications at all found the opportunities 'limited':

> I would if they'd let me; I'd go and learn people things. I'd find meself being useful instead of just going down there for the sake of it. In this kind of jail, you just can't do that kind of thing. In a sensible kind of jail (like X), people are settled down, they know when they're getting out. In here, everyone's a bit crazy; you can't be seen being

a bit clever...

..There's another main reason why I don't do it: I might be up for sentence in two weeks and there's no point in me getting settled into anything here. By the time I'd have got anything started, I'm going to be shipped out like a parcel again. (CG)

Lack of motivation to negotiate a place on education for themselves sometimes reflected a downward psychological spiral, interpreted by the staff as indicating a choice or lack of interest:

I don't know. I put down for classes, but I don't know whether I want to do them now. I was thinking of doing a foreign language and just disappearing out the country, but now I can't be bothered. (CG)

The importance of basic reading and writing skills was obvious:

Before I came in here, I used to get E's in art and woodwork and that. But now I enjoy these classes. And another thing is, before I came in here, I'd never written a letter or read a book in my life. It was a struggle at first, but now when I put pen to paper, I don't know when to stop. I've got that many things to say to my wife. (SG)

Many more wanted to develop their educational or work abilities. Well over a half of each group said that nothing they did in custody was interesting or important. Those who did find things interesting reported education, work, gym (especially the comparison group) and activities carried out in their own time (reading, painting, etc.) as being the most interesting:

Yes, but it depends on which you level you come in on. A bloke that can't handle life on the out, there a lot of them people in here, they just can't survive. They come in prison, nobodies, they set themselves up with their little skims and scams, they feel someone after a while, they're treated the same as everybody else which is a good thing. They can get on education, they can do something with themselves or even in the workshops, they find it rewarding because they're sitting in the workshops doing their little thing however boring it is and they've probably not worked in their lives before. (CG)

Physical Education in Prison

Over half of the subject group and well over a third of the comparison group were not doing any physical education in prison (see Table 4.60). For many, this was a sign of other difficulties (ie bullying amongst the younger prisoners). Others were not allowed to because of their physical condition, its limited availability, their location on the hospital, or their (older) age.

Activity in Prison

Prisoners were asked a series of more general questions about their activities in prison. They began with 'how do you spend you time in your cell?' Noticeably fewer of the subject group could find ways of occupying their time whilst in their cells (see Tables 4.61 and 4.62). Only fifty seven per cent of the subject group described themselves as active in their cell. This is consistent with the earlier study and suggests that the poor coping model developed in that study can be applied to a wider population than sentenced young prisoners alone. Few would read or listen to music, and more would sleep or do nothing. A typical response was:

> Just thinking about things in general...there's not much else I can do. Think about things that went wrong...crime, and one thing and another. Thinking back. (SG)

On the other hand, ninety five per cent of the comparison group could find something to do:

> Reading; well, trying to read a book; writing letters, listening to the radio; I'm just starting a little bit of matching. (CG)

> Either drawing, writing, playing cards, scrapping..(CG)

Some of the (younger) comparison group prisoners became aggressive with their cell mates:

> Interesting question...I converse, you might say, with the outcast kid. I don't clean the cell, if that's any answer to your question. The outcast kid spends a lot of time worrying. We take the piss out of him. (CG)

Older prisoners (and many of the young) were more constructive with their time:

> When I was on remand, I spent all my time preparing my case. (CG)

> I read, do my matching, hobbies. I've just finished my caravan, so I'll try and get it sent up the road. Then I'll leave it a week and start another one. (CG)

The subject group also spent more time in their cells. Over forty per cent of the subject group reported spending twenty-three hours per day in their cells, compared to 21 per cent of the comparison group (Table 4.63):

> At the moment I'm spending 23 hours a day because we're waiting on machines in the workshop. We've been waiting a month now (CG)

> It depends whose on (the hospital). If it's somebody who's not too willing, you spend just about the whole day in there. If it's somebody who's alright, you'll probably come out for association once or twice a day. (SG)

All day. You get half an hour's exercise. (SG)

For many prisoners the amount of time spent out of their cells could vary. Some managed to organise their routine so that a minimum of time was spent locked up:

> I go to the gym at half eight in the morning, come back at half nine. I'm in there until half past eleven, get my dinner, banged up then until half one. If there's gym in the afternoon, I go to that. If there's not, I'm banged up until after tea. If we've got association, I go to gym. If there's no association, we're banged up then until the next morning. Sometimes it's 23 hours a day; sometimes it's only twelve hours a day. (CG)

The subject group reported feeling more bored (particularly at weekends), and, even more significantly, not being able to find ways of relieving this boredom (Table 4.65). They were more likely to sink into depression - or to find their misery made worse:

> You feel bored all the time. You start banging your head against the wall. (SG)

> I suppose there must be ways, but I just don't bother. I could read, but there again, I can't be bothered. I just can't get into it. (SG)

> There's nowt you can do. All you can do is slash your arm. (SG)

> I just slash up. I'm like a balloon that gets full of air. It makes me feel better. (SG)

> There's nothing. It's not just boredom; it's problems outside, I'd say, that gets on top of a person, inside. And when you ask for someone to talk to, you can't get no-one. You can ask, but you don't seem to get no response. Then you sit here. You think, what's the point? (SG)

More of the comparison group found ways of deflecting feelings of boredom:

> You get down sometimes, obviously. Prison life does get to you; there's no way you can overcome it. I think if you let yourself, yes. I mean, I've been to the doctors this morning. I see them sitting in their cells. I think you could fall into that way if you allowed it. (CG)

> I wouldn't exactly say I was bored. There'll be times when perhaps I'll be reading and I want to do something else, it's getting monotonous. I don't think I ever really get bored, because I've always got something else to do, know what I mean? (CG)

But all prisoners found this part of prison life a struggle, and had to call on strategies and resources specifically geared towards coping with the challenge:

> I think it's getting a bit easier, but sometimes you go on

a downer and everything hits you back again and it takes you a bit to get back up on your feet again. It's just when there's naught happening. (CG)

It's hard when you first come in because you're used to your outside life and it hits you hard then. You have to get used to the routine and get your head down, and then you can cope better. (CG)

Less now, because I've thought of ways of doing things. There are two things: I follow the markets daily, so at least I'm in touch. I get two or three daily newspapers and two or three weekly magazines. (CG)

Well you have to, don't you? I understand that there are people who don't, but I'd have to, even if it's only listening to a bit of music for an hour. It's amazing how fast that hour goes if you concentrate on it. (CG)

Only 28 per cent of the subject group, but 42 per cent of the comparison group, thought there were rewarding things to do in their current establishment (Table 4.66):

Not really, no. I mean, OK, there's hobbies what you can do, like matching, but if you don't know how to do it and you're just starting to do it, you get bored with it very quickly. I do. (SG)

Yes, they can if they want; they have everything that they want here - in fact, too much at times. Yes, you can always be occupied. You've got all education, you've got courses on, you've got a big library here, you can do model-making - or anything you want. It surprised me, after being at prison X, you know, banged up all the time. (CG)

Education for a start. I mean, to be honest with you, the education in here is a bit basic, but I get work sent in from the outside. There's nothing really to stop you doing anything you really wanted to. I think there's a lot you can do if you put your mind to it and you go about finding out how to do it. It doesn't fall into your lap. (CG)

It was clear that 'going about finding out how to do it' was a skill not all prisoners had.

Family and Outside Contacts

There were few differences between the two groups in respect of their contact with families and friends. The extent of contact was much the same as were the considerable number of problems reported in connection with visiting - their sporadic nature, the distances involved, time off work, domestic arrangements, physical illnesses and ailments, strained relationships etc (Tables 4.69 and 4.70).

Similarly, both groups were clear that visits and letters helped them get

through the sentence (see Table 4.74):

> Well, I've just had that one. I have had a prison visitor come and see me. Without that, I don't know what I'd do. She comes almost every week. I organised that through the chaplain; someone told me about it. (SG)

> Yes, it gives you something to do at the end of the day. It gives you something to think about. (CG)

> They take the strain off it. (CG)

> Oh yes. That's all I get up for every day. If I wasn't getting a letter at diner time, I'd just think, well, there's no point in getting up this morning. (SG)

> Yes; Well you know you've still got people that care for you. That do give you a one hundred per cent boost, you know. At first when I first went into prison I just said to myself, right that's it, I've lost everything now. I didn't write to no-one for a month and that nearly done me head in, then at the end of it I put a letter round to everybody apologising for the trouble I'd caused, to my children, to my sisters and brothers and then the letters started coming in then. (CG)

However, the value which both groups placed on contact may have disguised the particular importance they had for the subject group, the latter being significantly keener to receive more letters and visits than the comparison group (Tables 4.71 - 4.73):

> Yes. It would make it easier for me because I'd know then that there is somebody out there who cares, whereas when nobody comes to visit me, my head automatically thinks, there's no-one who cares about me, there's no point in being here. (SG)

> Well, at the moment I'm having less and less and it's getting me down. I've had two letters and a postcard. (SG)

> Yes. How can you think big of yourself when you're not getting no visits? There's some guys in here who think because they're getting visits and you're not, that you're some kind of joey for them. (CG)

Most prisoners reported feeling either anxious (26 and 22 per cent) or excited (44 and 45 per cent) before a visit:

> You get the gutted feeling...in case they don't come. (CG)

> Well, I was expecting my brother and my brother in law, but I had a feeling in my heart that my wife would come. I couldn't sleep. I knew I'd drop on the floor if she did; I was all temped up. Then when she didn't come, I was really down again. (SG)

Interestingly, (and emphasising their greater vulnerability), the subject group were more likely than the comparison group to report feeling

depressed after a visit (66 and 38 per cent respectively). This feeling might last hours, until the next day, or for several days (see Table 4.76). Some said 'it's still there':

> Yes, in a way, I wished they hadn't come. (CG)
>
> Terrible. (CG)
>
> Heartbroke. Tears you apart, because you know they've suffered. You put on a brave face. That assault (against this prisoner), that ruined it. It ruined the image because I was trying to tell them I was alright. (SG)

Thinking About Outside

Two thirds of the subject group and half of the comparison group reported that they thought about and missed people outside 'all the time' (see Tables 4.77 - 4.78). The hardest times were when trying to go to sleep, when banged up, and at significant times in a routine outside (going to and from work, weekends). Or:

> At night and that, and when other people get their letters. It does my head in. (SG)

However, significantly more of the subject group than the comparison group (85 per cent compared and 58 per cent respectively) found that thinking about the outside made being inside 'harder'.

> Harder. Because you can't touch them; you can't be there with them. (SG)
>
> Worse, much worse. My mother brought some photo's for me, and I told her she shouldn't have brought them, because it's only brought back lots of memories I'm trying to put behind me, and face what I've got to face. In a way it's a comfort and I can show them to the people who are here - 'this is my family'. But I keep them in an envelope, because when I get them out, I just cry. (SG)
>
> Harder. See them visits and them letters and them things: at the end of the day, they do make it harder for you. If I didn't have nothing to sit down and worry about, I'd just get on with my jail, wouldn't I? But you sit there thinking about your wife and children, this, that, this, that..(CG)

Significantly fewer of the subject group were keeping in touch with the outside in other ways while in custody (38 per cent of the subject group, 56 per cent of comparison group followed current events for example). Similarly, fewer of the subject read newspapers on a regular basis (Tables 4.79 - 4.80).

Contact with Probation Service and Outside Agencies

Over a third of both groups had not had any contact from the probation service since coming into prison (see Table 4.81). Of those who had received contact, over half of the comparison group, and a third of the subject group had found contact useful, mainly for practical ('welfare') reasons, but also for less identifiable reasons: just having the contact was felt to be a help.

Few prisoners from either group had contact with any other outside agencies. Seven of the subject group and three of the comparison group had a prison visitor; four of the subject group were seeing a Samaritan, and a few prisoners had contacts with alcohol and drugs counsellors (see Table 4.82):

> Just the Samaritans. Prison visitors and the chaplain put me in touch with them. I told the landing officer to phone them up. Our officer does these courses, just for 43's, on stress. There's one coming to see us. I didn't even know what they were for. They're not that much help. They just listen to you, don't they? I want someone to give us advice. (SG)

> Drugs counsellor, yes. I asked for it, through the probation here, and a couple of days later I got a visit. So probation in here have been useful, yes. (SG)

> Well, a woman from the Samaritans came after I slashed up, to talk to me. She asked me why I did it. I said I was bored and depressed, and lack of contact with the family. It helped a bit, but not that much. She asked me to write to her. It has crossed me mind a few times to write. (SG)

> Yes, I've got a prison visitor. I asked when I first come in. I got a leaflet from the prison chaplain, and there was a form on the back stating that if I wanted a prison visitor I should fill it in, and I've been getting the same visitor every week ever since. I find it very helpful. (CG)

Release plans

Significantly fewer of the subject group had any release plans. For both groups those plans they did have were often vague and unrealistic rather than specific and well-formulated (see Table 4.83):

> Well, hopefully to get settled down, like, if everything works out with our lass. I'd stop, you know what I mean, for the time being..(CG)

> I want to sell the house, move somewhere new, make a fresh start, get myself a little car, and just start me life all over again. A new life. (SG)

For some, suicide was (still) an option:

I've thought about my options. I could kill someone, come in as a lifer, that's it finished, or I could kill myself. That's cropped up once or twice. Or go on the straight and narrow - get a job, get a bird, have a decent life. But you make these plans, and when you get out of prison and you're walking down the street, you don't know what you're doing. (SG)

Thinking about the past and future

Significantly more of the subject group spent time thinking about the past:

Every day. Certain parts more than others. Things I've done wrong, people I've hurt, if things had been different. (SG)

Only slightly fewer of the subject group spent time thinking about the future (see Table 4.96):

Now and again, There's not really much point. (SG)

I haven't really got much of a future. (SG)

Significantly fewer of the subject group felt optimistic about their release and their future prospects: less than a third felt they had a future to look forward to:

No. I don't even think I'll get out of here. I think I'm going to kill myself. (SG)

I don't know what'll happen. I don't know what I'm going to do. I don't know. (CG)

Relationships with other prisoners

Less than a quarter of either group described themselves as having close friends in prison. Most recognised limits to the sorts of friendships it was possible to have in prison. Lack of trust, and an atmosphere of fear and unstable hierarchies of power pervaded many of the wings. But significantly more of the subject group saw themselves as being 'on their own' in prison, not really being able to mix freely with others (see Table 4.84).

The subject group was also more likely to report having difficulties with other prisoners. Recent inquests and investigations have shown that many young prisoners injure themselves or take their lives as a direct result of bullying. The results of this study (as shown in the next chapter) confirm the importance of this factor - over a quarter of the suicide attempts by prisoners interviewed in the study were related to pressure or victimisation by other prisoners. Many (but not all) of these problems revolved around the young, and/or Rule 43 prisoners:

Yes, threatening me for canteen and all sorts...(CG)

I've just lost 21 days if I get sentenced. I'm not a violent person, unless you feel your life is being threatened, because

of a black guy, threatening me on the landing, yeh? And he didn't get seen, you know what I mean? Anyway, I went over and told him, and he was still mouthing off, so I cracked him about seven times, but it wasn't deliberate, it was just an impulse, because he was getting away with it. The screw said, 'if you're going to fight, make sure we don't see it', he says, 'offer him in your cell' and stuff like this, 'get him out of the way'.(SG)

Yes. But even on the Rule you can still get some, with the same lads. I've been threatened quite a few times. I've even been interrogated by two prisoners about my offence. Two days before I went to court, they interrogated me all night...they kept me awake all night. (SG)

Yes. I was accused of being a cell thief. Whenever lads in here believe a rumour, you've had it. (SG)

Yes. I was shocked. I wasn't even thinking about any violence in prisons. I just got beat in, on X wing, in the dinner queue. One of them came and saw me crying against a locked door - they took me over the hospital. (SG)

Yes. People calling me Quasimodo, hunch-back of Notre Dame, bullying sort of things. (SG)

Loads. It's me offence and that; just people making rumours up and rubbish; just people calling me a nonce and a beast and that, and an animal. Down here everyone's in the same boat. I'd rather not be on 43, but I've no choice. I was beat up with a broom handle. The staff were there, but they didn't see it, it was in my cell. I wish I hadn't come on Rule 43 now. It's twice as worse. You get called a nonce all the time. (SG)

Occasionally, relationships between prisoners were described as supportive and close:

Well, as I said before, outside I don't really get on with people. When I first came in I was really down, I didn't have any fags or nowt. This lad who they moved me in with, they seem to move all the suicidals in with him. He thinks he's a bit of a psychologist, you know what I mean? You know, and he really got me over it, he used to give me smokes and all that. (SG)

Well I've got my co-accused in the same cell as me. We're good friends. (CG)

On the whole, shared cells, especially between three prisoners, could be dangerous. Some preferred to share, and for a few, it was important that they could do so. It was not just in cells that violence became inescapable:

Not this time, but last time I did. I hit him over the head with a chair. What it was, he put the word out that I were a grass. All idiots took his word and started beating me up and punching me and that. I just bottled it up. I didn't tell

nobody. I was getting punched all over and I didn't know what to do, I didn't know which way to turn. Then I got to see my mate on a visit. He went mad. The only way I could do it, the man who started it, I had to get to him, and I had to hit him in front of everybody. So that's what I did. I hit him over the head with a chair, in the TV room. I got took up to the block and I lost 56 days remission. But everybody was giving me cigarettes and apologising to me then. I didn't like doing that, I felt really guilty for hitting him. I don't like bullying, it's not on. But I had no choice, it were either that or go through and be a punch bag for everybody. (CG)

Relationships with staff

There was a slight tendency for the subject group to report more difficulties in their relationships with staff than the comparison group (see Table 4.85) - but the differences were not marked. For example, a quarter of the comparison group but only 10 per cent of the subject group described their relationship as 'good'. Most thought that there was a slightly uneasy (or non-existent) relationship, unless you were a 'model prisoner'. These responses varied according to establishment, prisoner group and personal experience. On the whole, continuity and depth of contact seemed to result in better relationships:

> Well, them what's on landing regular, they're pretty decent. There's one in particular, you can ask him anything. It's him what helped me out and took me into hospital and what not, cause he could see I were really down and I were losing weight. (SG)

> I get on with them very well indeed, with talking to them about different things. (SG)

> I don't antagonise them, but we're not close. (CG)

> They're alright, if you get on the right side of them. (SG)

> They're a load of arseholes. They won't do owt for you. Like, he only got me that letter because you were there. If you hadn't been there, he wouldn't have got me it. (CG)

A quarter of the subject group and 14 per cent of the comparison group said it was not easy to get along with staff in their current establishment:

> Yes, but once you start wanting stuff, needing stuff, they start being patronising. So in times of need, they kind of switch off, because they have to do work. (SG)

> Yes, there are one or two that you can get on with. Those you can get on with are very helpful. (CG)

> Some are alright. They do communicate with you, But they can say hard things. They'll turn round and say to you, 'go and sit with the other outcast', things like that, which isn't very nice. With all respect, I know these people have to work

here and the place must become very dull for them as well, I respect that, but people like myself, we're unconvicted, we've never been in prison before. They could at least if they can't give you a kind word, or see the funny side, they could not say anything at all. They say things like, I bet you he's never had a good woman in his life. That hurts. (SG)

On the other hand, over two thirds of both groups said the staff were 'quite' or 'very' helpful:

> If you ask for it, yes. As I say, if you got bad news and you're waiting to get in touch with somebody, if you talk to them, they will make you a phone call. If you go and look for it, they'll try and resolve it. If they can't help you, they'll take you to probation or a governor. You have to go to them. I have seen a change in attitude from last time. (CG)

> Yes, they usually are. Whenever I've asked them for something, they've always done their best to try and help me out with it. They don't talk to you about your situation, but I have found that they'll say 'good morning' to you when they're walking by and that. (SG)

> They try not to be. They tend to sit down with a cup of tea and like, that's it. I tell you, if they were a little more active, they wouldn't get so bored, especially in this part of the prison. (SG)

Less than a quarter of either group felt that staff got close to prisoners - although many also felt that it was beyond the boundaries of their role to do so. Again, this was harder to achieve in the local and remand centres, where staff and prisoners moved about more:

> Well in a prison like this, a local prison, staff haven't really got the time. They pick the people who want to stay at the prison and they know them, cause they stop here and get good jobs. But the rest are in and out, they haven't really got the time to get to know people. (SG)

> Some of them'll come and talk to you, they'll come and sit in your cell. Like I say, you'll get the odd one who'll just bang you up and don't give a shit about you, and then you'll get one who'll sit down and talk to you, see what's going off. (CG)

Importantly, the subject group saw the staff as being helpful mainly in personal ways (49 per cent of subject group, 12 per cent reported by comparison group), whereas the comparison group saw them as being helpful mainly in practical ways (58 per cent comparison group, 32 per cent of the subject group). 'Personal ways' might mean 'listening to you', 'saying good morning', ''showing an interest' or 'trying to understand'. 'Practical ways' would be 'sorting out your problems' 'letting you go to the toilet', 'giving you a phone call'.

Similarly when asked how the staff could be more helpful, significantly more of the subject group wanted them to be more helpful in personal ways, (51 per cent subject group, 26 per cent of comparison group; see Table

4.85):

> Understanding; they could be a bit more understanding and compassionate. (SG)
>
> Instead of just walking up and opening your door, if they just said, 'alright? how are you?', just had a quick chat with you. Even a minute. (CG)
>
> They could help you sort out your problems. On the day, all you hear them talking about is 'I'll be going home soon'. (SG)
>
> For a start off they could have took me into the office and shut the door or sat me down. I just stood there and he could tell that I were upset because I were crying and he just didn't bother. He wanted to pass it on to Chaplain. (SG)
>
> It's hard to explain. More understanding and to listen you know, to listen. See now on my last sentence I spent time at ... and that was a totally different regime to what it is here. It was first name terms there and if you went to an officer and asked him he was willing to listen to you and give you advice, here the only word they seem to know here is No. No matter what it is, it's No. (SG)

The use of isolation

Not unexpectedly, there were significant differences between the two groups in their experience of isolation - prisoners in the subject group were more likely to have been isolated as a result of suicide risk, or segregated from other prisoners on Rule 43 (see Table 4.87). Both of these procedures had led to longer periods of isolation for the subject group. Three quarters of the subject group reported feeling shocked, uncomfortable and unhappy about this. It felt like punishment:

> This is the first time I've been in this part (the segregation unit) because they kept putting me in the hospital. I've been in there about seven or eight times. It's garbage, because you're put in a strip cell. I've been brought down for slashing up, but I've also been put in a strip cell because my pad mate had tried to commit suicide and I didn't think that were right. I'd done nowt wrong. (SG)

It was certainly not a therapeutic response to suicidal feelings:

> Yes, I went in on Thursday and came out on Monday. I was in stripped...well, I had what looked like a straight-jacket on at first, but I pulled a buckle off and tried doing my wrist because, like I say, I was just being foolish, stupid, thinking of meself. I was just feeling sorry for myself and not thinking of my family...
>
> ...Alone. I felt so alone, you know? Four walls, nobody there. I thought that's how prison life would be. I just had the quick visit off the doctor in the morning. (SG)

Oh, that's just another big joke of theirs, isn't it? They should know that if they stick someone in a place like that, where they can't smoke, you don't have nothing to sit on, you have this horrible, grubby little mattress on the floor and a couple of blankets and that's it, and a bucket to pee in, then like, you're going to feel worse. (SG)

Hard done to. They weren't looking at the problem, the root of the problem. They were just saying 'Oh, you should cope with it more'. I was saying 'I can't'. (SG)

It was terrible. Cold. Lonely. (SG)

Reception Procedures

The sample's perceptions and experience of isolation had important implications for reception procedures.

Almost all prisoners reported having seen the doctor and/or a hospital officer on reception into prison (see Table 4.90). A third of both groups spontaneously recalled suicide risk as being amongst the questions they were asked during their reception interview. A further 10 per cent remembered having been asked about suicide when prompted (see Table 4.90).

However, the prospect of isolation in a protected cell (a 'strip cell') meant that the process of identifying potentially suicidal or 'at risk' prisoners on reception had its difficulties:

I saw the doctor. He asked me if I was feeling suicidal or depressed. I said no. I was feeling a bit down, but I didn't want to say owt. I didn't want to go in strip cells. They saw in my record that I'd had a go before. They looked at me and said, 'let him go'. (SG)

He asked me if I were suicidal, if I felt like harming myself. I said no. I were frightened, more than anything. I didn't know where I were going. I were lost. (SG)

They asked me if I were feeling suicidal. I said I were feeling a bit depressed, like. They took me down to the ward. I'd only been in the ward five minutes and they put me in a strip cell. (SG)

Well, there'd been a note sent up from the police saying that I was suicidal, or that I could be, and I'm not. And that's been on me card, you know, since I came in, you know, communal cell, that I hadn't to be in a cell on me own. It was probably because I were upset down at police cells, which is understandable for anybody. I've been down to see the psychiatrist a couple of times, just asking how I'm settling in and how I feel. He's just keeping an eye on me. I wouldn't say he's been helpful. They don't seem really interested, they just want to ask the questions and get it over and get you back out. (CG)

> They asked if I was suicidal. I said yes at first, and then I said no. Because he said, 'if you're feeling suicidal at the moment then we'll put you in the strips'. So I changed my mind. (SG)

> When I first came in, he asked me, 'do you want a razor?' And I said, 'no thank you, I've already shaved', and he said, 'no, to slit your wrists'. I told my mother about that. (SG)

> He asked, had I tried to commit suicide in the past. I admitted to that. Then he said, 'Do you feel like commiting suicide now?' I wasn't going to turn round and say yes, man because they'd bang me in strip cells. [Were you feeling suicidal then?] I wasn't suicidal, but I mean I were a bit dodgy; I were a bit shaken up about coming back in. He said 'You look a bit worried, you'. I thought bloody hell you're not getting me down strip cells. No chance. (CG)

In general, there was a feeling among some inmates that the use of 'strip cells' was an unofficial hospital 'policy' to minimise the possibility of the system being 'manipulated' by the prisoners.

Experience of health care

Almost all of the subject group were either currently in the hospital, or had regular contact with the hospital. A small number only were receiving medical treatment. One young prisoner said that he was in the hospital because he had just been circumcised, as a result of an indecent assault by another inmate. Well over half of the subject group reported having a negative view about the care they were receiving or the conditions in which they were receiving it. This was particularly so when contact with the hospital was largely limited to experience commensurate with unfurnished, protective accommodation - 'strip cells'.

> I think they are very cruel. You daren't tell 'em you're depressed in case they put you in one of them strip cells. Instead of sitting down and talking to you, taking a few minutes to talk with your problems and help the bloke get sorted out..... he might have a thousand and one problems, but at least he's getting the talk, isn't he? (SG)

A third of the subject group had been referred by the wing to the hospital as result of suspected suicide risk. This had also happened to seven of the comparison group. Over half of the subject group (and a quarter of the comparison group) were on some type of medication: either anti-depressants, sleeping tablets, tranquilizers, a mixture, or a prescription for physical ailments:

> Yes, I'm on this drug largactyl. I haven't been taking it for two weeks. When our baby died I started taking it again, it just bombed me out. It's like an alternative to suicide. (SG)

Almost half of the subject group were either currently seeing or had been referred to a visiting psychiatrist (compared with 23 per cent of the comparison group). The reasons for referral were slightly different for each group, more of the subject group being referred for depression,

suicide risk or assessment, and more of the comparison group being referred for particular problems.

Many of the subject group expressed a wish to see a psychiatrist - although the perceived role of the psychiatrist was not always clear (in anyone's mind):

> No. I would like to see one though, really, to see if there's something wrong with me. I don't think there is. Alright, I've tried to commit suicide, but that was for different reasons. (SG)

> My psychiatrist told me at all costs, I should avoid seeing the prison psychiatrist. He said it would be trouble, he'd probably write me up as some kind of psychopath. (CG)

Problems experienced by remand prisoners in seeking specialist help for their problems are rarely addressed, but present serious issues. Not least of their problems is the fear that consultations will affect court reports and the outcome of hearings.

Aspects of imprisonment

Inmates were asked what, in their view, were the worst aspects of imprisonment (Table 4.93). Answers related to family contact, losing their freedom, boredom, conditions and 'other inmates'. Staff were sometimes heard saying, 'the only thing that gets to them in here is losing their freedom'. This was occasionally said in a dismissive way, as though losing one's freedom was not a major issue. 'Losing freedom' in practice might mean losing everything:

> Just being in prison. Not being able to sort my life out, outside. All me things going up the spout: my business, money, relationship..... They wonder why you get down. It's because no-one's got time to talk to you. (SG)

> The boredom, monotony, and the knowing that nothing positive is going to come of it. (SG)

> The dirtiness of the place. It's filthy, it's full of vermin. You can't get washed, you can't have a shower. (CG)

> The worst of all is if you've got problems out there, family problems, then prison is horrible. Because like a few weeks ago my wife was going to divorce me and all that. I rang up and she told me on the phone. Then she came up the next day and told me on the visit. And when you come on the wing there's nowt for you. You get banged up, there's two more inmates in your cell with you. You can't discuss your problems. And they don't want to know, they've got their own. You talk to an officer, they can only help you so far because they're not skilled enough in that respect. So you like, you've got it in your head and your holding it in. (CG)

Most prisoners lived 'day by day', neither planning their time in custody,

nor seeing it as in any way connected to their lives in the community. This was especially true of the subject group, three quarters of whom reported living their time 'one day at a time'. Few prisoners reported using their time in custody to achieve anything, but this was significantly more frequently reported by the subject group, three quarters of whom described themselves as 'just getting through it'. A further 17 per cent said they would have liked to have used their time inside constructively, but that they could not (see Table 4.94).

Many more wanted to develop their educational or work abilities. Well over half of each group said that nothing they did in custody was interesting or important. Those who did find things interesting reported education, work, gym (especially the comparison group) and activities carried out in their time (reading, painting etc) as being the most interesting:

> Yes, but it depends on which level you come in on. A bloke that can't handle life on the out, there's a lot of them people in here, they just can't survive. They come in prison, nobodies, they set themselves up with their little skims and scams, they feel someone after a while, they're treated the same as everybody else which is a good thing. They can get on education, they can do something with themselves or even in the workshops, they find it rewarding because they're sitting in the workshops doing their little thing however boring it is and they've probably not worked in their lives before. (CG)

Over a third of each group said they would not talk to anyone in prison if they had a problem or were feeling down:

> There's nowt really I can do apart go to chaplain, that's only people I trust really. Because if you go to officers and you say you're feeling depressed they just throw you to one side down in the hospital. (SG)

> Nothing; there's nothing you can do. If you go in your cell and shut the door there's somebody in your cell anyway.

> Suffer, You can put in to see probation or the chaplain but they don't have much time. There should be someone you can see in prison you can just talk to if you have a problem; somebody who has nothing to do with the system. (SG)

More of the comparison group (a fifth) said they would find a way of occupying themselves, to distract themselves from feeling down. Small numbers said they would go to staff or other prisoners (see Table 4.95). When asked specifically 'who they would turn to for help', almost half of each group said 'no-one'. Eighteen per cent of the subject group and 10 per cent of the comparison group said they would turn to staff. Interestingly, the comparison group were more willing to turn to other inmates than the subject group (see Table 4.95).

When asked what they thought the Prison Service should do to make the situation of people like themselves more tolerable, most suggested several improvements, or improvements relating to regime provision and 'training' opportunities (see Table 4.104). Other suggested improvements were better communication with staff; more family contact and conditions in the prison:

I think they should have a group of trained officers. I think women officers as well, you can talk to a woman a lot more than you can to a man. And I think they should have training so they understand the problems and that.... (CG)

Well I think they should find more schemes for prisoners to work on to occupy their minds while they are in prison; something more constructive to do... (SG)

More work, more access to outside, to your families. Like in here the visiting hall is too small: it's pathetic. It's packed out every day of the week apart from Sunday; and you've got prisoners each side of you with their visitors. And once you break off and start thinking what else you're going to say you sort of listen to their conversation. (CG)

I think they should be discussing more about rehabilitation for inmates because that is the only real solution to people coming back to gaol. [What sort of things do you mean?] Well I think they should view the inmate, actually talk to the inmate, try and find out where he's going wrong, his weaknesses and so on. (CG)

Suicidal thought and action

Attempted suicide and its motivation is examined in more detail in the next chapter. There were a number of questions relating to suicide in all interviews however. Fifteen per cent of the comparison group reported having had thoughts of suicide during the sentence. One had made a suicide attempt, and several others had come close (see Table 4.106).

I did this time.... With all this with my wife and the way I feel the police is just setting me up. And they're allowed to get away with it. They can make you do a sentence on remand, and then on the day, you get found not guilty, and you can't do a thing about it. (CG)

Yes. This morning. Last night. Because I think I'm going to be in and out of here all my life; so I'm just a waste of space, aren't I?. I thought I'd cracked it when I got this job, but that last sentence broke me.... it really done my head in, and when I came out, there was no way I could ever go back again. But I couldn't get a job, there was nowt there... so I had to go back out doing things... if my girlfriend finished with me now, I'd be on a rope before I'd even finished reading the letter. (SG).

A couple of times, yes. Even at times now I think it's just not worth living. Sometimes I have very bad dreams and it gets me down. (CG)

Since I did it last time, I have thought about doing it again. I've even thought about overdosing. These people, right, they think 'oh, he's trying to commit suicide, he's daft, he don't know what he's doing'. But we think - I've done it - we know

> what it feels like to be hurt, they don't. All they're thinking is, he's daft. They don't know what you're going through. They don't know what your mind's thinking. You can't talk to no-one in here, so you take it out on yourself, and that's why the majority of people commit suicide in prison, because they can't talk to no-one. (SG)

Slightly more (over a third) of the comparison group knew other inmates who had committed suicide in prison, casting doubt on the assumption sometimes expressed by medical and other staff that the problem is 'contagious' (Table 4.107). It was unpleasant to hear stories of cell-mates or friends, 'someone I done two borstals with', committing suicide:

> The guy I was padded up with in Armley hanged himself. I was asleep. He was a heavy drugs user, glue sniffer. I didn't know he was going to do it. He had a bad background. Didn't care about himself. I woke up and asked him to pass us a fag - no answer. I got up, and saw him - aargh! They took me to the hospital. (SG)

Several reasons were given by inmates for others' attempts: they couldn't handle the sentence/custody; depression, particular problems (expressed slightly more frequently by the subject group) including domestic worries, and boredom:

> I wouldn't say it was because of the way they were treated by the screws, but I would say it was more because of a loss, a feeling of a great sense of loss from all that they've had, you know, just gone in seconds. (SG)

> I suppose a lot of folk would put it down to attention seeking, but I don't see it as that, I think it's desperation, you know, frustration. (CG)

> Wanting compassion and someone to talk to. (SG)

> There's always the case of being bullied. I suppose that's enough to frighten you to do it especially in a place like this, and you feel you've got no-one to turn to. And the fact of being in prison for so long and being away from your family and friends and so on. (CG)

> I think it's mainly problems on the outside with family and things like that, or they feel threatened. But a lot, they think there's no hope for them and they go to, maybe even go to an officer, to like be reassured about something and they get no joy and I think that's another problem, there's no understanding. (CG)

> Because of the hopelessness of the situation and the inability to do anything about altering it. (CG)

Significantly more of the subject group thought others' attempts were serious and that 'knowing the person' was the best way to tell how serious the attempt was.

Not all self-injury was 'a genuine attempt at suicide', however dangerous:

> Yes, an ex-pad mate had tried it. A few weeks ago, when he were up on the fours. He slashed his wrist, and there was blood spurting all over. He were in court the day after he did it, and he got bail. He thought that if he slashed up he'd get bail, and he did. Scarred for life, he cut through his tendon. He just closed his eyes and did it. I was just lying in me bed reading a book and I heard, splash, splash - Oh Jesus! I got up and it was just spurting out, and I said 'Get up you silly bastard!' I dragged him off the bed, I got hold of him, grabbed his belt, wrapped it round his arm, got towel, tied that round the cut and battered the door. It was in the middle of the night. It took twenty minutes before they came. He could have died. You kick shit out of your door and they just think it's someone messing about. People do it, cry wolf. It were a brand new razor blade and he didn't realise how sharp they were. He weren't messing about doing little scratches, he did it right hard. He went to outside hospital and everything. I had nightmares. I kept imagining the blood dripping. I had to clean up all his blood, and with all these AIDS things about, I didn't like that. The staff just called him a stupid little bastard, they knew why he'd done it. If he was genuinely depressed they'd show a lot of sympathy. There's a lot of idiots in here. Most of them don't slash up properly. He did. (CG)

Even those who didn't think that most attempts were 'serious', added that they could quickly become so:

> No. But when a person cries out for help, I think when they get rejected, it makes them worse. I mean, I remember one chap in the hospital, he kept battering on the door and shouting and that. Two days later, he was dead. He was crying out for help. He didn't get any. I think.... sometimes they don't take the cry for help serious. You're looking for somebody to talk to you and show you some kindness, and if you don't get it.... bullying can play a part, debt can play a part, drugs can play a part. (CG)

The possibility of suicide occasionally united staff and prisoners in a moment of common concern:

> I talked someone out of it once, at prison X, saved somebody's life. I come through with this guy and they though we was buddies. We was in a way, and I was on association and he got a 'Dear John' and he was in his room and he cut his arms there [inside, long] instead of there [wrist], and there was blood all over the place. And the screw came down and he says, '[name], can you come up and talk to your mate?', and I said 'Yes, what's the matter?', and he said, 'I'll tell you when you come up' and there loads of screws about on the landing, they was going to bust the door open and go in, like, but that would have made it worse. So he said, 'he's cut his wrists, would you go in and talk to him?'. So I said alright, but I didn't know there'd be that much blood in the cell,

so... when I went up and looked through the spy-hole, I thought 'shit', like, you know what I mean? So I went in and I took the razor blade off him, chatted to him and I says, 'look, let's have a walk over to the hospital, see if we can get it stitched up', like. They let me walk in his cell, but they wouldn't let me walk over to the hospital with him. But anyway, the next day the Governor came to see me, and he said, 'Look, we can't take time off your sentence for that, but it was very good the way you handled X. Cheers.' But the officer that took me upstairs, he came into the room and said, 'Maybe the Governor's told you this and that, but here's sixty cigarettes'. That was real good. (CG)

SUMMARY

It was in terms of coping with their custodial experience that some significant differences emerged between the two groups.

The subject group were very much more likely to be inactive in their cell - far fewer of the subject group reporting reading or writing, listening to music etc and much more likely to report that they spent their time sleeping. They were only slightly more likely to report being bored - but had much greater difficulty in thinking of positive ways of overcoming it. They were less likely to find ways of distracting or occupying themselves if they 'felt down'. They were less likely to plan their time and more likely to live simply 'day by day'. They were less likely to say that they were using their sentence to achieve anything. Where young prisoners were concerned, significantly fewer were doing (or wanted to do) physical education - usually because of associated bullying.

Significantly more of the subject group saw themselves as being 'on their own' in prison, not really being able to mix freely with other prisoners. In addition, the subject group were more likely to report having difficulties with other prisoners - this being more characteristic of the young prisoners (eg bullying) than the adult prisoners.

Significantly fewer of the subject group spent time thinking about the future and when they did, they were distinctly less optimistic about the prospects. They were much more likely to have sleeping problems and to score high on the Hopelessness Scale (a psychological scoring instrument that has a well established association with suicide risk).

In general, a powerful and coherent picture of poor coping emerges. Both groups found the range of things to do in prison rather limited, but the subject group was significantly less able or willing to cope with this state of affairs, was more bored and less willing to believe that anything could be done about it.

There were striking differences between the two groups in their perception of staff and how staff should relate to them. For example while both groups were similar in the extent to which they found staff helpful or unhelpful, the subject group were much more likely to look for and appreciate help of a personal kind ('listening to you', 'showing an interest' or 'trying to understand') than the control group who preferred help of a more practical or instrumental nature. in many ways this was an encouraging finding as it

suggests that developing slightly more personalised approach would be particularly effective more in helping to counter the anxieties of this group (though obviously more difficult to apply in the remand situation). Additional support for this approach was suggested by evidence that the subject group were more likely than the comparison group to avoid contact with staff.

The subject group received rather fewer visits and letters, were more likely to want more visits and letters. They found that thinking about people on the outside a more painful experience than the control group. They were less likely to keep in touch with current events, read newspapers etc. Finally they were much less likely to have any plan or idea of what they would do after release.

Not unexpectedly, many of the subject group had spent long periods in isolation, either in a hospital strip cell or segregated from other prisoners on Rule 43 (Own Protection). Three quarters of the group expressed negative feelings about this experience, and there was evidence that, in some cases, fear of being put in a strip cell had acted as a disincentive to admitting to suicidal feelings - especially during the reception process. A proportion of prisoners also believed that the threat of the strip cell was used as a way of minimising possible 'manipulation' by prisoners.

Footnotes

1. Some of the interviewees had been held in police containers for some time due to a policy of 'locking out' once overcrowding reached 'unacceptable' levels.

2. It is a major oversight of prison suicide research that the 'initial impact' literature has been neglected, despite the stark over-representation of suicides early in custody (see Conclusions). This neglect is largely because the research has been carried out by medical and psychiatric researchers, few of whom read prison sociology. One exception is Backett, 1988.

CHAPTER FIVE

SUICIDE ATTEMPTS IN FOUR PRISONS: IN THEIR OWN WORDS

Suicide? It's bad news. I know I've attempted it myself, but I can't explain it, do you know what I mean? In a way I want to and in a way I don't. I want my life to be completely different. (Prisoner)

Introduction

> I melted a razor blade into a toothbrush...I done that to get a better grip of it. I tried to cut my left wrist but I couldn't, because...well, it was a mess. So I swapped hands and cut my right wrist. Then I swallowed 140 gram of Tamezipan so I could fall asleep before the "end".
>
> I was lying on the bed - you know, waiting patiently [to die], and he came into my cell for my tray. That's what they say, but they don't normally come in your cell for your tray, you put it out when you go to work in the afternoons. So I think he must have looked in my flap, and he came in and asked me what was going on and he see'd the mess. I think they were keeping an eye on me. I had to have 49 internal stitches. It was a very serious attempt. I couldn't cope with the way I was, the way I felt at the time.

This chapter begins with short summary statistics of the suicide attempts and related incidents involving the sixty-two prisoners in the subject group. (The relevant tables can be found in the Appendix). However, from the outset, one of the major aims of the study had been to investigate the 'possible motivations and intentions' governing suicide attempts and self-injury (see chapter one). Consequently, the bulk of the section is devoted to a qualitative presentation of the interviews themselves, very largely letting the prisoners describe the circumstances and reasons for their actions 'in their own words'.

Section I: Suicide Attempts in Four Prisons: A Description

More than a third of these interviews were carried out within one week (but usually up to three days) of the incidents being described (see Table 5.1). A third of the prisoners involved were under the age of 21 (see Table 5.2). Thirty (49 per cent) were on remand, two (3 per cent) were convicted and awaiting sentence, and thirty (49 per cent) were sentenced. Two thirds were 'adult', twelve (29 per cent) of these being under 26. There was a slight over-representation of prisoners charged with or convicted of violence and/or sexual offences (see Table 5.3; some of this over-representation was due to the nature of the establishments in which the research took place). Over half of the incidents involved cutting arms or wrists (see Table 5.4); over a third took place in shared accommodation (whether or not the other prisoners were present). Almost half of the prisoners were on Rule 43 (see Table 5.5). Well over a third of the incidents took place within three weeks of arrival into custody (see Table 5.6). Over a quarter occurred between six o'clock and midnight, although for many this information was irretrievable or inapplicable (see Table 5.6). A third of the incidents required stitches, transfer to outside hospital, or to the prison hospital (see Table 5.7). Over half of the prisoners said they had definitely or partly wanted to die at the time of the incident. Others were 'not sure' (see Table 5.8). Almost a third of the incidents were planned for more than an hour beforehand (see Table 5.9). In five cases, a suicide note had been written (see Table 5.10). Most were seen by a doctor or psychiatrist as a result of the incident. Few were seen by psychologists, probation officers,

or other specialist staff, either immediately or in the long-term (see Table 5.11 and Chapter 7).

Over half of the prisoners were located in protected rooms, in stripped conditions following the incident. Others were located in rooms in the hospital, or in a ward (see Table 5.12). A third of the incidents resulted in a change of location for the prisoner (see Table 5.15). Only four prisoners said that what they had done had led to an improvement of their situation (see Table 5.13). Over a quarter of the prisoners thought they were likely to repeat their actions, a further quarter thought they might (see Table 5.14). These are likely to be conservative estimates, given the numbers giving 'other' reasons - many indicating a reluctance to admit such thoughts.

Differences between young prisoners and adults

More of the young prisoners had cut their arms (55 per cent cf 22 per cent); more of the adult prisoners cut their wrists lengthways, felt to be a more serious method of self-harm (13 per cent cf nil). The three food-refusers were adult. Slightly more of the adults required transfer to outside hospitals (31 per cent cf 10 per cent). Slightly more of the young prisoners gave 'contact problems' and 'pressure or victimisation from others' as a main reason for the incident. More of the adults gave 'frustration and anger' as a main reason (41 cf 10 per cent). More of the adults gave guilt as a main reason (41 cf 10 per cent). None of the young prisoners gave 'medical reasons' as a main reason. A slightly higher percentage of adults said they had wanted to die at the time of the incident (47 per cent cf 25 per cent). Slightly (but not significantly) more of the adults had thought about their attempts for longer than one hour.

Far more of the young prisoners ended up in protective custody (in stripped or semi-stripped conditions) as a result of the incident (90 per cent cf 52 per cent, $p<.02$). More of the adults became prison hospital in-patients; more of the young prisoners were returned directly to the wing, put on Rule 43 or located in the segregation unit as a result of their self-injury ($p<.05$). More of the adults saw the medical officer or the psychiatrist again after the first twenty-four hours ($p<.02$). The two prisoners visited by the Samaritans were young prisoners. The interviews with young prisoners were more likely to occur within three days of the incident. More of the adults (41 per cent) were well into a long sentence (over 12 months) at the time of the incident. Significantly more of the adults had been charged with or convicted of sexual offences (39 per cent cf 10 per cent). The young prisoners were more likely to be charged with or convicted of robbery and theft.

It would appear, then, that some important differences emerged between adult and young prisoners incidents at the general level (specific incidents might have resembled each other). The perception of 'YP slashings' as 'not serious' may have exaggerated the results by leading to differential treatment.

Section II: Suicide Attempts in Four Prisons: Motivation

The following section begins with a large table, compiled from all the answers to the open questions about the motivation of the interviewees' suicide attempts. The responses to the 'closed' questions, where options were given, are shown in Table 5.17. 'Prison pressures' were chosen by over three quarters of the suicide attempt group. 'Depression' was chosen by over two thirds. In the table to follow, an attempt has been made to let the categories emerge from the answers given, to retain the value and quality of the information received. The various responses have been organised into meaningful categories and groups, so far as this was possible. This table summarises a large and vivid range of answers. After some discussion and experimentation, it was decided to present an 'unadulterated' and qualitative selection of the results. The selection tries to be balanced, informative and fair; only occasionally has the gruesome been omitted in favour of the expressive. There was nothing that could be added to these expressions - they say everything that could be said, without intrusion. The question actually asked in the interview is shown, followed by a selection of the responses received.

Table 1.

Main reasons for suicide attempt (open question)		N=62
Reason		No. %
Domestic:	Relationship Break-up/Threat/	22 (35)
	Domestic	21 (34)
	Contact Problems	19 (31)
	Bereavement/Illness	10 (16)
Situational:	Relating to Charge (nature, severity, impact on family, states innocent)	19 (31)
	System Frustrations1	18 (29)
	Upset at being in Prison	17 (27)
	Pressure/Victimisation	17 (27)
	Unable to Cope	14 (23)
	Regime Frustrations2	11 (18)
	Boredom	2 (3)
Strategic:	Change of Location (eg. to hospital)	13 (21)
	Wants Practical Help	10 (16)
	Lack of Attention	6 (10)
	Manipulative/Blackmail	3 (5)
	Seeking Sympathy	2 (3)
Emotional:	Depressed/Fed Up	33 (54)
	Guilt/Shame	16 (26)
	Frustration/Anger	15 (24)
	Communicating Distress	9 (15)
	Emotional Relief	4 (6)
	Fear	6 (10)
'Medical':	Mental Illness (+ borderline)3	7 (11)
	Drugs/Alcohol (withdrawal/problem)	4 (6)
	Medical Problems	2 (3)
Other:	Wanted to Die	20 (52)
	Personal 'Inadequacies'4	4 (6)
	Other (eg. daring)	2 (3)
	Don't Know	1 (2)

1. System Frustrations: bail refused, remand location, unwanted transfer/change location.
2. Regime Frustrations: Rule 43, bang-up, adjudication, request refused, escorted visits, etc.
3. Mental illness (and borderline): hearing voices, claustrophobia, panic, etc.
4. Personal 'inadequacies': immaturity, weakness, low self-esteem, lack of social/verbal skills, etc..

In Their Own Words

Q. Can you describe to me exactly what you did?

I measured the floor, I measured the bed, the fitting and made a couple of wedges so it couldn't be moved. Then I got a cardboard box and I gathered every available newspaper and magazine I could. And what happened was I got some rope out of here because I'd been thinking about it for some time and when it came to the actual time I couldn't find the rope so I had to use some string that we hang the mirror up with, I had to use that. Put the bed into position, the door was wedged end to end. I put the box on the bed with all the paper inside, tied the string to one of the beds. I put all me photographs on the bed, set fire to the paper and tied meself on to the bed, because I had to make sure that I couldn't back out... ... My pad mate was on a visit. It was also me wife's birthday. (What happened then?) Well I'd miscalculated. The heat from the flames started to burn me and just literally started to take the oxygen out of the room, so I started to strain on me hands on the string. It broke and all I did were move up to the other end of the bed and I sat there and then eventually the smoke started to...and what I feared before would happen I went to the window and started to shout for help... ... The water in fact aided me with what I wanted to do. In future I'll remember that because the more water you put on the more smoke it makes which is what I intended in the first place. So if anything it were in a way helpful. I was in the infirmary for about 3 days. Then in a strip cell. The staff were calling me names and that. I definitely wanted to die and I still do...

Q. Where were you located at the time?

I was by myself at the time. My pad-mate was at court.

No, I wasn't on my own. I was in a cell with somebody else. He's in the hospital now with his nerves! I must have lost nearly all my blood!

Q. What method did you use?

I got my shirt that I was wearing, just tied it round my neck and I was going to put it on some bars on windows, but they caught me before I did it, and me pad mate rang bell.I was in cells down there, [on hospital].

I had a pair of trainers on with nylon laces, and I took both laces out of the shoes, wrapped them round each other and formed a loop, which I strung through the bars, and suspended myself about three inches from the ground.

I took seventeen tablets - a mixture. It was a waste of time in the end, 'cause they were for depression! I thought it would be enough. I got my paracetomol from the night orderly; the

rest I was being prescribed.

I just sat on my bed and I just felt really depressed, so I broke a razor up, got a new blade and cut all my arm up. It's the first time I've ever done it in prison. I needed 32 stitches.

I think that was the final push...I didn't really do it to commit suicide I just felt, well half of me said, 'Oh, it's not worth fucking living any more, going through this hell and torment'. It's mental torture for another three years to come out to zilch, you know? I was feeling lousy so I just popped a couple of pills, didn't feel anything off that so I popped a couple more, when I got to about 10 or 12 I just said 'Oh shit', and just did the lot.

Q. Why did you do it; what was going on at the time?

Me charge. And this place.

Depression and anger. What it was, I was thinking all about the family and what was going on all around me, and with me not having any letters for a week or two, I just thought, well there's no point in me being here, no-one cares about me.

Me pad mate getting on me case. I slashed up and he just broke down, because he didn't think I'd have the bottle to slash up. Just grief.

Well I was told that my mum and dad had been killed in a car crash, and I just snapped a razor to bits and just started slicing my arm. I was on Rule 43. They know that I aren't in for a sex offence or nowt like that but they'll just do owt to you, just start getting your head in bits.

Just getting another five years. I still don't think that I'll manage to survive it, get out. I don't think I'll survive that long.

I was depressed, upset. It was more about my children. I got a letter from my ex-girlfriend saying like we weren't getting back.

I couldn't really call it depression, because I wasn't feeling anything emotionally...Not understanding, because I didn't know what was happening.

There was no hope, no light at the end of the tunnel. Once you're in the system you'll never get out of it; the only way out is to become dead or anonymous, because that's the only way they will ever leave you alone. That's the only way you can ever start to rebuild a life, because once you've been in this system and they know about you they will arrest you for things you don't do. They will put you inside a prison for things you don't do and they will generally fuck up your life all the time.

I'd got a letter from my girlfriend and it...was just a bad letter saying I've stood by you through it all and why can't you stand by me...Saturday tea-time. My pad mate were there and I just broke down crying and he said 'what's up with you?' and I just showed him the letter. And I come down for tea, I didn't actually get any; I went straight to the SO and asked for a phone call and he told me to wait 'til Monday and put an app in to the Governor. [Did you tell him what the problem was?] Yes. I were crying in front of him. As I were going he said 'Do you want to see the chaplain?' I just walked off. I got into my pad. I just, I'd calmed down a bit, I'd stopped crying and that. I told my pad mate to hide all the blades. He asked why and that and I told him. He'd known about my attempts before because we'd just talked about it. He were bringing me round, sort of thing, because he was saying 'it's not a Dear John; she's saying 'If this', and 'If that'. There were no definite, 'this is over'. He were just helping me, talking to me all the time. [Why did you tell him to hide the blades?] Because as soon as lights were out I was going to cut myself, and I didn't want to. My wrists and my neck. [What was stopping you?] It was just what he said, the doubt. He says 'why don't you wait 'til morning and see chaplain and get them to ring up'. And that's the only thing that stopped me from doing it. If there'd have been no chaplain and I'd have had to wait 'til Monday I don't think I'd have made it.

[Why do you think you've been thinking like that since you came here?] I don't know. I think it's the place depressing me and because people pick on people. I was picked on [in other prisons] but not so much as you do here. I would like to get out of this place nearer home.

[What had made you feel like trying to hang yourself?] Just being in that cell all the time, so depressed.[What was going on in the cell?] Well, lad I was in with started threatening me...just says that he reckoned that he could put curses on people. He said he'd put a curse on me from devil. That's why I carry me Bible around with me all the time. I just keep thinking they are going to get me. [Do you believe him?] I don't know if I believe him, but I think I'm a bit wary about it. [Why had this lad started threatening to put a curse on you?] I don't know really. Ah that was it, I was constipated and I hadn't been to toilet for two weeks and they give me an enema and I was on pot every 5 minutes, he said If you do it again, I'll kick your face in, all this lot. [So what did you do?] I rang the bell and told prison officers. They wouldn't do nowt. They said they hadn't any room to put me that's when I tried to hang myself.

Why did you feel that it was worth doing that to get a rest in the hospital? Because I needed it. If I hadn't have rested then I'd have been hanging or I would have hurt somebody else. You get to a certain point where you can't take it any more and if you can stay this side of that line which is very, very thin, then you can sometimes manage it yourself, because

you can't expect help off anybody else. So you do certain things, you either cut yourself or injure yourself and that keeps you this side of the wall. I mean I believe nobody wants to cut themselves or try to commit suicide in here because they know the treatment they get. It's the fact that they just get too much and they don't know what to do, because the treatment you get after you've tried to commit suicide...I wouldn't treat an animal like that.

Q. **Had you discussed the problem, or how you were feeling with anyone?**

...The only way not to, is to get some kind of help. At the moment I'm having self-awareness [Probation run group]. I've just written - I'm sending the book in on Monday - 12 pages I couldn't believe it myself. It's all about how you feel. The one who does it, she tries to help by feeding back. You write to her in your book about how you feel and she writes back and gives you the correct way, the way you should try to feel, talks about all your defences and triggers that you have; your childhood and that. (Do you find that helpful?) It's very hard to, you write in your book about how bad you feel and how much you hate yourself, and somebody writes back to you and says, 'No you're not a bad person', it's hard for you to believe that. Some of the things that she says are hard to accept as right. But some other things that she says I do, I do understand and take it in. But I've got a long way, a long way to go...it's all a matter of building self-esteem and confidence.

Yes, that one officer. As I say, he noticed, and he could see that I'd lost a hell of a lot of weight, and he got me in a corner and sat me down, and I told him I'd just got this letter and it had really done me. Anyway, he said, 'do you feel suicidal?' and I said 'no, I'm not going to do owt like that', but he could see - he said he could see I was bad, so he took me over to the hospital.

No, why should I? They don't want to know about my problems, they've got their own. That stress class helped, but they haven't done it for ages now.

No, I mean, you can't get close to any of the officers in here, no way. They treat you with contempt, and they're patronising. There's the odd one that you can talk to, but you get shut off from those prison officers by the others, you know.

I'd tried, and not been allowed to.

No. I went to talk to one about it but it's just knowing which one to talk to, because they're all...caring and understanding. So I just want to, just find one. [What would you tell them when you do find the one you want to talk to?] I just want to sit down like me and you are and just talk it over.

[Why did you walk away when the SO said did you want the chaplain?] I was just too upset. I didn't want the lads to see me. Because it was just at the doorway, and all lads were getting their tea and that lot and it were just embarassing.

I saw the psychiatrist and two officers from X wing came down to see me and said I could come and talk to them if I feel down. But I'll do what my mum used to say if something didn't work: try and try again 'til it does. But I wouldn't do it in the hospital. I'll wait 'til I get back on the landing.

Only one, only one sat down and listened to me...He give me 5 free letters to write out to my family. He does help you. He's a marvellous officer, he does his job right.

Q. How helpful were they?

It was like, one morning I rang the bell and asked if I could see the doctor because I was feeling down and that. They brought me over and I just told him more or less what I told you. He said that like, he asked me if I wanted to go back to Grendon, if that'd be any good, and I said yes, so he said he'd write a letter, and he's done that as far as I know. And he kept saying things like, 'well, promise me you won't do anything stupid?', and I just felt like laughing at him because I'd just spent about three quarters of an hour telling him my problems and I'd been telling him that I felt like doing myself in and that, and he comes out with that - as though, just because he's going to write to Grendon, that's going to solve everything. You know, expecting me to promise that I wasn't going to do anything stupid. I've been in strips ever since.

Uhm, I'm not saying they don't go out of their way to be helpful, but they haven't really been helpful to me, because I don't really see them as talking to me as being honest; you know, sincere and that. [How could they be more helpful, then?] By not believing themselves right all the time. I don't know whether they're suspicious; I think they just don't want to be outdone; they don't want to think we'd put one over on them.

They were alright, but - it was just the way I was feeling. Same as now, really. I wished I hadn't told anybody. I'd have been better gone.

I wouldn't say they're helpful; they're just worried.

No. I were expecting the SO to come round looking for me, because there's not going to be that many lads upset and crying in a pad on a Saturday night. But he just left it at that. And I've seen him since and he hasn't said owt.

When they took me down to the hospital most of the officers said, 'Oh, is it you again, you scouse dickhead', excuse my language but this one this night he was good to me, he was

hugging me, saying 'breathe properly...'

No. After I returned from outside hospital ...they then dragged me down the strippy, put me in the strippy and left me there for a day and then he come round in the morning, the doctor, with three of his mates and he just said 'are you all right?' and I said 'Yes'. He said, 'We'll send you back up then'.

[Help from the chaplain?] She were a lot. I expected her, she were on about she were busy...I were expecting her to like leave a message with one of the officers, but she came back straight away. She'd had a word with girlfriend and it were all sorted. She told her that I was upset and everything. They're not allowed to let me make a phone call; in other prisons you're allowed to make phone calls. I mean I've had phone calls for an hour or more talking to someone when I've been far away and not had any visits. I'd have only wanted 10 minutes. That's all it took her, but I weren't even allowed that...I mean I went through me offences and stuff because that weren't helping much either, because I felt she [girlfriend] had just given up on me, you know what I mean? She'd had enough and that lot. So we talked about that and she says that if I ever want to talk to her about anything she's always there, sort of thing. But even that, you can't get to them when you want them. I mean if I wanted her [lady chaplain] now I'd have to look for, the only way to get round it it to put an app in in the morning. That's the way it is. If you want to go toilet you have to put an app in! It's that bad, you know.

Q. Was your attempt impulsive; did you do it without thinking about it beforehand, or was it planned - had you decided beforehand that this was something you were going to do?

It suddenly occurred to me to do it then. I was involved in a fight about one or two hours prior to it. Maybe that helped me along the way a bit.

It's not like I was planning, it was just like...I knew she was going to say something, but I didn't know it was going to be anything about divorce. That was what hit me. She wasn't going to let me see the kids. I just couldn't take no more.

Well, I'd been thinking about doing myself in for some time. [When did you first start thinking about it?] When I first got sent down. Even before I got sentenced I felt like doing myself in, because I knew that I was going to prison.

Oh I've planned it. Planned it in my head, planned all the things I'm going to do to myself. Like put ropes round my neck and positioned myself and things like that, you know what I mean. The only thing that's holding me back is my children. They'll have nobody if I die.

I cried for a bit and then I said to myself I might as well finish it now.

I sat there and I thought quite some time, I tried to turn it over in my mind, what have I got, what future, and it was zilch, nothing. I haven't got a future. And then this feeling of hopelessness; you're like a baby in here, like a baby. I've tried most of the channels to get help and it seemed in that time I'd just been fobbed off and so I thought 'Oh shit, who cares, who cares a damn if I die?' It's a horrible feeling this pleading for help and you don't get nothing. You're crying out for help, it's gut ripping and you're getting nothing. And you daren't come up here and say I feel slightly suicidal', you know what I mean? Or 'I do', or 'I don't, but I did two hours ago'. Because if you say that you get put down the strip cell. What's that going to do to a guy? You daren't even be open with them which is criminal, as you might say.

Q. Did anyone know you were thinking about it?

The Chaplain. He just said I'm not going to get anywhere with it, and I said I'm going to get rid of all my problems.

Nobody know apart from the SO but he didn't know me name, he didn't recognize me or owt and so, it were a good job in a way because if he'd have known how I was feeling because it's got in my records, you know, communal cell, he'd have put me in cell. When you're feeling like that, unless you want to go in strip cell, you've got to keep it quiet.....I could have been in there for a week, and in that week I can't get messages by phone or anything. And it would just depress me even more so when I got out the first opportunity I'd definitely have done it. I mean the first time I went in strip cell in here I come out more depressed than when I went in. I lied to doctor saying I'm not feeling depressed now, I'm all right and when I got back to pad there was a letter waiting for me from my girlfriend and that stopped me doing it again.

I went down the other week and told them I were feeling depressed and that, at tea time sick hatch, and he says 'Oh talk to one of officers on landing, you tell them, say I feel a bit down'. They say, 'You shouldn't get into trouble; if you didn't break law you wouldn't be in here, then you wouldn't feel depressed would you?', then they shut your door.

Q. Did you take any precautions, or leave a note?

I did leave a note, yes, to my probation officer, actually. There was one person who was alright about everything all the way through, probation. But she was my outside probation officer. She's moved to another department now.

No, you don't have any pens or anything. And anyway, no one would have bothered.

Q. Was there anything in particular that made you feel so bad on that particular day?

I'd absconded from [prison A]. My wife had come up to visit me with my daughter, then I phoned up at the weekend and she wasn't in. I had a message to phone her back immediately. She told me that my daughter had been taken into care. I went and told the officers, the lad in there even knows about it, and the officers didn't give a shit about me. They said, 'well, there's nowt we can do about it at the moment, just wait and see what happens on Monday'. So I thought I'd take the law into my own hands and just go and sort things out. I was going to go home, but I handed myself in in the end; I phoned the police. I realised what I had done, being completely mixed up in myself. I lost 65 days. They could have taken the whole 90 days off me, but they didn't really realise the situation what I was stood in. As far as I'm concerned they couldn't understand why I'd done it. Next thing, I cut my wrists.

Q. How serious were you, do you think, about the attempt/injury? Did you intend to kill yourself? (Or was it a bit of both?)

I was unconscious for seven hours. I spent two days in the Royal Infirmary.

A lot of cutting is not serious. I've got about 160 stitches on my chest from different cuts, but a lot of it is either as a direct or indirect scream for help. This time I really meant it. I was off.

Exactly! I did want to and I didn't want to? Do you know what I mean?

Partly. I knew it wouldn't help. I just thought, if I ask for help I'll just get thrown in strip cells, so what good does it do you? Either do it right, or don't do it. I felt even more depressed. If my mother found out I'd done it again, she'd disown me - to think she's got a son that's a nutter. I've told her it gets depressing in here.

[On a scale of one to ten?] There isn't a scale really. Like I say, when I start getting angry and frustrated and there's nothing to do, and bored...I just do it. It's just I'm not bothered if I live or die.

Partly. It was serious and not serious at the same time. It relieves the depression, releases it when I injure myself. Outside, if I don't injure myself, I'd go out and get into trouble, or I'd go and punch hell out of someone.

I partly wanted to die. [Why more serious this time?] Because I started thinking about it, and got meself wound up about it, then it got even worse, so I decided to do it, then as soon as I saw the vein I stopped because it was bleeding enough. [Were you very frightened?] A bit, yes. [Has anybody been to see

you this time?] No apart from you. If I go back on there, even I go on protection, I'll still do it again, because the windows, they'll shout and blame me, all protection are doing it, that means that it'll start over and I'll slash up. Next time I do it, it will definitely be worse than this cut. I'll do the thing next time.

Q. What happened immediately afterwards?

I was just seen by the prison psychiatrist, who said I'm not psychiatrically ill.

To excuse my swearing, I was extremely pissed off to find I was still here. I got over the feeling of actually failing, but I was not at all pleased. People were saying I was lucky to be alive. Alive, yes; lucky, no. [How do you feel now?] The same. Not to the same extent, but my thoughts are all the same: negative. I went to outside hospital to get stitched up. I was told there that I was going to be transferred to another prison, because of this incident - which is here.

I didn't tell anyone. I just did it to see if I could go all the way through the vein without it hurting too much. After a couple times, I just thought, no, I won't do it. It didn't hurt, it was just that as I was wiping the blood away, I could actually see the vein and that kind of out me off; you know, I could see the blueness of the vein, and it made me kind of sick, and I stopped doing it.

I saw the doctor. He didn't understand my problems, do you know what I mean? OK, he was the doctor, they say that they understand, but they don't.

[So he took you down to the hospital - did he say anything to you?] Oh yes, he said if you're going to do that why don't you make a good job and do it right. He said , 'fucking about with YPs with little scratches!' He said, 'If you're going to slash up, do it right. Do your throat or something'. I couldn't believe it, I nearly fell down stairs.

Q. Has this incident helped to alleviate your problems in any way? Has it made anything better for you?

Well, it's put a couple of scars on my arm, and that's about the only difference.

It made me feel as though I know I've got the bottle to do it if it comes round again. I know it's not right to do it, but I know it's better than going through the pain of being here all the time and that.

It didn't make things better, it didn't make them worse. It didn't make any difference. It didn't do anything.

No. You do it so that the doctor will realise, so that he'll get someone to come and talk to you and that; talk about your

problems, like a Samaritan. I'm going to put in an application to see a Samaritan now. But no-one comes.

[You left here and you went back on the wing - what happened then?] I was all right for a couple of days and there was something in paper, right? I was in paper, what I've been accused of, robbery, when I took this woman's handbag. But I was at me mum's when it happened. Because I was in paper, they think I did it, so they were going to beat me up. I would have got worse than this, so I beat them to it, so I could get off the wing. Even if I try explaining that to them [the lads on the wing] they still won't listen. They came into my cell, a few of them, one punched me and said 'we'll find out it's you for definite, then we'll do worse than that'. So then I just did this.

[When you got back did you ask for protection?] Yes; I didn't get it. I told them I'd feel more safe up there so they said 'that's not a good enough reason'. If I go back up there now I'll end up doing it again I know for definite I will.

Q. And what happened in the longer term, after the first twenty-four hours?

The Chaplain came to see me - he was alright. Asked me why I slash up. He said, 'did I want a prison visitor?' I said, 'yes, alright then'. Then I waited three weeks and no visitor. I put in an application to see the Chaplain. I say, 'where's my prison visitor?' He said, 'hasn't no-one come to see you?' 'No'. So he said, 'I'll have to get on to that' - I said, 'don't bother'.

Well, people have been coming up to me saying I can come and talk and that, but it's very difficult, you know, knowing that they belong to the prison, you know what I mean? You can't trust anyone in here.

Nothing. The prison should look at the problem, look at the reasons why they're doing it, try and help them. They could at least help by giving you some time, not bang you up all the time - that really is wrong. Even if it was only walking up and down the landing, it'd help, cause you're not banged up looking at four walls. It's like being a pigeon in a box.

Q. What sort of help were you looking for?

I was looking for someone to talk to, somebody to sit down and have a conversation about anything and everything. I wanted to understand everything.

Q. Are you likely to do it again? Are they still keeping an eye on you?

They're definitely not keeping an eye on me, because...I can tell you because you ain't going on to them, but I felt a bit depressed on Monday, and I thought I'd do it with food. I was taking my food, and then when I got it in my cell I was

throwing it in my bucket. That only lasted until Tuesday dinner-time and I thought, well, it's going to bore the tears out of me, because it's about 60 days. I was pretty bored after one day, so I had to leave it alone. They didn't notice, no. I do feel like having another go...I don't think it'll be the blade again. I think it'll just be back to motorbikes and reckless driving and hope for...one day there will be a good enough accident, enough to finish it off.

Well, the next time, well there won't be a next time, but I've showed them this time, I could have been dead; this time they will listen to me. This sounds as though I'm threatening somebody, I'm not threatening anybody to listen to me, I just want to talk to somebody, somebody who's willing to sit down and listen for half an hour, that's all. I've had all of this inside of me for what, God, 20 odd months now; it's eating me alive.

Very. [Soon or?..] 2 days before I go out, or it might be the day before. It depends how close I can get to me EDR. Out there scares me a lot more than in here. Because I've nothing, nothing out there now.

[Why repeat?] Same as ever, thinking of our lass; thinking of our lass and the bairns, wanting to be with them, wanting to see them, like the baby I haven't seen him since he was born. I sent a VO 4 days ago, she must have got it...

Q. Are there any other comments you would like to make? Anything else you want to say?

What I really need is psychological help...Understanding would be a better word. Understanding, rather than paying £250 a week or whatever it is, just to keep somebody like me in prison. But they've never once tried to sort my head out, or rehabilitation, which they could probably do for half that amount...

It's all sorts of things, like. I could say things that are still happening from years ago. It's like, whenever I try to tell them things, about how I'm feeling, they all seem to have a ready answer, and I know they're wrong and like they don't see...It's mainly the officers on the landing 'cause they go around like treating everybody the same, and I don't think that's how it should be, because everybody's different. I know there are other people in here like me, you know, who've been through what I've been through, but like, I've been in care from age six to sixteen, and from 16 I've been in prison, with the exception of about five months. So, like, when I tell them I need to be taught the basic things of life, they turn round and say to me, it should be up to me to go out and learn these things. But how can I when I don't know what the things are to learn? When I go to someone else, they just say the same things but in different words. I've just got fed up with it.

Other people [pad mates] wouldn't have been bothered. They'd have left the blades lying about because most of them think if,

you know, he does a good job then I'll get bail. It's like most of YPs, you know, these that have been hanging themselves that's all it were over. They've said to themselves 'Well, if I try to hang myself I'll get bail and my pad mate'll get bail'. And they egg them on, you know, Do it tonight and we'll get bail tomorrow. [Do you know that for certain?'] Yes I've had first hand experience of it. Most of it's done in jest, like I said, do it tonight and we'll get bail tomorrow. But I've heard people serious, you know, 'I'm going to get me pad mate to hang himself tonight'. You can frighten people because there's no escape. The only thing you can do it put your tally down and wait 'til officer comes round and then say 'Oh, he's bullying me'. Nine out of ten times your pad mate won't let you put tally down, you know.

I think like, when they have these spates of hangings like with the YPs there should have been someone to talk to. Somebody they would trust. They've got signs for everything else, like racial equality. There should be a sign if you feel depressed see so and so, it's strictly confidential. But that person should be like an officer so that if you go to him nobody knows you're going for suicide. You could be going for other things so it stays virtually confidential. And I think you should have time to talk to him, like through night, because that's the time when it hits most people. Like, if I wanted to hang myself or cut myself in here...that would be a cry for help, because you know during the day someone's going to open your door. If you do it at night you've got like 8 hours, and if you cut your wrists you can pretend to be asleep and nightwatchman don't know.

[Do you know you can ask to see a Samaritan?] Yes, but they're not here, are they? I suppose it would take a day or so to come through. They've got probation officers in here, so why can't they have Samaritans?

What did the doctor say to you? He said don't be stupid, there's more to live for than that. [And what do you think?] I don't think there's nowt to live for really.

Footnotes

1. There was no significant difference on day of the week although for certain subgroups (eg. the young, first timers and those on remand) weekends seemed to be slightly more frequent. Whether or not this is shown statistically in the results, it is clear from the ensuing qualitative information that many prisoners in distress are given "wait untill Monday" responses from the staff (See this chapter, passim).

CHAPTER SIX

THE STAFF

They say that security is the top notch. Not to me it isn't; human life is the most valuable thing as far as I'm concerned, and I'll go to any lengths, and I mean any lengths, to stop somebody doing theirself in. (Hospital Officer)

Possibly if they had more consideration for the prison officer, they would get more value back from them. We do a very hard job. I'm not saying I don't like it, I do. I enjoy dealing with people, it's the best job I've ever had. But I do wish that people outside were more concerned about us. We're only a member of public doing our job. We seem to be isolated from the public, and if anything happens, they think it's us that's done it... (Officer)

Well, obviously no-one wants to come in here and find a load of dead people on your hands - the paper-work's too involved for one thing. (Officer)

Remember: You have the most direct daily contact with inmates. Using your skills in observation and knowledge of behaviour can make the difference in preventing serious incidents and maintaining the stability of your facility. (Office of Health Care Services: Suicide Prevention Handbook, California Department of Corrections)

Introduction

The study was wholly dependent on staff in the fieldwork establishments for the successful arrangement, facilitation and completion of the research. It is a significant reflection that few organisational difficulties were encountered in the field, and that the level of support and interest received throughout the project was sometimes overwhelming. The researchers continue to receive invitations to visit and re-visit establishments still eager to inform and be informed about suicide and suicide attempts in prison. Without this interest, concern and participation, the research would not have been completed as quickly or so sanely.

Like others (for example, Hay and Sparks, 1991; DiLulio, 1990; Home Office, 1992a), the researchers were persuaded that prison staff are one of the most under-used and under-valued professional/practitioner groups that there are. Similarly, governors, area managers, specialists and others contributed to the research in a way that constituted a research finding in itself.

This chapter outlines the results of long, semi-structured but formal inteviews with one hundred and thirty staff members of all grades and types, carried out in the four fieldwork establishments. The material is also informed by the countless hours of less formal discussions which were held in tea-rooms, on landings, over lunches, (occasionally) in bars, and by the pilot study, described in chapter two.

The interviews began in a loosely structured way, asking for a description of the officer's daily work, and then went on to ask detailed questions about the nature of the job, prison suicide, its prevention, training, problems with suicide prevention procedures and the context in which they were carried out. The interviews were tape-recorded, and lasted between three quarters of an hour and two hours (see chapter two). As reported in the previous research, staff often commented that they found the interview an interesting and rewarding experience, and felt pleased that people were so interested in their work and their views. The initial aim to interview about one hundred staff members was exceeded, largely in response to offers ('so, when are you going to interview me, then?'), suggestions ('you really ought to speak to X') and the general enthusiasm of the staff.

In the account which follows, the term 'staff' refers to all types and grades of staff working in Prison Service establishments, unless otherwise specified. For much of the analysis, the total group interviewed is divided into three categories: 'uniformed officers' (basic grade, senior and principal officers), 'hospital staff' (basic hospital officers, senior and principal hospital officers, hospital governors and medical staff) and 'others and specialists' (governors, psychologists, chaplains, education officers, probation officers and works instructors).

Section I: The Role of Staff in Suicide Prevention

It is often said, particularly by those outside the Prison Service, and by other criminal justice agencies, that prison staff cannot appropriately be expected to be the primary agents of care in establishments. Their security and discipline functions exclude or conflict with it, and time is insufficient;

the role of an officer is not compatible with 'welfare' work. This debate has had a long and interesting history (eg. Jepson and Elliot, 1985; MacAllister, Bottomley and Liebling, 1992; OPCS, 1985) and need not be addressed in detail here. The crucial point is whether staff have a role to play in the support, observation, identification and care of prisoners at risk of suicide and, if so, what sort of role should this be?

Two preliminary but essential points need to be made here. Firstly, the word 'prevention' has been, and continues to be, tainted by its association with both the psychiatric assessment of suicide risk and inquest preceedings. The very word carries an unwelcome tone of failure. The word 'awareness' is probably a better alternative, but a more helpful approach might be to change the terminology altogether from 'suicide prevention' to 'support for vulnerable prisoners'. The terminology is important because such a change of vocabulary would facilitate discussion of the appropriate role of staff (see Hay and Sparks, 1991:2). Are staff specifically 'preventing suicides' or are they 'looking after inmates' in a much wider sense? The latter focus may be a more helpful place to begin.

Secondly, it was very striking how different daily life could be for officers according to the type of prison, or indeed the type of wing on which they worked. To some extent, officers in local prisons were doing an entirely different job to officers in (the one) training prison(s), and yet in other ways, they were the same as officers in any other type of prison. Is being a prison officer a routine task?:

> My job? Well, it depends what job you're on...dealing with a thousand and one requests: private cash, visits, legal aid, and all that. Between food and water, there are all these things to do. (Officer)

> Every day is different. Trouble is, there are so many constraints on time, you tend to put their problems on hold. It's particularly difficult here. Some things, you forget to go back, because something more important crops up - the prison's got to run. You can say, for example, that it'll take half an hour for me and a colleague to slop out a landing, but during that time, when breakfast starts at 8am, in half an hour's time, if you get a couple of major welfare problems, you can't really do anything about it, bacause you've got the landing to slop out, you can't stop what you're doing. (Officer)

There is no experience quite like sitting in a landing office on an overcrowded remand wing, with a constantly open door, staff coming in and out, prisoners coming in and out, phones and bells constantly ringing, people arriving on and off the wing, questions being asked, requests being made (shampoo, razor blade, cell change, application, visiting order, letter, job change, go to PE, see the PO...), time schedules to keep, 'bodies' to count, move, receive and discharge. Some of the tapes reflect this apparent but organised chaos. Getting to the end of the day, still smiling, was no mean achievement for anyone! This aspect of the officers' working environment was particularly important in two of the fieldwork establishments and will be developed later. (In the account which follows, the relevant tables are at Appendix IV).

The Role and Nature of Prison Officers' Work

Hay and Sparks have argued that the particular difficulties and complexities inherent in the role and nature of being a prison officer have been neglected in both theoretical and policy debates, and that this 'comparative silence in an area of otherwise lively and contentious policy debate' (Hay and Sparks, 1991:2) sets unfortunate limits on the potentially 'key question of outlining a viable future for the occupation of prison officer' (Ibid.):

> There are several reasons for this state of affairs. One is that it is actually much more difficult to state convincingly the full variety of things that prison staff have to know or do than the official received wisdom has yet generally acknowledged (just as it is much more difficult to do it and much more difficult to train people to do it)...On the one hand it can be presented as self-evident; the basic common sense of the sturdy men and women doing what comes naturally. On the other hand it can be regarded as too delicate and difficult a thing to be stated clearly at all: prison officers have special abilities, but we can't quite say what they are, nor teach them...Prison officers have not always been their own best advocates in this regard, perhaps owing to some combination of modesty and impatience of the generally fickle and ill-informed level of public interest. Neither, however, have they been very well served by those above them whose job it is, or should have been, to provide them with a clear and consistent sense of identity and purpose, and a vocabulary with which to describe themselves and what they do (Hay and Sparks, 1991:2-3).

This argument was reflected in much of what was said by staff about the nature of their work in prisons, and how their role in the management and prevention of suicide could not be taken out of context - in short how "Good suicide prevention means 'good custody'" (cp. Rowan, 1991).

Consequently, in order in order to put later questions about suicide and its prevention into a context, staff were asked a series of questions about the nature of their work: the aspects of it which they found most valuable and how important they thought 'welfare work' (however defined, see below) was. Half of the staff (51 per cent) thought that relationships or 'looking after inmates' were the most valuable aspect of their work (see Table 6:1):

> Solving their problems, when you can get round to doing that, because it builds up relationships and trust. (Officer)

> I suppose sorting out some of their problems. If they feel that they're banged up and nothing can be solved, a simple phone call or a letter, or even reading their letter to them, can maybe calm them down. If I can go home and feel I've achieved something, I feel quite happy with myself. (Officer)

Only two officers felt that security stood alone as being the most valuable aspect of their work. Some of the more senior staff felt that dealing with officers, facilitating and encouraging the staff was the most valuable

aspect of their particular role:

> That's a difficult one, really - it's all valuable, it's all essential. I think trying to keep staff morale is one of the most important parts of my job, quite frankly. And obviously, from time to time we do deal with inmates, and sometimes that can be satisfying, especially if we get a successful conclusion. (Principal Officer)

Not surprisingly, different departments tended to see the valuable aspects of their work in terms of their own specialism:

> Daily, face to face contact. It's a very large question. I don't think you can answer that in these terms because our job varies to such a degree that something may come about today - for example, an inmate is injured on the sports field. You go and deal with him in a first aid situation, until he is removed to hospital, then you know the person has recovered - that is valuable. Or if a person tries to hang himself and you're the hospital officer on the scene, and you cut him down and the person survives - that is valuable. So there's a lot of value in the job, but you couldn't put it in the one sense, I don't think. (Hospital Officer)

Almost half of the staff did not think any aspect of their work was 'least valuable' or 'not valuable': they thought their work as a whole was valuable and that every aspect of it made a contribution to the whole:

> Not really. I'm part of a team. You rarely get a day when you don't do something valuable. (Officer)

Not surprisingly, 'paper work' (spar forms, multiple documentation of procedures, etc.), 'administration' (disciplinary and other procedures, call ups, escort work, etc), and the prison routine (opening and closing doors, standing out on exercise in freezing weather, 'the routine things you have to do every day, like they have to be fed, slopped out..'), were often described as a 'waste of time'.

There were important and unresolved questions about what was meant by the term 'welfare work'. Different staff groups and types tended to work with different definitions of what it might be:

> I think it falls into two main areas. One is dealing with the problems that might cause a prisoner to be anxious about his incarceration. The second is dealing with problems which might hinder him when he's released...The two broad things, one to make people settled when they're in custody and secondly to help people settle when they get released. (Governor grade)

> Oh I would define welfare work as sort of a concept for looking after people based on a mish-mash of psychology, sociology and a smattering of useful law, a dangerous smattering probably. And just being a nice person. (Prison Chaplain)

> Anything that makes the prisoner more content with his lot. People put tags on, like: that's a domestic, or it has to

address some particular problem; but I think in a more general anything that helps the prisoner get through his sentence relatively trouble free and with some understanding of what's happening to him, is all welfare work. (Governor Grade)

I think all prison officers do welfare work without realizing it. Really it's the daily interaction between the staff and the inmate without putting a title to it. (Officer)

Importantly, almost three quarters of the staff were prepared to classify 'welfare work' or 'dealing with inmates' problems' as a very important part of their work (see Table 6:2):

Well, yes, because of their lack of contact with the outside. If they've got a problem this is one of the reasons a lot of them breach the rules. Because they've got a problem outside, they get a bit wound up, and they do things that they wouldn't normally do. (Officer)

I think prison officers should be actively involved with inmates on a daily basis, and that doesn't mean just supervising them whilst they're watching television, it's about talking to them, it's about communication. It's a matter of being part of the regime for the inmates; a team. (Principal Officer)

Only 5 per cent of staff thought welfare work was not very important:

Yes and no. It boils down to the basics again. You'll get people who'll abuse it. For every misdemeanour, they want the welfare. It is a good thing, if it's used properly. You always get those who - you know - "my wife writes every day, but I've not had one today, can you get some-one to ring up..?" It creates a lot of work, which you can ill afford; you've got 68 whinges. It can do good for someone who needs it, but it's got its problems. (Officer)

However, while the bulk of staff were happy to classify 'welfare work' as a very important part of their work, far fewer of them (one third of the sample and one quarter of officers) were prepared to define it as being the most important part of the job:

Well, looking after the inmates. Seeing that they are mentally and physically fit.

Often the spin-off effects of this type of work was couched in other terms:

It's contact with prisoners, and the understanding that they build up, otherwise half a dozen prison officers couldn't achieve half of what they do. (Governor Grade)

Dealing with the inmates. By talking to them and managing to deal with them properly you find out who's behind this and that, the tensions on the wing, you know how it feels, you can walk in and feel whether it's tense, happy, whatever. That's your barometer - when you get to know them. That's the essential thing, these are the people we've got to deal with.

> And when you've got numbers like this and you can't always give them what they want, you try hard to do that. (Principal Officer)

Rather more of the sample (about one third of the staff and almost half of the uniformed officers) thought that security was the most important part of a prison officer's job. Hospital staff were almost as likely as uniformed staff to see security as being the most important part of the job (see Table 6:3):

> Monthly pay, I suppose! The most important part of my job is containment. At the end of the day that's what it comes down to - that the inmates are behind the wall. (Officer)

Some were disgruntled that this was the reality of their job:

> Well, we could quote what the government come up with about treating them with humanity and assisting them on release, but considering we've just had one cell fumigated for lice, I can't say that we're doing much more than making sure they're fed and housed.

A fifth of all staff thought the whole job had to be seen as equally important:

> Well there are two. The first is security, but the most important part of a prison officer is his ability to get on with inmates. (Officer)

> All round, from the smallest problem to the largest one. Whatever officer says it's not part of my job, then we can stand a wooden indian where he's stood. (Senior Officer)

> Being a prison officer virtually. The whole job. (Officer)

Half of all staff felt there was no conflict at all between security and 'welfare' responsibilities (see Table 6:4). This figure was slightly higher amongst the uniformed staff (56 per cent), less than 10 per cent believing that there was a clear conflict between the two aspects of their work. Interestingly, governor grades and specialists were more likely to identify a conflict (24 per cent) or potential conflict (32 per cent). Staff doing the job evidently develop different perceptions from those who may be more exposed to theory and literature!

> I think they're compatible. Lots of people do have problems reconciling the welfare role, thinking that it's a soft option when in fact the two go hand in hand. If prisoners have got problems and they're managing to talk to a landing officer about their problems whatever they might be it may well be that this heads off a future conflicting situation. (Principal Officer)

The Role of Staff in Suicide and Self-Injury

Over two thirds of the staff felt that suicide and self-injury were problems prison officers should have to deal with (see Table 6:5):

> Yes. Coming from wing x where we prided ourselves on being able to spot problems...I would have had anybody from [prison x] or [prison y], to come along to the YP's at that stage, where we were working at the time and say, right, you've got a problem with YP's, watch me through my daily work and I will show you that this is how you deal with it. We often said that people should come along and watch us work, we had a very good repartee with inmates. The whole team had a very very good relationship with inmates. The key? It's being able to talk to them; being able to see the man come out in the morning and spot that he's a different person, and to pull him across and say, 'what's the problem?', and to talk in his own language, and if he's going to shout at you, to shout back. (Officer)

> I think they have a lot to offer to minimise them, and I am convinced, having spent a lot of time on x wing, that we would have had more suicides were it not for prison officers, not just in the reaction, cutting them down or getting first aid to them, but the proactive stuff - limited as we were, given the numbers and referrals. They were doing a lot more as we moved away from the high numbers. (Officer)

A further 25 per cent expressed some reservations or felt that they should not have to deal with it ('well, let's just say we have to - there's nobody else here!'):

> No, I don't think we should have to deal with it. We do have to deal with it because they're unpredictable facts of life, but no, I would say that prison officers can deal with people attempting suicide initially, but the after-care, no, it should not be our problem. It should be people trained to deal the depressed and the mentally ill. We're not mental nurses. (Officer)

> As to whether as a Prison Service we can deal with suicides and self-harm, I don't know...I don't know whether it's in our power to, you see. I really tend to feel that from outside the service it seems like its something to do with or even wholly to do with prison conditions, or the way that the prisoners are treated by prison officers, whereas my experience of it is that it's not actually that at all. What leads to suicide and self-harm is much more to do with outside pressures or it's the fact of being in prison, it's not what it's like in prison. So myself, I don't think we can deal with that, because it's not within our power to deal with that. It's like saying, can we deal with crime? Well, no; we're just at the end of the line, really. (Officer)

However, while staff clearly felt that self-injury and attempted suicide were problems which they should deal with, they were noticeably less confident that they were able to deal with them. Over quarter of the staff (27 per cent) thought that prison officers felt unable to deal with the problems of suicide and self-injury (see Table 6:6). It was also a result that varied considerably from establishment to establishment. It was least true of prison 1 (the training prison) and most true of prisons 3 and 4 (the largest locals with the highest throughput; see Table 6:7):

> No, because there's been no training at all. If we had an inkling of what to look for...it's only from experience that pick it up and you'll think, watch that kid there, or someone might drop you a hint to watch out for Smith. (Senior Officer)

The same officer then went on to talk about how he dealt with prisoners he felt were at risk and actually illustrated his own abilities despite the lack of confidence he expressed moments earlier:

> You try to talk to them before he gets to that stage. I had a lad last night, said he was going to smash up or slash up because he didn't want a transfer. I spent hours talking to him. This morning, he's gone, no problem. Was it talking to him? officer might have just locked him up - then he'd have slashed up. (Officer)

Staff tended to feel that without 'special' or 'specific' training, they were operating in the dark, despite also feeling that they had years of valuable experience in managing the problem, albeit less formally (and more variably) than the Circular Instructions might recommend:

> To a certain degree. I think we are the people, we can spot it, you can see a prisoner who's going down. As for dealing with it, I think all we can do really, coming back to welfare, we can sort of talk to them, but I don't think we have the training in which to counsel. We've been trained to spot I feel but not to counsel, where all I can do really is try and refer to the hospital. (Officer)

As ever, a further problem was lack of time and resources:

> No I don't believe for one moment that we have got enough time to give the problem our full level of commitment to it per individual. (Officer)

> If you'd asked me that question three or four years ago, I'd have said no. There has definitely been some improvement, although there is still improvement that could be made. I think it all boils down to having the staff and the time and the resources to facilitate this. There has been an improved awareness and improved training. (Officer)

When asked what their role should be in the management and prevention of suicide and self-injury, almost half of the staff mentioned contact with prisoners, communication and observation as being their most appropriate role (see Table 6:8):

> I think our role is actually being aware of the inmates that we have in our charge. As time goes by you very quickly become very familiar with their characteristics and characters so that you know if at any time they're not acting as they normally would do...it's basically knowing your inmates. (Officer)

Contact. Between staff and prisoners, with external agencies and with the hospital (Officer).

> Well, I think it's got to start with talking. It starts when a man first comes into prison. If you sit down and say, "Right, do you feel like suicide? If it even flickers across your mind, please tell us." On the one's, with the YP's, we were able to do this. We sat down and we had a very good that started it...you would find out from him his fears. He may not be going to have problems at home, but he may be afraid of the prison, that may be enough. If you don't have a situation when they first come into prison where you can sit down and alleviate these problems, then that'll drag on and on. (Officer)

Crucially, staff were aware that 'suicide prevention' and its effectiveness depended on the broader context in which it was being carried out:

> I don't think you can treat suicide prevention as a bolt-on extra. I don't think it's like a 'go-faster' stripe you put down your car. It's got to be an intrinsic part of the care and routine of the establishment...you've got to have an atmosphere where they can talk to people about their problems you've got to have good access to people outside, including uncensored mail, telephone calls, visits... (Governor grade)

Staff pointed out some of the difficulties inherent in the role they thought they should be playing:

> ...But when it comes to my end, it's more likely that you walk into his cell and he's already cut himself or tried to hang himself, then it's too late. (Officer)

> In a place like this, it's difficult. We've got a changing population almost daily. We're trying to get staff to work in the same wings and on the same landings each day, but without a static population it's difficult to build up a relationship with a prisoner whereby you could spot it. (Officer)

Over a fifth of the staff thought they had several roles to play, normally including both of the above:

> The only thing we can do is try to pick it up as early and quick as possible, and then we may be able to find out the source of the problem, invite people in, like the Samaritans, which we do have in, the welfare, and we can get the ball rolling and try and sort the problem out for him. We do talk to people, if we feel we can help them. (Officer)

> To be alert to any signs. To be on the lookout, to be aware that it happens, obviously, and those kinds of qualities will come from officers who take an interest and get involved and listen to inmates and who are approachable to inmates. It's being vigilant. (Governor grade)

Responsibility for the prevention of suicide was felt to be 'everybody's' responsibility by over half of the staff (but by three quarters of the hospital staff; see Table 6:9):

> I think it's everybody's responsibility, from the basic grade officer, to the Governor. We're all responsible in certain ways. (Officer)
>
> Everybody's, including the people who send them here. (Governor)

The distribution of responses here between staff groups is interesting, 14 per cent of governors and specialists claiming responsibility for the Prison Service itself, or 'management', a view which staff shared to some extent:

> That's quite a good question, isn't it? Well, I think it must come from the prison department and the policies that formulate taking into account all the information that is put before them, and then it falls down to the Governor to implement those policies, and basically it's an input by anybody who's got any good ideas to come forth with. (Principal Officer)
>
> The Governor's - he's in charge of the establishment. (Officer)
>
> I think the overall responsibility is the Governor's; however, I think it's his responsibility, and rightly enough, to pass it down to all the staff through our initial and continuing training. (Officer)
>
> Us. It's got to be us because we're the grass roots. (Officer)

Others were rather specific in their choice of a responsible group:

> It's the combined responsibility of the SMO or the MO, the psychiatrist and the governor. Beyond that, it's ultimately the Home Office's responsibility. (Officer)
>
> That's difficult. I think it's the staff's job, but then I think it's up to management to supply the right number of staff. (Officer)

Training in Suicide Prevention

(i) Local training

Almost two thirds of the staff interviewed claimed not to have received any local training in suicide prevention. This result was partly a function of the timing of the fieldwork, which began well before the most recent initiatives in suicide prevention training. There were also large differences between establishments on this variable (greatly exacerbated by fieldwork timing as well). Staff at prison 4 (the last prison worked at) were most likely to report having received local training: see Table 6:11).

There were very real problems in providing adequate or sufficient training for uniformed officers when time and resources were short. Indeed, the situation sometimes occurred where fully trained regional or local 'suicide prevention training officers' found themselves with no officers to train. Because of other commitments, scheduled sessions were often cancelled, or were sparsely attended.

Training officers occasionally arranged special training sessions during fieldwork so that the researchers could attend. Even so, at two establishments where the officer concerned was keen to do this, it eventually proved impossible.

Lack of training was a sensitive issue and was frequently mentioned during the interviews and informal discussions with staff. It was certainly clear that where training was being or had been carried out, staff would take this as an indication of a higher level and genuine commitment to suicide prevention. This reduced cynicism, provided a symbol of support for staff, encouraged their own commitment and increased their confidence:

> Yes. It was interesting. There were pointers in it that I didn't realise at the time, but they made sense. Yes, there were things I didn't know before and once I was told about them I thought, 'oh yes, they're right'. (Officer)

It also had other spin-off effects:

> I know the suicide package has helped some people to start looking at prisoners as people to be cared for and not just to be locked up. (Governor grade)

(ii) National training

Two thirds of the staff said they had not received any national training in suicide prevention either. Unfortunately, where training had been carried out, it was not always well received: it was felt to be inappropriate, inadequate or unrealistic. Of the 29 per cent of staff who said they had received national training, more than a third described this training as 'limited'. (Of the 33 per cent staff who had received local training, almost a half described it as limited). This category, like most, was not given to staff, but emerged spontaneously in their response to open questioning (see Table 6:11).

> National training only at my initial training course, but it was just basically telling you what forms to fill in and what the procedure is. (Senior Officer)

> Yes a morning for three hours I think, the sucide prevention course, the local package. [What did you think of it?] Well I can't remember it! (Officer)

> I thought it useful. I thought it raised very good discussion points but I don't think we've had enough time to give it the attention it needs, because we had one session and that was it. There's been no follow up. It was given by a training

> officer who went away on a course, so it's what I term second-hand. I think it ought to be given by people who have been involved in that kind of field for a longer period of time. (Officer)

Despite the widespread lack of training reported, two thirds of the uniformed staff were aware of how suicide prevention procedures operated in their establishment:

> If we get one through reception, say, who is apparently suicidal they'll be brought, we'll decide on how much of a risk they are. We can still use unfurnished cells and if we thought they were a real risk we would do that, purely, whether the department liked it or not, because in my opinion it's far better for me and the department as a whole if we have to use an unfurnished cell, to prevent somebody killing themselves then we've got to use it, no matter how unpopular it is. But we look at whether we can place them in a furnished cell on say 15 minute watch, or whether we can place them on the ward. Again it depends on what their attitude is how much of a risk we think they are. The same assessment goes on if we get them referred from the wing as well. But the final thing, it's up to the doctor where he wants to place them and he will write it in the medical record where he wants them located. Sometimes we do put them on the wings depending on the space available on 15 minute watches. Anyone who has been referred to us on the 1997 referral form will automatically be placed communal cell when they go on the wing. And we also have a communal cell in the hospital if we need it down here. We've got four options down here, and 15 minute watches and communal cells on the wings. (Hospital Officer)

A futher quarter of the staff had a patchy or partial knowledge of what the procedures were (see Table 6:12):

> I've got a folder in there that I resort to. We would take all necessary, logical steps to, if an inmate is believed to be a suicide risk because of information that has come to the staff, fill in the appropriate form, alert the hospital and then they would take it on board from that. Follow the procedure according to the forms. (Principal Officer)

All the hospital staff and more than half (58 per cent) of the governor grades and specialists knew how suicide prevention procedures were organised at their prisons. However, staff at prisons 3 and 4 were much more likely than staff at the other prisons to report a thorough working knowledge of suicide prevention procedures, 87 per cent and 76 per cent respectively being able to recount to us in detail what those procedures were (see Table 6:13). Again, this was partly a reflection of timing and the increase in training as the fieldwork progressed. Other influences may have been the high profile of suicide at particular stages in the latter establishments. It is significant that the more informed staff were about procedures, the more they felt that training was necessary.

Staff mentioned a number of problems with the way suicide prevention procedures worked at their establishment (see Table 6:14). The problems

reported fell into several categories: communication (usually between departments reported by 21 per cent staff), lack of time (10 per cent), lack of training (8 per cent), or several of these (19 per cent). Other problems mentioned were lack of counselling and psychiatric staff, a general dislike of forms and paperwork which were felt to militate against time spent with prisoners, a feeling that the policy was too general to be useful, that it failed to cover the problems, or was geared to protect the Service rather than the prisoner, lack of staff, and attitudes of cynicism and complacency.

> ...officers at [this prison] do have a little more time than most and we ought to find the time to sit down and have a chat, do it ourselves really. But it's covering one's back all the time, that is the big problem with prisons, you see. If you make a mistake then you could be out of a job. That's why people do it. It's departmental policy that forces people wrongly. (Officer)

> Pretty well apart from the staff occurrence book. Everyone's in a rush when they come in in the morning and, we, who reads it, you know? Usually I'm afraid to say most things are passed on verbally which isn't really the way of doing things. (Officer)

> Probably not as well as they could. Why? It boils down to the cynicism of staff: "Oh, he'll be all right, he's only doing it for your attention, he's a soft bugger". (Senior Officer)

Improvements to the procedures tended to reflect the above distribution of responses, most of the staff feeling that if the particular problem they had identified was addressed, things would work much better:

> To encourage staff to get out on the landings more and mix with inmates more. For them to get to know them, rather than, which happens on a lot of the wings, they're encouraged to stay in the and the inmates to come to them. I think the officer should be encouraged to go out to the inmate. And it doesn't mean making your presence felt on a landing but just wandering about and popping in a cell, just having a chat and if it shows that they don't really want you there then you go. (Officer)

> Educating the staff better. Trying to get away from the old welfare screw or discipline screw. We're all discipline officers and we should all be welfare oriented, that's why we're here, that's why I'm here anyway. It's this old macho thing, you've got to be hard. I can be hard but I'm not paid to be hard, I'm paid to be professional. And I joined this job because I wanted to work with people. (Officer)

Communication and Co-operation Between Hospital and Discipline Staff

A specific question was included about communication and co-operation between the hospital and discipline staff, as this issue was raised so often in discussions about suicides in prison, and was shown to be significant in the previous study (Liebling, 1991). Less than a third of the staff thought that relationships and communication were good (see Table

6:16). Most thought that 'clear problems', or 'some problems' existed:

> .... what happens is that they get referred to the hospital, the hospital could chat to them, they could send them back within an hour and say, "well, we think this man is quite sane and he's not liable to do any injury to himself", and that is the end of the matter. Doesn't do any good to anyone really in my opinion. (Officer)

> Improving, it is improving. You used to get situations where you would ring up the hospital and say I've got X here, not necessarily suicidal, but he's not well, and you used to get feeling off the staff, irrespective of rank, "who says you're qualified to say it?"....I must admit of late if I've ever rang and said, "look I've got an inmate here, somebody could do with having a talk to I think he's cracking up a bit", or what have you, 99 times out of 100 now, they will say send him up. If they send him back saying there's nothing wrong, well I've done all I can. (Senior Officer)

Some of these views were 'historical' and probably inevitable, given the widespread myths and prejudices that many specialist groups (not just within the Prison Service) have of each other. But some of the feelings were bound up with the problem of perceived responsibility for suicide and its prevention. If staff felt unsupported by the hospital in their efforts to identify and offer support to someone felt to be at risk, a less constructive response to the whole issue of suicide risk would result.

Significantly more problems were reported between the hospital and discipline staff at two of the establishments (prisons 1 and 3; see Table 6:17), emphasising the importance of the prison context in this respect. For example at prison 4, where recent local circumstances had united the staff to some extent, an unusually high proportion of the staff (53 per cent of the staff) reported that relationships between the two departments were good. One of the other locals also reported good relationships (36 per cent) and again, particular changes and developments at this establishment may have accounted for this positive response.

Section II: The Causes of Suicide in Prison

Identifying and Responding to Suicide Risk

As reported in the earlier study, many of the signs known to be indicative of self-injury or suicide risk are known to be associated with poor coping behaviour, and can (in theory at least) be discovered or observed by staff relatively easily. Naturally this depends upon there being some continuous level of meaningful contact between staff and prisoners. Most of the staff looked for some kind of change, signs of depression (withdrawal, not eating, staying in his cell, and so on) or a combination of these. A small number of the staff relied upon information from other inmates, from the inmate himself or from an intuitive feeling they could not define:

> A change in his behaviour pattern, but this is, of course, one of the problems, because you'd only notice it in someone that you knew well and saw often. If I went up to a strange

> wing I wouldn't know if somebody's behaviour pattern was different from what it was the day before. I think our greatest asset to suicide prevention are inmates who come and tell you. (Officer)
>
> Wanting to go on his own, staying by himself, morose, twitching, looking round at people, not wanting people walking round behind him, you can spot it on exercise, and just ignoring people. With me it kind of rings a bell if I see anything like that. I kind of say Aye, aye, what's going on here, you know. (Senior Officer)

Staff were asked which - if any - particular groups they felt to be most at risk of suicide or self-injury. Almost half of the staff felt that either no particular group was at risk (8 per cent) or that several different groups were at risk (38 per cent). Groups identified as being especially at risk included the young (20 per cent), Rule 43's and sex offenders (12 per cent), 'inadequates' (some of whom might also be on Rule 43) (10 per cent), remand prisoners (5 per cent) and first timers (2 per cent).

At this point, the attention of staff was drawn to the fact that the remand population is over-represented in the suicide figures. Many expressed surprise at this and wondered why this might be. Uncertainty and the anxiety this would provoke was felt to be the main reason by almost half of the staff. Other reasons included conditions in remand centres, the proximity of the offence, frustrations and delays inherent in the remand process, and injustices.

When asked, 'what would you do with an inmate who you thought might be at risk?', most of the staff suggested that they would pursue the problem, finding out more about it, refering to the hospital and informing the wing. Two thirds of the uniformed officers responded in this way. Some would simply refer directly to the hospital (21 per cent), and 7 per cent said they would deal with the problem themselves:

> First I'd try and deal with it meself. I'd ask him what the problem was....And I'd tend to keep a close eye on it then...if it started he was really depressed and there was obviously something seriously wrong then I would have a word with the SO and I'd make an entry in the book (Occurrence Book) and go through the procedure again...And I'd get the general feeling of all the other officers as well who come into contact with him. And if it was a general consensus of opinion that he was in a bad way then I think we'd go through the hospital procedure then. I have asked inmates 'Do you think of topping yourself?'. You say it in a casual sort of way because if you give it the air of authority they tend to shy straight away, but if you say, 'you're not thinking of topping yourself, are you, you're not going to do anything stupid are you?' and then automatically, 9 times out of 10 they'll tell you. They'll give you a truthful answer. It usually helps to ask I find. (Officer)

The staff were asked how much attention the problems of suicide and self-injury should receive in prison. Half of the staff thought that a great deal of attention should be paid to them and many said that they

deserved more attention than was currently being paid. A small group (9 per cent) thought that less attention should be given (most commonly the hospital staff). The word 'attention' was loaded in this context, because of the frequent assertion that self-injury is 'just attention-seeking behaviour'. However, only one or two (mainly hospital) staff, used this argument. In these cases they were probably distinguishing rather too clearly in their minds between suicide (deserving of attention) and self-injury (demanding and therefore not deserving attention). This point is returned to below.

The Causes of Suicide

When given a list of factors to rate in terms of importance in the build up to suicide, staff tended to chose those factors located within the individual or his individual circumstances (depression, bad news and guilt) as being the most significant (see Table 6:19). Even so one third of the staff thought that 'prison pressures' were also very important as a cause of suicide. Similarly, most staff felt that the causes of suicide were either due to 'personal' factors alone or to a combination of 'situational' and personal factors (Table 6.20):

> Of suicide? Everything. The list must be endless. I would think from what I've seen usually the shame situation comes into it a lot. The sentence. The groups of individuals being got at. That does occur. (Senior Officer)

> Of suicide? Number one is being rejected by their loved ones, their girlfriends...I'm not saying that is top priority but that's number one and another one would be feeling guilt, especially if they've come from a reasonably good background and never been in trouble before and their parents or girlfriend or wife might say "That's it, I don't want to know, you've let us all down", and it's a guilt problem. That's from the outside. And I think from the inside is problems which they're getting within the prison, maybe bullying or problems they have on the landing which is mainly bullying, whether it's sexual bullying or physical bullying. (Senior Officer)

Aspects of imprisonment felt to contribute to suicide risk in establishments were problems with outside contacts (reported most frequently at the training prison), other inmates (reported more frequently at one of the locals), 'system frustrations' (reported less frequently at the training prison) and conditions, or several of these:

> The loss of dignity in the first place. You come into prison. Stand there, take your clothes off. He stands there totally nude, where he's never had to do what he's told before. You will use that toilet there, which has only got a half door on it. It's completely alien to the way everybody's been brought up. All the private things suddenly become public things. You're alienated as well from everything you've ever known. Everything's decided for you, all the decisions are taken. You will get up, you will have breakfast, you will shave, you will go to work, you will be locked up again. No free will. (Senior Officer)

As can be seen from Table 6:21, staff rated factors contributing to self-injury in only a slightly different way, putting 'temper/anger' and 'boredom' as very important factors more frequently, but on all other variables, their choices were the same. This is important as it illustrates a recognition - implicit in much of what the staff have to say, but often explicitly resisted - that suicide and self-injury are part of a continuum of distress, with common roots:

> Of self-harm? Attention-seeking, boredom, frustrations, gangs, to get out of the environment. (Officer)

> Self-injury? I think they have, mainly, they're depressed...and they might have problems at home, they might even have problems within the prison, bullying. They don't necessarily want to die, what they want is people to be taking notice of them and maybe taking them away from that environment on to another environment even if it's a matter of going down to the hospital or an outside hopsital. Getting them away from the situation they're in. That's why you've got to notice these situations before it actually happens to the self-inflicted. It's difficult. (Senior Officer)

Before being asked to complete the pre-coded check-list of factors contributing to suicide and self-injury, staff were asked an open question about the causes of such problems. Their answers were many and varied, and often went into quite a lot of detail. A series of categories were formulated from the answers they gave and this can be seen in Table 6:22. They fell into groups of individual and situational factors, only one or two being impossible to allocate on this basis. Family and outside pressures, for example, were sometimes talked about as situational factors, but were also conceptualised (particularly by staff) as relating to the individual rather than his situation in prison. This variable was therefore left in the mixed group.

It is interesting to compare the responses for suicide with those given for self-injury, particularly at the end of the table, where 'attention-seeking' and 'manipulation' of various types were identified as being major 'causes' of self-injury. ('Specific' manipulation indicates behaviour on the part of the inmate which was targeted at a particular aim or objective, ie a change of location, a visit; 'general manipulation' reflected responses that did not seem to be associated with any particular aim).

What is significant about these results is the frequency with which staff responded to the open questions about both suicide and self-injury with reasons relating to pressure from other inmates. It is also clear that guilt, shame and remorse were felt to be important factors in suicide (but not in self-injury).

Some interesting differences emerged between establishments. Staff at one of the local prisons which was having particular difficulties providing activity for its young prisoners, were slightly more likely to choose 'boredom' and 'prison conditions' as very important factors in suicide, and at two local prisons were significantly more likely to choose boredom as a very important factor in self-injury. 'Pressure from other inmates' was not specified as frequently at the training prison as at the other three as a

factor in suicide or self-injury. 'Being a first time offender' was most frequently chosen by the largest local prison; as was 'fear and uncertainty'. 'Anger' and 'helplessness' were chosen more frequently at one of the local prisons as important factors in self-injury. At another local prison, 'specific manipulation' was specified significantly more often by the staff as a factor in self-injury.

Prison Officer's Perceptions of Life in Prison for Prisoners

The tendency of staff to locate the causes of suicide and self-injury within the individual and individual circumstances (rather than pressures generated by the custodial experience), was paralled by a tendency to underestimate the struggles, both social and emotional, that some prisoners have to undergo in order to survive the experience of imprisonment.

This is hardly surprising, given their exposure to those who cope well and constantly challenge them, and the speed with which most interaction occurs. Issuing letters, locking doors, checking and counting prisoners in vast numbers, working to deadlines with limited resources, are features of prison life which are not conducive to dynamic interaction and the building of relationships (particularly in local prisons where most of the fieldwork was based). That they occur despite these limitations is a tribute to the survival of the human in the unlikeliest of circumstances.

This general view of imprisonment as being relatively painless, despite the recognition of variation amongst prisoners, contributes to the tendency amongst staff to locate the causes of suicide within the individual, and importantly, to underestimate the power which officers (and others) have to alleviate the 'pains of imprisonment'.

For example, over three quarters of the staff interviewed described staff-prisoner relationships at their establishment as 'very good' or 'good'. Only 12 per cent thought that relationships could be difficult, or that they depended on the staff member or inmate concerned. Almost a quarter of the staff thought that it would be difficult to improve relationships, or that there was no need to (see Tables 6.30 - 6.31).

Similarly, more than half of the staff felt that inmates did have opportunities in their establishments to improve themselves. even though they also felt that, on the whole, prisoners did not make any constructive use of their sentence.

However, just as further questioning of staff had revealed the importance they attached to prison-based factors in explaining inmate self-harm, so they were fully prepared to admit to the painful aspects of imprisonment for many inmates. For example, over half of the staff described the prison experience as an 'indifferent' or 'negative' one for inmates, while three quarters of them thought that inmates had to worry about their own physical safety whilst in prison (Table 6.32).

In general staff take considerable pride in the contribution they make to a prison life and, in particular, the officer/inmate relationship on which this life is built. Consequently, they can often combine a unique awareness of the 'pains of imprisonment' which many prisoners endure, with a defensive tendency to minimise or overlook certain aspects of them which

make it difficult to carry out their basic duties. Hence the tendency to locate the problem of self-harm within the individual, rather than the individual's prison experience.

Links need to be drawn for staff, where they are not already being made, between aspects of imprisonment and the vulnerability of many prisoners to suicidal thoughts, feelings and actions. The critical importance of their own role in combating these feelings needs to be stressed clearly and constructively.

Section III: The Prison Office's Experience of Suicide and Self-Injury

Staff at one of the establishments known to have suffered a spate of suicides, suicide attempts and self-harm gave vivid descriptions of their experiences:

> I'm sure you never feel comfortable, especially when you come across a suicide. My first set of nights here, I cut down six attempts and found about four or five slashings in one seven night period. There was about six in the first four nights, actually. That was when there were twelve hundred prisoners here. One or two of them were very serious. When we were getting so many, it was possible that there were only four staff and myself on duty, and we'd all be attending to one, then somebody else does it at the same time - you can't attend everywhere. We were lucky to get there in time. They can be very upsetting, actually. (Principal Officer)

> The staff do an excellent job. But when I was on my last period of nights, we had so many slashings of wrists and all that, it was just a question of, "if there's anybody else, would you tell them to just wait?!" We just couldn't handle them quick enough. It started about twelve o'clock and we had something like five, one after the other, and we just couldn't do it. (Officer)

A growing interest in stress amongst occupational groups has been matched by the growing awareness that prison officers - particularly in certain types of establishments or following particularly harrowing incidents - suffer from what must at times be excessive levels of stress and anxiety (Bowden, 1991; Bagshaw and Baxter, 1987; Poole and Regoli, 1981, Cheek and Miller, 1983, Posen, 1985, Smith, 1984, 1985). Some of this stress arises directly from the nature of their work, and some of it is related to special conditions or circumstances (such as the 1991 riots and disturbances; see Staples, 1990; Woolf, 1991). Some may be personal or 'domestic'.

It was therefore important in the course of the research to respond to staff's eagerness to talk about their own experiences, ranging from their reactions to self-harm incidents to their more personal experiences of depression and occasionally, suicidal feelings.

Experience of Prison Suicides

Fifty six per cent of prison staff had experienced a prisoner suicide during their career, and a further 29 per cent had experienced a serious attempt. Not surprisingly, more of the hospital staff had experienced a suicide (over two thirds). Also not surprising, this figure was highest for staff in the largest local prison (Table 6.24).

> Well, yes, one or two come to mind. One was at [prison x]. This prisoner had been locked away at lunch time and we were on patrol. Somebody rang the bell of another cell, he was on his own. We went round there and he'd gouged his neck out with a small stub of a pencil and taken the jugular out and there was blood everywhere, the whole ceiling. He'd actually got to the stage...he'd committed suicide. He'd lost blood at such a rate that he'd attempted to get to his cell bell and he couldn't reach it on the wall. You saw that vision of his hands trying to reach and coming down the wall. It's not a nice sight; death leaves that feeling...Another one was a cell fire, this was again over a lunch time lock up. This was at [prison y], he was up on the top landing, he'd rang the bell, and there was not many staff there to deal with things so he hadn't had his bell answered straight away. He'd barricaded up and sealed the door and window, with sellotape. (Principal Officer)

The unexpected suicide, the 'out of the blue' experience could make such a tremendous impact on staff dealing with the aftermath that they often generalised about all prison suicides in the light of these experiences ('you'll never prevent suicides', 'they just don't show the signs').

> It was shock, just absolute shock. I just couldn't believe it when they told me. (Principal Officer)

> Yes - that one last year. It was a strange one. He was waiting to go to court, he was on judge's remand - JR'd - and to be honest, you wouldn't know he was there. He was so quiet and unassuming, and kept himself to himself, and that was it. He was never a person who had shown any signs of anxiety or It turns out he had a very long history of mental illness, alcohol problems...his cell mate had asked me if I could move him out of his cell, because he was dirty. He'd only been in there a couple of days. Within an hour, he'd committed suicide. (Senior Officer)

Almost half of the staff having experienced either a suicide or an attempt reported having felt shocked and upset at the time:

> You can never get used to it, obviously, and they all use totally different methods. And certainly if you've got to try and get a young member of staff to go and open other cell doors when he's just opened one and found a guy hanging there, stiff, with his tongue hanging out, it's a little bit of a shocker. I mean, you do get hardened, to a certain degree, but you can never ever take it as just one of those things.

(Principal Officer)

I don't know. It was in my formative years as a prison officer. It made me want to pack the job in. (Officer)

I felt terrible, actually. (Senior Officer)

When asked if there was adequate staff support after incidents such as these, over two thirds of the staff felt there was not. A further 17 per cent felt there was some, or that it was improving:

No. I don't think there is adequate staff support for any incident. (Principal Officer)

There will be. It's starting. I don't think there has been in the past. I think we're at last getting rid of the macho, roughie-toughie image of the 'screw'. (Governor Grade)

It's getting better, but the two I've been to, I never got any counselling at all. I think they could do more. (Principal Officer)

It's a two-part answer I'm going to give you. The first part, no - because I don't think the department is that concerned about staff at all. They're more concerned about the publicity they're going to receive, that everything has been done correctly, and that the procedures were followed. But in saying that, from a middle-management point of view, the last few courses that I've been on, there's been a lot of stress on looking after staff after they've been involved in incidents...including finding someone who has committed suicide. So, yes, they're now beginning to look at situations. But I still say that the department is not really all that bothered, they're doing it rather superficially, sort of saying, 'we must do something'. They could probably do a lot more. (Senior Officer)

Unifomed staff were least likely to report an improving scene on the issue of staff support (see Table 6.25), which probably reflected the characteristic time-lag which exists between the introduction of a policy change (see introduction) and any perceived change in the field. Staff in the training prison (prison 1) where fieldwork began in 1990, were significantly less likely to feel there was adequate provision for staff support following a suicide, 96 per cent reporting that there was none (however, see conclusion for account of Prison Service responses to this need).

Prison Staff Suicide

The first research project carried out in young offender institutions, had shown how staff were acutely aware of their own problems (depression, suicide, alcoholism, general levels of health, etc) and how they felt that these were ignored by management in comparison with those of prisoners. Piloting of staff questionnaires for the present study had revealed exactly the same pattern of concerns and some direct questions were added about

staff experiences of stress and depression (Table 6.26).

Nearly all staff said that at times they had experienced unreasonable levels of stress, or depression:

> They do. I've one off at the moment - good lad, must have about fifteen years' service in; he's seen it all, done it all...A fortnight ago he was good as gold on the landings, yet he's suddenly gone off with anxiety. He's been in touch with the Governor, he just can't face coming in at the moment, the pressures have got to him. So you do get it. Different people might go home and start drinking; there's all sorts of ways. (Principal Officer)

Almost two thirds of the staff thought that the causes of staff stress, anxiety and depression were due to the 'nature of the job' (Table 6.27):

> Oh, of course they do, everybody does. The ones who deny it are the ones who are under the biggest strain. It's a stressful lifestyle, isn't it? It's perhaps a feeling of isolation. Every time something goes wrong there's an inquiry and then a form comes down and the staff think at the end of the day, is that all my personal worth is - a form? There's not enough problem-solving on a personal basis, you can't talk to anybody...So at the end of the day you probably take everything home, which is one of the reasons why there are so many divorces. Or I know a lot of staff who turn to drink, and there's a lot of sickness. That's their way of coping with a lot of stressful situations that they don't really like to admit to. (Officer)

Some of the staff identified reasons related to their job which were specifically related to recent changes or particular problems such as numbers or staff shortages:

> It's just the pressure of dealing with these people all the time...I mean, you're bad enough dealing with the hundred and odd you should have, but when you're dealing with twice the numbers, you're chasing all the time for equipment, clothing, seeing that they get their exercise, their visits, everything's a rush all the time..it doesn't give you a minute... (Principal Officer)

> I lay a lot of the blame at the feet of Fresh Start, the new shift system we were conned into. Let me put it this way: the prisoners would love to take a hostage, but they can't find one! There's nobody there to do what they're supposed to be doing. They've got so many jobs to do in the same space of time. So when you get a prisoner come to an officer, he's probably on his way to do another job. I actually think it's quite remarkable at times that we are able to identify these people and do something about it. (Officer)

These reflections were important in understanding some of the apparently 'hardened' attitudes towards suicide and self-injury that were perceived, or which were reported by prisoners. The nature of a prison officer's job, in some circumstances, demanded a certain level of 'detatchment':

> I think the nature of the job. You're dealing quite long hours with other people's problems. You go home, and especially when the kids are young, you're too tired to look after your own family. So you're doing it under stress, and you're probably dealing with your family harsher than what you would inmates. You get no time to recover - you're doing exactly the same job when you get home. Twenty-four hours a day, you're dealing with other people's problems. You have to learn to accommodate certain pressures - to deflect the ones that, in your opinion, don't matter, and you deal with or absorb the ones that do. But when you're younger - for the first ten years - it's a matter of absorbing the lot. Staff get used to self-injury...I remember my first self-injury, I just panicked. I would be like a normal outsider, I didn't know what to do. Now, I don't...you learn to accommodate the situation. The SS got used to murdering the Jews, didn't they? In the end, it didn't mean anything. (Officer).

> You get depressed about things that happen outside, you just don't want to come in here knowing you're going to have to listen to all their problems...you've had an upset with your wife, or numerous things that happen out there, that you have to carry in here. When you come through those gates, you have to turn all that off. Sometimes you can't - you end up getting annoyed and sending them away, which is a bad way. (Officer)

In order to explore further some of the comments expressed in both the previous and current projects, staff were asked about their personal experience of staff suicides. Almost half of the staff (47 per cent) said they knew or had known an officer who had committed suicide (see Table 6.28). A further 10 per cent said they knew an officer (or sometimes, officers) who had made a suicide attempt. Others knew officers who had contemplated suicide (5 per cent):

> I know two that's actually done it, and three or four what's either been unsuccessful or who've contemplated it. One, young lad, was domestic. One was partly work-related. You never know; had they been in a manual job they may have been able to cope with their difficulties better than being in a stress job. I realised that after being off for two months myself. When I got rid of it all and thought, you can see why people get fed up. You don't realise it until you've been away from it for a long time. (Officer)

Staff were not asked whether they had ever contemplated suicide, but the information was recorded if it was forthcoming. Two members of staff said that they had made a suicide attempt at one stage. The reasons were different in each case, but when discussing their feelings at the time, both spoke about how isolated and unsupported they had felt, and how unable to find anyone to listen to them. Four other officers talked about having reached a stage where they were contemplating suicide. One officer, not formally interviewed, also talked of present thoughts of suicide.

Staff Morale

Staff were asked how they would describe morale at their establishment at the current time (Table 6.29). Almost a third of the staff thought it was good or very good. Some even thought that Fresh Start had improved morale:

> I'd say it's fairly good here...I think it's quite a good jail to work at now, compared to what it was. They're not working long hours now, like they did, and I think the staff is better off for it, since the numbers have gone down to two to a cell. (Principal Officer)

Many would refer to their wing or their shift as being particularly good, working as a team, having good relationships amongst themselves and with inmates, and overcoming the sorts of problems other wings might be having. A further third of the staff thought morale was 'moderate'. A third thought it was poor or very poor. Differences between establishments were marked, those at prisons 1 and 2 (the training prison and the small local) more often feeling that morale was good or very good, and those at prisons 3 and 4 more often describing it as poor or very poor:

> It's very low. Having said that, we are all very supportive of each other, and we're still able to do the job and even have a few laughs and a joke now and again. We feel let down and disappointed. We're sent all the rubbish from all over the region, and we get kicked in the teeth for it. We want things to improve, but we don't want to be blamed if they don't. ...We want the ability to do our job. (Hospital Officer)

> Not all that high at the moment. Well, we've had two pieces of industrial action where we're trying to get staff; people's hours is going up and up; I think everybody on this wing is at least double-shifted, where they're getting at least an extra eight hours in when we're supposed to be working two. They're not getting their time for their leave off, and it's just building up all the time. This is what gets staff down. Then again, it's your numbers. You're fighting a losing battle all the time, you don't get a respite, and it all starts again in the morning: 'have you got this kit?', 'have you got that kit?' - you're having to chase all the time. We're short of shirts and pillow cases; I had to give someone two spoons to eat his dinner with last night, they don't send us enough. They send us for our CNA which is 370. We're looking after 600. We just haven't got the gear. (Principal Officer)

Older staff, usually at principal officer grade, were more likely to express reservations about the level of morale:

> Morale? People like each other; they get on together; they work as a team terrific, but they're brassed off with what they're doing up top. Now that's all part and parcel of morale. Now, if a bell goes, that means a member of staff is in trouble, staff will answer. But morale as to the way the prison is going and Fresh Start and all the new bits

> and pieces, they're...like me, they're counting the days until they get out. Loyalty is a two-way thing. We're expected to be very loyal, but we don't feel it's a two-way thing. We got bad publicity over overtime - we were the bad dogs who were responsible for all the high bills in the Prison Service. We feel we're 'necessary evils'. There is more and more talk about professionalism and yet they're turning the job back to what it used to be - turn-keys. (Principal Officer)

That younger staff were more favourable about Fresh Start was inevitable, but the balance of opinion on a wing sometimes depended on the strength of feeling expressed by respected principal officers such as the above, who often combined their cynicism with a very real and effective concern for and interest in their staff.

Several areas of suggested improvement were raised in the interviews:

> ...dealing with prisoners as people has got to be taken out of the political arena if you are ever going to make progress (Governor Grade)

> I think the Prison Service has a failure complex...we should take control of our own destiny more (Governor Grade)

> The main problem as I see is it's viewed as a bolt on extra. The main thing I think you've got to start thinking about is never mind about suicide prevention committees and everything else, we ought to have an inmate care committee of which suicide was a standing item. We keep talking about suicide prevention, instead of talking about care, of which suicide prevention is a topic. (Governor Grade)

The communication of information, at every stage, could be better:

> We don't know anything about them. One of the things I've repeatedly asked the police: how come that when somebody's in the dock the magistrate has in front of him very often a home circumstances report, precons and maybe a medical and yet those papers don't come together again for about five weeks afterwards? There's something wrong, and it actually ought to be an obligation on the court that all the documentation that was considered when sentencing, goes with the prisoner. It ought to be fundamental. (Governor Grade)

A sense of purpose, and direction, was badly needed. Without these:

> ...every prison, you'll find that some people think they're running Colditz...If the organisation doesn't give people proper goals, they decide their own. (Governor Grade)

Discussion

The Prison Service is a distinctly 'verbal' organisation and staff are

natural communicators. However, during the course of the research (both for the present study and for the earlier study in young offender institutions), a picture emerged of a rather uncertain profession. Staff were often stifled by uncertainty and by the sense of isolation identified by Woolf in the aftermath of the riots which marked the beginning of the research. Lacking a perception of themselves as supported, valued and professionally trained, they often expressed a degree of cynicism and bitterness which contrasted sharply with the examples the team saw of effort, achievement and a very real concern for prisoners.

Staff were confused, and at times rather depressed themselves. The legacy of years of local and national political struggle between the Prison Officers' Association and 'management' was difficult to ignore. Officers could mouth the words 'fresh start' when they talked about prisoners, but 'Fresh Start' for them was still a bone of contention, at least for large groups of staff. Time, hours, staff shortages, and lack of training, were issues pervading almost every conversation. There was a tension between the instinct to protest and the instinct to care.

Nearly half of the uniformed officers (43 per cent) thought that contact with prisoners and communication with them was a primary role for them in suicide prevention (Table 6.8). Even so, this is probably an underestimate of the importance of this aspect of their work in preventing self-harm. It is an example of how it is difficult to measure the value, as well as the 'quantity' of staff performance. This is particularly important in the light of an increasing emphasis on 'Inmate Activities' to 'measure' regimes. No-one can say how many suicides have been prevented by the ordinary daily communications of staff - or how many more might be prevented were this sort of communication increased. The role of staff in suicide prevention has its key in an extension of the three principles of 'individualism, relationship and activity' put forward by Dunbar in 1985:

> ...All of this is predicated on an acceptance of activity as the core of what goes on in prisons. Activity means what each individual, whether staff or prisoner, is doing; what use is being made of time. That implies a basic orientation towards those who work and live in prisons. (Dunbar, 1985:86)

Losel has pointed out that three important dimensions vary in the organisation of penal establishments, reflected in the amount of time psychologists spend on each: security issues; counselling, treatment or relationships with prisoners and organisational time spent with staff (Losel, 1992). This third dimension - the management and development of staff - was an important mediator of treatment effectiveness in therapeutic prisons in his studies. The other crucial determinant of providing a threrapeutic and supportive regime was a prior clear theoretical formulation of the work staff were trying to do. Together, these findings indicate that staff need to know what they are trying to achieve, that they need to feel supported in their endeavour, and that time has to be invested in achieving these ends. This emphasises the point made at the outset, and reiterated in the Woolf report and in virtually all subsequent discourse, that security, care and justice need to be carefully balanced against each other in order to run manageable and humane establishments for prisoners. The same balance is required for staff.

The discipline officer...is the backbone of suicide

prevention (Rowan, 1991).

SUMMARY

Staff perceptions are an important determinant of approaches to the problem of suicide attempts in custody, and the conflicts involved in its management and prevention. As in the previous research, staff were extremely pleased that people were interested in their work and their views.

- Problems of communication and co-operation were very apparent: less than one third of staff thought that relationships and communications between the wings were good most identifying 'some' or 'clear' problems. However, significantly more problems were reported between hospital and discipline staff at two establishments relative to the others. The trauma of local circumstances and particular changes and developments appear to have accounted for the differences and emphasise how local attitudes and initiatives can substantially improve relationships between departments.

- Almost two thirds of staff interviewed claimed not to have received any local training in suicide prevention and a similar proportion claimed not to have received any national training either- although this party reflected the timing of the fieldwork which took place before the most recent wave of training began. Lack of training was a sensitive issue and it was observed that where training was being or had been carried out, staff tended to take this as an indication on the part of management of a genuine commitment to suicide prevention.

- Staff were asked which groups they felt to be most at risk of suicide. Very few (only 5 per cent) identified the most at risk group - remand prisoners.

- Staff were asked a series of questions about why prisoners committed suicide and self-injury. A rather complex picture emerged. About one half of those interviewed regarded suicide as resulting from both personal and situational factors - but nearly as many ascribed it purely or mostly to personal factors. However, in response to more detailed and open questioning, staff were just as likely to (spontaneously) mention situational factors as personal or mixed factors - and, in particular, pressure from other inmates. This suggests that while there is some recognition of the prison dimension of the problem it is something that may still need emphasising.

- Ninety per cent of prison staff had experienced an inmate suicide or serious attempt at suicide during their career. Fifty six per cent had experienced a suicide, or both a suicide and attempted suicide(s). Not surprisingly, more of the hospital staff had experienced a suicide (over two thirds). Also not surprisingly, this figure was highest for staff in the largest local prison.

- Staff expressed concern about their own levels of stress - more than ninety per cent claiming that staff experienced depression, anxiety or unreasonable levels of stress. 58 per cent knew an officer(s) who had committed or attempted suicide.

Footnotes

1. In addition, it is worth referring briefly to the argument articulated by Goffman and symbolic interactionists that the 'relationship without compassion' is not a feature of the individual but a feature of this sort of work (particularly under these conditions). Staff may want to have a relationship with prisoners, but the fact that they 'issue' goods and services illustrates one of the ways in which interaction becomes an administrative rather than participative action in an institution. Parallel circumstances operate in hospitals where patients are disempowered, and staff assume a credible authority, based not on relationships but on power. We are indebted to Graham Towl for pointing out this important point.

2. Bauman shows dramatically how modern institutions, a managerial and bureaucratic ethos and the distancing effect such an ethos brings about make brutality not just possible but inevitable. His main concern is with the Holocaust. This analogy may seem extreme. It is not. A medical officer refered to prisoners who self-injure as "untermenschen" - "they can't even commit suicide properly." He was not in any of the fieldwork placement establishments; but he was happily tape-recorded during interview. The use of isolation in stripped conditions for those at risk of suicide has occasionally made Bauman's thesis seem credible.

CHAPTER SEVEN

THE ROLE OF SPECIALISTS

Introduction

The previous chapter concentrated on the work, attitudes and feelings of prison officers, hospital staff and governors - an inevitable reflection of the central role played by these staff groups in the every day life of a prison. There were other groups however, who made a contribution to the research and who played (or could play) a significant role in the prevention of suicide and the minimisation of suicidal feelings in custody. They were prison chaplains, Boards of Visitors, prison visitors, Samaritans, probation officers, psychologists, teachers, and instructors. There is not the time or space here to discuss each specialist role at great length, but it was felt important to reflect upon the potential contribution each might make to suicide prevention.

The Specialists

The Chaplaincy

The Chaplaincy talked in great detail about taking problems seriously, about relationships and about providing support:

> I think the overall work of the Chaplaincy is to support people, try and help them, or meet any needs they might have. I inherited a Chaplaincy that was held in high regard by the staff, as my predecessor spent a good deal of his time ministering to the staff. (Chaplain)

The role of the chaplaincy in relation to prison suicide prevention tends to be restricted to ministering to the bereaved, or visiting those who have made suicide attempts. But their potential significance is far greater than this. As listeners, they carry both a responsibility and a capacity to faciltate an environment in which listening and talking is possible. Those who see themselves as ministering to the staff create for themselves an even greater credibility; they have all the advantages of being identified with few particular groups, yet have a certain level of access to all areas of responsibility, management and practice within establishments. Their role is to see all who live and work in prison 'as God might see them' (whatever they may feel or believe!), and to encourage others to do the same.

> There is a tender spot in every prisoner's heart, be he foul as he may. Society, likely enough, has never put its hand upon it. Reach that spot, use every influence, strain every effort to get there, there you will find at least a fragmentary remnant of the delicacy and refinement of innocence, bring to bear upon the dying embers the power of sympathy and interest...by such means alone you can unbar the gates of his unenlightened soul and admit the light and sympathy of society. Conquer violence by gentleness; attempt the reverse and you convert our gaols and prisons into high seminaries for the cultivation of...crime; society meanwhile looking on complacently, not knowing that by so confining and segragating her criminals coupled with unnatural treatment, she is making them more injurious than ever if she had kept them in her bosom. (Bedson, in James' History of the Prison Service

Chaplaincy in Canada pp.43-4).

> We are not what we appear, but what we are becoming; and if that is truly what we are, no penal system is fully just which treats us as anything else. (Ibid.; see also Bottoms, 1990)

The role of the Prison Service Chaplaincy should be to ensure that these ideals are communicated and heard; ultimately, that 'we sit where they sit' (James, 1989), and build our prisons from there. They are ideally placed to be 'listeners'.

Boards of Visitors

The terms of appointment for Boards of Visitors members state that:

> Members shall satisfy themselves as to the state of the prison premises, the administration of the prison, and the treatment of prisoners (Rule 94(1))

During the course of the research, several members of Boards of Visitors in some of the 20 prisons were spoken to. The researchers were also invited to contribute to their Syndicate Conference, held at Newbold Revel (24/25 April 1992). This enabled some of the issues raised in the informal discussions and observations to be explored in more detail. The opportunity was also taken to circulate a short questionnaire to Board Members attending the conference.

Replies were received from 10 local and remand prisons and from six category B training prisons, in one area.

The questionnaire contained six questions in which Board Chairpersons were asked to outline the role their Board currently played in suicide prevention, and to describe the role they felt they should be playing. They were also asked to outline the suicide prevention procedures currently operating in the establishment and indicate if there were any problems in the operation of these procedures.

Seven of the 16 Boards indicated that they were full or observing members of the Suicide Prevention Management Group, in several cases these appointments had been made only recently and in one case arrangements were currently in hand. It was a matter of some concern that five reponses to the question about their role in suicide prevention consisted of the single word 'None'. One or two establishments' Boards commented that they were 'high profile' boards known to the great majority of staff. Another replied: 'Because of frequent visits to the Hospital (not less than weekly) it was considered wasteful for a BOV member to sit on the SPMG when monitoring is virtually continuous'.

The majority of those completing the questionnaire felt that they were aware of the nature and extent of attempted suicide and self-harm in their establishment. They tended to depend on recorded information, and were not at all aware that this may be flawed, or be an under-representation of the actual level.

A wide variety of answers was provided in response to the question 'What should the role of the BOV be in relation to suicide prevention?' For example, monitoring and reviewing procedures, training, awareness and communication of information in the establishment, as part of the Boards' watchdog role; responding to the needs of individual prisoners, drawing staff's attention to particular prisoners, initiating the referral procedure themselves; providing care and support (not 'counselling') for prisoners; caring for and supporting staff, and making suggestions to enhance the regime. Some Boards also saw themselves as having a campaigning function, over particular issues.

The questionnaires indicated that most Boards were aware of the official suicide prevention procedures as laid down by the Prison Service. Six Boards drew the researchers' attention to the involvement of the Samaritans in their establishments, others to the use of communal cells, to counselling and to making sure the inmate is not left alone. Only four responses mentioned the use of 'strip cells'. This figure seemed surprisingly low - the research suggesting that 'strip cells' or unfurnished rooms were still being used frequently.

Several problems were mentioned relating to the operation of suicide prevention procedures:

a) Staff training and awareness
b) Resources (e.g. time, hospital space).
c) Identifying vulnerable prisoners.

Six Boards thought that the procedures were working well and they had experienced no particular problems.

Only three Boards had participated in local suicide prevention training, although a further six had made arrangements to do so in the near future.

The information provided in these questionnaires indicated that Boards have adopted a wide range of responses and roles to the problem of suicides and suicide prevention in prison. Some have taken a very proactive role and are fully involved in all aspects of the problem, being involved with inmates and staff, taking part in suicide prevention management group meetings, post suicide debriefings and in staff training. Others have taken a wider and more generalized view; they have absorbed suicide prevention into their monitoring, awareness raising and pressurising role. A few appear to play little or no role. It is worth considering how far the roles adopted by different boards have been influenced by the size of the problem experienced by their establishment and by the type of establishment.

The interest and enthusiasm shown by Board members during the course of the research was impressive, and it would seem important to encourage their wish to enhance the credibility of their 'watchdog' role, now that their adjudication function has been abolished. They were eager for guidance, information and instruction, and gained a great deal from sharing information and good practice amongst themselves at this conference. Their role in suicide prevention could be more carefully considered and specified, and could include:

- Monitoring and reviewing suicide prevention procedures, training, awareness and the communication of information

- Responding to the needs of particular prisoners
- Suggesting improvements to prison regimes
- Offering support for staff, where appropriate

Prison Visitors

Many complaints were heard about the lack of Prison Visitors; prisoners and staff often said that the waiting lists to see a visitor were long. When available, they often provided a valuable 'listening' service to prisoners. In one establishment a visitor and the prison (hospital) staff had formed particularly close links, so that vulnerable inmates were sometimes referred to her. The availability of visitors was known about, and their value unquestionable, for those who received visits from them. New establishments and those with few links should not underestimate their value.

Samaritans

Defining a role for the Samaritans in prison is difficult, as the actual contact time spent with individuals (particularly on the telephone) seemed minimal. Requests for this type of support were rarely forthcoming. Whether this is due to the recency of their role in establishments, or the stigma attatched to asking for help from them (and their unfortunate association in many minds with 'suicide prevention' rather than the provision of support for the distressed), was unclear. What they do provide clearly, is a supportive presence, either on SPMG's, on wings, or at arms' reach in the community. They contribute valuably to training, and those few prisoners who had spoken to Samaritan volunteers were positive about the support they had received. One hospital made referrals to Samaritan volunteers; this was successful because prisoners initially reluctant to the idea, became persuaded that a valuable help-line was being offered.

There are some 'barriers' to the effective use of Samaritans at present: establishments' fears about confidentiality and prisoners' preconceptions about their role. Their aim is to present themselves as an additional source of support for those who need it. As such, the provision of a full-time Prisons Link post (see Introduction) seems very valuable. Such a post makes it possible for the Samaritans to work 'proactively' with establishments, and the publicity involved in the announcement of the fully-funded link post encouraged establishments to ask for Samaritan support. In the words of their Prison-Link coordinator:

> It was noticeable at the beginning of the year that there was not as much contact with young offender institutions as with other establishments. Part of the reason for this was thought to be 'there's still some Borstal ethos around in young offender institutions and I suspect that in some of them the care levels, the support levels are higher than in some adult prisons'.

In May of 1992, Samaritans were on 109 suicide prevention management groups:

'There were some governors and senior medical officers who were actually very keen to involve Samaritans. And there were other branches who were very keen to get involved; so it came in both directions. I did a lot travelling round the country in 88 and 89; I went to most regional governors conferences, so I'd actually done quite a lot of the spade work...

A considerable amount of time had to be spent overcoming issues of 'confidentiality':

'But some of it struck home and they knew their establishment needed support so they went for it. Sometimes they were establishments that were in all kinds of trouble like X, but places like Y, where we'd been knocking and knocking and knocking on the door, it was only when they came to me about two years ago, I suppose when they were in the depths, that things moved forward. But once it started, it accelerated at an enormous pace'... ... 'In most of the large remand prisons, volunteers are visiting on a regular basis now. I actually have a list of what's going on in every prison in the country. quite a lot of good work going on in Induction Wings, and on Induction programmes; that's progressing very well. But, at the other end, there's a token membership of the SPMG and "We'll call you if we need you". There are never any emergency calls. It takes a long time on the SPMG for the trust to be established, for each prison and branch to work out what's the best way of working together. What's right for Brixton isn't right for Wormwood Scrubs, what's right for Holloway isn't right for Cookham Wood, so to a certain extent I have to leave the prison and the branch to work through it together'... 'I suppose what we want in three or four years time is to be able to say anyone in prison has the same access to the Samaritans as anyone in the community. That's what we're moving towards'.

'Hopefully, what I try and encourage branches to do is to offer the same support to staff as they do to prisoners. I mean some branches have gone at it too prisoner orientated and they need a bit more encouragement to actually enable the staff to realise that we are there for them as well. 'The Prison Department itself have asked me a couple of times to visit prisons where there has been a staff suicide'.

Their involvement in the 'Listener scheme' (see Introduction and Davies 1992) has been a major contribution to a change of emphasis within establishments in relation to suicide prevention. One of the most significant effects of the involvement of the Samaritans in prisons has been to bridge the gap between custody and the community. On both sides of the walls, this has had important and beneficial results.

Probation

The research produced an important example of good practice for probation

departments working in prisons. This was based on the experiences at one of the fieldwork establishments, where serious problems had been encountered, including the suicides within one year of six young remand prisoners.

Most of the suicide attempts and incidents of self-harm occurring at this establishment involved young prisoners. Strategies aimed at reducing the problem included reducing cell occupancy from three to two inmates per cell and reorganising the Suicide Prevention Management Group, using a broader team approach. A Care Team for staff was also set up, which maintained support for staff until after the inquest, where necessary. A Group Manager working on the YP wing played a key role in tackling the unprecedented number of suicide attempts and self-injuries occurring at the prison. Statutory obligations had to be fulfilled, staff required support and the regime for inmates had to be maximised. These aims were to be achieved within the real constraints of low staffing levels, high reception and discharge figures and the limitations of working within a Victorian building with little scope for activity. Other problems needing to be overcome were the excessive TOIL owed to staff, high levels of sickness, low morale (exacerbated by negative media coverage), increasing levels of self-harm on the wing and four suicides in nine months.

These objectives were met in part by implementing recommendations made in a report carried out internally. Cell lighting was improved, officers received Suicide Awareness training, communications were improved, using a wing occurrence book and a 1997 file, and cell allocation was improved.

Guidelines in CI 20/89 were followed, particularly with regard to the route taken by 1997 referral forms, so that the originator of the form was informed of any outcome. Liaison was encouraged between medical and discipline staff, the chaplaincy, probation and the Board of Visitors. Improved training fostered a team spirit on the wing and improved relationships between staff and inmates and confidence in handling suspected suicide risk. Senior staff presence on the wing was important, as was open discussion with staff about how they were handling incidents and their after-effects. The level of TOIL was reduced, with a subsequent reduction in staff sickness levels. Officers were encouraged by the probation department to participate in group work with inmates on offending behaviour and substance abuse. Aspects of the regime were enhanced and the levels of activity increased. A wing-based library was introduced. Early identification of inmates considered to be at risk greatly reduced the level of serious suicide attempts and suicides.

Before this prison suffered from this 'epidemic' of suicide attempts and self-harm, the probation department had played a low-key role in suicide prevention. Each department within the prison had been working in isolation. As a result of efforts made establishment-wide to tackle the problem, the probation department became an integral part of the management of suicide and self-harm. They enhanced links with the community (eg. families, outside agencies, field probation officers and solicitors) and also undertook a co-ordinating role within the prison, liaising between the wings, medical and discipline staff, chaplains and governors. Information was shared, case conferences were initiated and a more supportive response to self-harm was developed. Individuals were treated as such, recommendations were made in each case and follow up action was planned. Cases were reviewed at the Suicide Management Group meetings. Visiting psychiatrists, and more recently prisoners were invited to participate in

the Group meetings.

As a result of these changes, the probation department and other departments at the establishment became more confident in dealing with incidents, and with the media - who were having a detrimental impact both on the extent of the problem and on staff morale. In the case of a death in the establishment, families were offered support and advice, they were welcomed and encouraged to come to the prison; almost any request for information or involvement was accepted. A crucial change of atmosphere - an opening up - made relationships both inside and outside much more constructive. The problem was 'shared'. This sharing of responsibility reduced the fear and anxiety that is inevitable when dealing with such a distressing and traumatic problem. Within the establishment role boundaries were forgotten, and staff worked together; relationships between probation and prison staff were co-operative and effective.

Probation officers who ran groups were often spoken about with great enthusiasm. The balance between individual need - both practical/ welfare and counselling - and the needs of particular groups within each establishment was difficult to strike. Obviously the above example shows how probation and prison staff can work together in a most effective way. Barriers also have to be broken between these and other departments in establishments.

Psychologists

> Psychologists in the Prison Service are concerned with the assessment, treatment and training of inmates, the support and training of staff, providing services to management and doing research. Their range of tasks is wider than most other applied psychologists. The overall task of Psychological Services is to contribute to the efficiency and effectiveness of Prison Department Systems within institutions, Regional Offices and HQ. (Introduction to Post-graduate Training Course, Birbeck College)

Only one of the four fieldwork establishments had access to a psychologist on a regular basis, and this department was stationed outside the main gates of the prison. This may explain the relative 'absence' of psychologists in the research - in the Sample II phase of the project, they simply did not emerge as a resource. However, during the course of fieldwork, a number of psychologists were encountered and other people were willing to give their views about the potential role of psychologists or issues relating to psychologists. In fact, in three instances it was possible to match up psychology students looking for a research project with needy establishments desperate to take advantage of enthusiastic (and often free) labour.

As seen in chapter four, few prisoners had access to psychologists in any of the prisons, for any problem. If what prisoners themselves say in chapter five is taken seriously, this shortage of psychological support should somehow be remedied. Psychologists play an important role, not just in the support and counselling of individual prisoners, but in the provision of groups (in this context, social skills training, anger control, assertiveness training, managing stress, and so on). Some of this

work could be carried out by prison officers. At the very least, psychologists are needed to train them to do it, and to support them in their efforts. In addition, a tremendous need for evaluation - of aspects of suicide prevention procedures - but also of other aspects of prison life, could be met by psychologists were there enough to go round. Their role in establishments in practice can vary, and is not always clear. In some they have very little contact with prisoners.

Teachers, Workshop Instructors and Farms and Gardens Instructors

These groups of staff, neglected in policy and research, yet often having a deeper knowledge of prisoners' problems than any other staff group, emerged in the fieldwork as being amongst those with the most to contribute both to the support of prisoners, and to the identification of potential problems. It is significant that these groups often spend more time with prisoners than any other staff group. They are often left out of suicide prevention training, and do not always have sufficient contact with other staff in establishments to make the most effective use of the knowledge they have of individual prisoners. Education departments provided a tremendously important level of support for prisoners. One enthusiastic education officer in an establishment is probably worth ten televisions and a programme installing integral sanitation - provided there are sufficient staff to allow classes to run.

CHAPTER EIGHT

SUMMARY AND CONCLUSIONS

And what will be the result of your research? Another Circular Instruction about six inches thick instead of any real changes...The department have got their insurance policy. If they've got a system with forms then they think there aren't any problems...It's really a human relationships problem, it's not a form problem. (Governor grade)

They turn to crime because they can't cope outside, then they can't cope in here. Then they're asked stupid questions like, "are you feeling suicidal?". I'd just like to say that I'm glad somebody's interested. (CG)

While systems are important, people matter more. (Tumim, 1990:16)

Why inmates commit suicide? The system; the system is devoid of all love... the system doesn't sometimes give you nothing to reach for to make you want to live another day. The system doesn't really give you any form of understanding. (SG)

Introduction

> All we talk about is management systems and management issues. We never talk about prisoner issues. The staff are really beginning to think that their performance is judged on the routine things, like regime monitoring... It's about time a different sort of question was asked about routines and regimes...It is pretty obvious that in the less stressed prisons you get less suicides... A prisoner was moved here from [Prison A], without being told why, where they had a good regime and he had a cell on his own with all his belongings in. And he came here to an outdated and overcrowded prison, to a cell he was having to share with two other inmates. We had to tell him why he'd been transferred. [Prison A] won't have him back and they won't even tell us why, so how can we tell him? He'd just settled down here when he was told that he would be able to go to [Prison B], and now he can't go there, and none of us know why. He was nicked for not going on exercise; nobody asked him why he didn't go on exercise. No-one ever asked why. The fact was he was feeling completely depressed because of the situation he was in...things were just getting worse and worse [The prisoner discussed had recently injured himself]. (Governor Grade)

> Nowadays we compete with outside industry so we just can't get work. There are more prisoners being held for much longer periods and there are delays in coming to court. Yet the department have decided that if it's more cost-effective to put inmates behind their doors then that's simply what they do. We want courses, we want activity and we want to occupy a man during the day. Instead, he's in a cell, either on his own or he's in with people who change from one day to another. All his problems just bottle up until he just can't cope any more. This Circular, just like lots of other Circulars, denies the real problem. We never discuss prisoners at policy meetings. (Governor Grade)

The final chapter of this report summarises some of the important findings to emerge from the research. It reflects on the results of the research, draws links with recent literature and policy statements, and suggests ways forward. A typology of prison suicide attempts is also developed from the data, which shows how suicides in prison may be linked to other areas of prison sociological research.

The project grew out of a growing disenchantment with recorded information about suicide and suicide attempts in prison and with the traditional prediction approach to the problem (see Introduction). It was hoped that a research approach which focussed more on the situational and motivational aspects of suicide attempts would yield information of use to management, staff and prisoners in planning intervention strategies.

Two complementary studies were designed: an epidemiological study, which

looked at the nature and extent of self-injury in a representative sample of establishments and an intensive study based on interviews with prisoners and staff in four establishments.

Section I: The Epidemiological Study

This study was carried out in order to improve upon existing data relating to suicide attempts and self-injury in prison which was incomplete and unreliable. During the course of the study the opportunity was also taken to learn as much as possible about aspects of practice which seemed good and about problems relating to suicide prevention which seemed to have potential solutions. That information is summarised here.

(A detailed, impressionistic account of features of the sixteen 'representative' Sample I prisons visited during the course of the epidemiological study is contained in Appendix 2).

Summary of Epidemiological Data

A carefully chosen sample of 16 establishments providing a representative cross-section of the prison population was selected. Contacts were made and maintained with all these establishments throughout the period of the fieldwork. Despite this 'face-to-face' contact, reinforced by telephone calls and letters, the epidemiological study was difficult and time-consuming to carry out. There were very real problems relating to the effective and consistent recording of self-injury in establishments. Staffing changes and absences, a reluctance to complete forms or to be seen as a 'top of the league' establishment, and time constraints, made the data collection exercise rather arduous. Despite these problems, a significant improvement on previous data was achieved.

Details were received on 305 incidents of self-harm carried out by 248 prisoners in some 16 establishments (which had been selected to be reasonably representative of the prison system as a whole). The data received was not a complete sample: regular checking with local sources of information and record-keeping suggested that the data were incomplete from particular establishments or for particular periods during the year. (The shortfall was in the busiest local and remand centres) Nevertheless, it constituted a significant improvement on previously available data, particularly in respect of the detail included. It found that:

- Just over half the prisoners (52 per cent) involved in the incidents were 21 or under (the youngest was 14 and the oldest 65), despite the fact that young offenders make up only about 18 per cent of the prison population

- 48 per cent of the sample were remand prisoners (compared with 21 per cent of the prison population) and 52 per cent were sentenced (79 per cent).

- Not surprisingly, most of the incidents (60 per cent) were reported from the local and remand centres amongst the 16 establishments, 20 per cent from the young offender establishments, and about 20 per cent from the training and dispersal prisons. No incidents were reported from the open prison establishment in the sample.

- There was no over-representation of short or medium sentence prisoners. Only very short sentence prisoners (4 months or less) appeared to be over-represented - possibly a reflection of the disproportionately large numbers of under-21s in the sample. Long sentence prisoners were slightly under-represented.

- The sample's pattern of offences (and charges) was not dissimilar from the prison population. Sex and violence and robbery offences were more or less in proportion to the prison population while only arson and criminal damage appeared to be significantly over-represented - although the overall number of such offenders in the prison population is small.

- Incidents tended to occur earlier, rather than later, during the sample's custodial experience.

- Only 26 per cent of the sample had been identified as being at some risk of suicide at the reception screening interview.

- Most self-injury involved wrist cutting, but a significant group used hanging as a method.

- Almost half of the sample had injured themselves before - a quarter on more than one occasion. Two thirds of those who had injured themselves before had done so in custody - 14 per cent within one week of the current incident.

- About half of those prisoners who injured themselves in the sample were placed in seclusion (protective custody) as a result. Less than a third were referred to a psychiatrist.

- 32 per cent of the sample had seen the prison medical officer less than seven days before the incident

- 34 per cent of the sample had been receiving medical or psychiatric treatment at the time of the current incident

- In many respects staff and prisoners shared the same views about the reasons and motivations why prisoners self-harm. Not surprisingly however, staff were more likely to mention attention seeking and manipulation as possible motives.

Important differences also became apparent when incidents involving adults and young prisoners were analysed separately (see further below).

The Management and Prevention of Suicide - Issues Emerging from the Field

(i) Problems

Several problems relating to suicide and its prevention emerged from this part of the research. Most of these related to recording practices and the day-to-day management of the problem (for example, location of the prisoner, the assessment of risk and the realistic possibilities for observation). Some problems were found in most establishments, but this list constitutes an analysis of all the major issues related to or noted by

the team.

Summary of Negative Features of Suicide 'Prevention' and Related Management Procedures Noted Throughout the Study (order does not indicate importance)

Recording and Reporting

- poor and haphazard recording practice
- conflicting and unwieldy reporting requirements
- inappropriate use of referral form 1997
- lack of/poor quality information on (especially remand) prisoners

Facilities

- poor facilities, particularly in prison hospitals
- over-use of 'protected rooms' (frequency of use and duration)
- the condition of many 'protected rooms'
- overcrowded remand wings
- over-large YOI's, with 14-21 age range

Procedures

- too hasty transfer to hospital (little referral for advice)
- inappropriate use of transfers for 'full-time' medical cover
- superficial and late (evening) reception procedures
- placement in segregation units for 'observation'
- reliance on '15-minute watch'
- frequent cancellation of SPMG meetings
- frequent cancellation of suicide prevention training
- poor communication between departments

Regime Provision

- lack of activity
- closure of workshops/cancellation of classes
- lack of specialists/counselling for prisoners
- high use of Rule 43/46

Staffing Issues

- inappropriate attitudes towards self-injury
- staff shortages
- low staff morale, high sickness
- lack of suicide prevention training (for all types of staff)
- under-use of suicide prevention trainers
- staff anxiety about inquests (and inquest 'trials')
- resistance to the use of Samaritans
- unresolved industrial relations problems
- staffing changes/absences/discontinuities (including doctors)

Other

- bullying and intimidation by/of prisoners

- trial delays, uncertainty (eg. parole delays)
- distance from home areas, problems relating to visits
- lack of consultation with staff and prisoners

These problems are many and varied, but each may militate against the improvement of suicide prevention procedures. Most speak for themselves and need little further elaboration. Doctors in particular complained of the conflict between the requirements of security and the aim of providing a therapeutic response to suicide risk. This was a theme to which many of the above features and problems relate. Lack of staff resulted in seclusion of the prisoner and very little contact - the opposite of what was needed. (Prison staff noted this conflict as well).

Staff complained of the continual and unmet need for more training in suicide prevention and complementary areas. Many of them were following procedures only because the relevant information had been passed down and handed around informally. In places, some of their commitment to following procedures was related to fear and to promotion prospects. They would sometimes know the procedures in detail, but did not relate these procedures to a concern for the distress of the prisoners. It was noted that staff were very keen on verbal ('face-to-face' as opposed to written) instruction and training, and that they called for refresher training, feeling they still had much to learn.

One major feature of all establishments visited was the lack of information they each had about what was going on in other prisons. Bad news tended to travel faster and wider than good news. Good practice was not often communicated, although significant improvements were noted in recent months.

(ii) Good Practice

Summary of Positive Features of Suicide 'Prevention' and Related Management Procedures Noted Throughout the Study (order does not indicate importance)

Recording and Reporting

- thorough and consistent recording practice
- appropriate use of referral process (form 1997)
- local monitoring and research (eg. of the use of 1997's)

Facilities

- the installation of telephones
- properly staffed hospital wards
- educational 'annexe's'; therapeutic communities
- minimal use of 'care rooms' (decorated by prisoners; cp. Swansea)

Procedures

- 'improvement objectives'
- user-friendly summaries of instructions and reports

- reviews following referrals
- case conferences, shared responsibility
- liaison with local psychiatric facilities
- the use of SPMG meetings (for reviewing cases/procedures etc)
- uniformed officers/industrial and education staff on SPMG
- early reception procedures (eg. 2pm) and the provision of tea
- suicide prevention packs and folders on wings
- staff vigilance; taking problems seriously (informal work)

Regime Provision

- the use of Samaritans (eg. at induction/leavers' fairs, etc.)
- sentence planning, induction units
- personal officer and pre-release schemes
- education, work and physical education provision
- group work (social skills, assertiveness training, etc.)
- listener schemes

Staffing Issues

- staff care/support teams
- staff 'personal development' and fitness time
- individual initiative, pride and enthusiasm
- suicide prevention training for all types of staff

Other

- nurse placement exchanges with local hospitals
- sharing information with other establishments
- active and purposeful regimes, proactive and professionally trained staff, and a atmosphere facilitating open communication.

'Good practice' was not difficult to find, but it was difficult to describe appropriately, as it often depended on a context of positive attitudes and support (both formal and informal) within particular establishments. The closed YOI and interchange centre for example had several natural advantages. It had a good regime, positive and committed staff, time to invest and no overcrowding. It had plenty of activity and unusually good facilities. The staff acted as personal group officers, so inmates' problems were picked up and there was room for some of these problems to be solved. Staff would make phone calls, or they would facilitate the inmates' ability to make a phone call. There was a commitment to and an interest and pride in suicide prevention.

Nevertheless, the same establishment also had specific areas of low morale, where particular changes had occurred or particular problems had been encountered, but there was nothing like the chaos and misery that had been seen in some of the locals and remand centres. However, the fact that this establishment had come so close to having a suicide (see details in Appendix 2) illustrates that even with all these advantages, they were still bound to face serious problems of suicide risk from time to time. There was an encouraging and welcome spirit of concern and time for a

difficult and sometimes vulnerable group of prisoners. Without this effort, the level of suicide risk encountered would almost certainly have been higher.

Section II: The Intensive Study

Summary of Prisoner Data

This part of the research was a study of self-harm which had the aim of providing detailed information about the situations in which those behaviours occurred, paying particular attention to the impact of the regime (including staff/inmate and inmate/ inmate relationships) on those behaviours.

Long, semi-structured interviews were carried out with staff and prisoners at four establishments: one training prison and three local and remand centres. In each establishment the prisoner group consisted of a 'subject group' (those prisoners injuring themselves or attempting suicide within one month of the fieldwork start date) and a 'comparison group' (prisoners selected randomly from the general prisoner population).

This section draws together some of the findings from the intensive study and, at the same time, illustrates how different prison populations are characterised by different patterns of self-harm.

Differences Between Suicide Attempters and a Comparison Group

In the descriptions of prisoners lives and backgrounds, the important differences to emerge between the subject (suicide attempt) and comparison (general prisoner population) groups were differences of degree.

For example, there were few differences between the two groups where most demographic and socio-economic variables were concerned - accommodation, employment histories, education (age left school, expulsion, qualifications) etc. Nor were there any differences where family situation was concerned - both groups being similar in respect of siblings, parents, step parents and the extent of the contact they maintained with them. Similar proportions had divorced or separated parents. Nor were there significant differences between the groups in respect of parental violence.

Nevertheless, a number of interesting differences emerged. For example, both groups were equally likely to have experienced local authority care at some time, but the subject group was much more likely to have been sent there as a result of family and behavioural problems than the comparison group (who were were more likely to be there as a result of offending behaviour)

Moreover, it was noticeable that more of the comparison group prisoners could articulate their histories, their growth into crime, and the pain of their lives in words, and more of them had developed strategies for dealing with that world: a world where security, love, reward, opportunity and hope were notably absent. In their place, material gain, risk-taking, 'moonlighting', impulsivity and immediacy took root (see Zamble and Porporino, 1988 for a description of 'prisoners' lives' in the community).

Once in prison, the scale and quality of the differences between the two groups were more marked. On most questions about the experience of imprisonment, the subject group both were, and saw themselves, as worse off. Each indicator of life in prison confirmed this overall pattern. Lack of motivation to negotiate a place on education (for example) for themselves sometimes reflected a downward psychological spiral, interpreted by the staff as indicating a choice or lack of interest. This inability to move into constructive areas of the prison world defined the 'vulnerable group'.

Not having anything to do was one of the most destructive aspects of life in (areas of the) local and remand centres, particularly for the young, the resourceless and the depressed. Only half the subject group could think of anything at all to do when locked in their cells. The subject group spent longer in their cells: over forty per cent reported spending twenty-three hours per day there (most of these were prisoners in the local and remand centres). Prisoners in the subject group found it much harder to find ways of coping, or of relieving their boredom. Indeed, more than one half could think of 'nothing' to do to relieve their feelings.

These findings were consistent with the earlier study and suggest that the poor coping model developed in that study can be applied to a wider population than sentenced young prisoners alone. Some prisoners find the experience of inactivity much more difficult to manage than others. These are the very prisoners who seem to end up in such a situation.

Visits and contacts with family were almost uniformly difficult for all prisoners, for a variety of reasons. They might be unreliable and sporadic, or they were problematic due to the distance, travelling, work, or strained relationships. Three quarters of both groups of prisoners reported having problems with visits. For those already vulnerable, problems with visits were crucial. For those not necessarily vulnerable in a marked way, traumatic experiences relating to family contact, or the lack of it, were enough to trigger suicidal feelings.

It was significant that the subject group saw their relationships with staff in a different way from the comparison group. For example while both groups were similar in the extent to which they found staff helpful or unhelpful, the subject group were much more likely to look for and appreciate help of a personal kind ('listening to you', 'showing an interest' or 'trying to understand') than the control group who preferred help of a more practical or instrumental nature.

It is clear from the material presented in chapters four and five that the use of unfurnished and protective accommodation ('strip cells') was extremely unpopular. Many of the subject group had spent long periods in isolation, either in a hospital 'strip cell' or segregated from other prisoners on Rule 43 (Own Protection). Three quarters of the group expressed strong negative feelings about this experience, and there was evidence that, in a considerable number of cases, fear of being put in a 'strip cell' had acted as a disincentive to admitting to suicidal feelings - especially during the reception process.

The problems of remand prisoners feeling unable to seek therapeutic or psychiatric help for fear of affecting the outcome of their case has rarely

been raised. It is an important consideration, given that most suicides (and therefore a great deal of suicidal thought and action) occur amongst remand prisoners. Other sources of help (such as prison visitors, the Samaritans, psychologists, the availability of skills training groups, and so on) may be more acceptable to and appropriate for prisoners in this situation. Staff can obviously play a major role, for these and all prisoners, provided they are not handicapped by overcrowding.

The situation in prison for Rule 43 prisoners emerged as a significant problem in the research. They are isolated, abused and in every way handicapped by the nature of the offence they have committed or are charged with, or by the personal difficulties their 'voluntary' segregation exposes. Even where active regimes are provided for them (and increasingly throughout the research, this was the case), they suffer. Provision for such prisoners, who make up at least eight per cent of the population and made up 39 per cent of the subject group cases - is being reconsidered. They are an 'at risk' group in many senses.

The Role of Bullying

The research confirmed the importance of the link between bullying and prisoner self-harm. Life in prison was frightening and violent for many (especially young and Rule 43) prisoners. Friendships were guarded; lack of trust, and an atmosphere of fear and unstable hierarchies of power pervaded many wings. Two thirds of those in the 'suicide attempt' group reported experiencing serious difficulties with other prisoners, while one quarter of the suicide attempts in the research were related to inmate pressure or victimisation.

Very little literature on the subject of bullying amongst young prisoners exists although the earlier study of suicide attempts amongst young prisoners contains some data on the problem (Liebling, 1992). Two (now slightly dated) American studies (Polsky, 1962; Feld, 1977) described inmate social systems whereby 'scapegoats' are dominated and humiliated by other inmates higher in the hierarchy. A (restricted circulation) report by McGurk and McDougal describes the nature and extent of bullying in one Young Offender Institution, the efforts made to reduce the problem, and an evaluation of these changes (McGurk and McDougal, 1986). Shine et al carried out a study of violence in Young Offender Institutions which included material on bullying (see also Ericson, 1975). This research provided substantial evidence to suggest that pressure and victimization by other prisoners constitute major factors in the development of suicidal feelings in custody, particularly amongst the young. It is clear that the contribution which bullying makes to the prison suicide/self-injury problem is worthy of systematic and separate research.

Learned Helplessness and Poor Coping in the Prisoner Population

Large groups amongst the prisoner population share the characteristics identified in studies of suicide risk in the community, of helplessness, hopelessness, low self-esteem, low expectations, poor problem-solving skills, low motivational drive and a 'depressogenic attributional style' (see especially Jack, 1992:128 but also Sapsford, 1983). Many have experienced multiple social and economic disadvantage, frequent adverse

life events, negative interpersonal relations and have a poor educational and employment history (see Prison Reform Trust, 1991). Such prisoners may be accumulating in a higher concentration in the overcrowded prison system, as alternatives are found for those who have a greater hope of succeeding in the community, as social dislocation increases and as legitimate avenues of survival close. Those most vulnerable (the 'feminine' group in Jack's theory of attempted suicide in women) are exposed to failure in a highly 'masculine' environment, where - to use his analogy, only the 'macho' survive. Imprisonment for men may actually demand the worst excesses of 'masculinity', in their least legitimate form, from those who find a way of coping successfully with it. It is less surprising, in this theoretical context, that 'the weak' and 'the inadequate' are so labelled, and require 'protection'. Jack's work focuses upon self-poisoning amongst women, but his theoretical approach and his research shows how,

> whilst the contribution of psychiatric enquiry to the description of self-poisoning has been great, its relative neglect by social science has led to the predominance of the psychiatric perspective and an emphasis on psychopathology and psychiatric epidemiology... a search for mental or personality disorder among self-poisoners and to the description of the socio-demographic characteristics. (Jack, 1992:19).

If the behaviour is seen as pathological - a model with little empirical evidence to support it - it is also regarded as essentially irrational and 'meaningless' (Jack, 1992:20). The pathology orientation inherent in the 'psychiatric paradigm' is inclined to impute the "manipulative" or "aggressive" motivation of the "hysterical", "inadequate", or "psychopathic" personality (Ibid.). This is a familiar refrain in prison. Terminology used in research and reports ('epidemics', 'endemic', family 'pathology' and so on) reinforce this medical/disease model. Jack's 'vulnerability-stress model' is suggested as a move forward from the pathology paradigm:

> This lack of power results in a perceived inability to control outcomes and events. Certain groups of individuals, such as the economically disadvantaged and those with histories of early family disruption, are more vulnerable due to their greater experience of uncontrollability (Jack, 1992:xvi).

Jack argues that women are additionally vulnerable to learned helplessness due to the effects of the sex-role system, their adaptation to this role by way of greater passivity and helplessness, the adoption of a 'dysfunctional attributional style' and the medicalisation of their social and relational problems. It is only later in his book that he makes clear the potential application of his theory to male self-poisoners, who will, he argues, resemble female self-poisoners. It is because of the marked over-representation of women self-poisoners in the community (by as much as nine to one amongst teenagers, and four to one overall; Jack, 1992; Hawton, 1986) that he concerns himself with the disproportionate appearance of such women in the self-poisoning and suicide attempt figures.

Two things make Jack's model of particular relevance to research on suicide attempts in male prisons. The first is that a significant number of

(particularly young - that is, under 26) male prisoners engage in self-injury. The ratio of males to females self-injury may be lower in prison to that reported in the community, and certainly would be lower were prisoners counted instead of incidents in the annual figures (see Table 1.1). The second important point is that his application of the learned helplessness model fits the data in both the recently completed research on young prisoner suicide attempts and the research presented here. There is a link between this model, relevant to 'young working class women' in the community, and what are known to be the characteristics of large groups of the prison population (see chapter four and Prison Reform Trust, 1991, also Seligman, 1975 and Sapsford, 1983).

The 'learned helplessness' theory provides an important development in thinking about the problem of prison suicide. A group of people are imprisoned who share to a large extent these characteristics of social, economic, and - as Jack illustrates - psychological deprivation. They (or significant sub-groups amongst them) are not future oriented; they do not cope well with negative events; the coping skills they do have are easily disrupted; they are 'especially vulnerable to helplessness in the face of multiple adversity' (Jack, 1992:203).

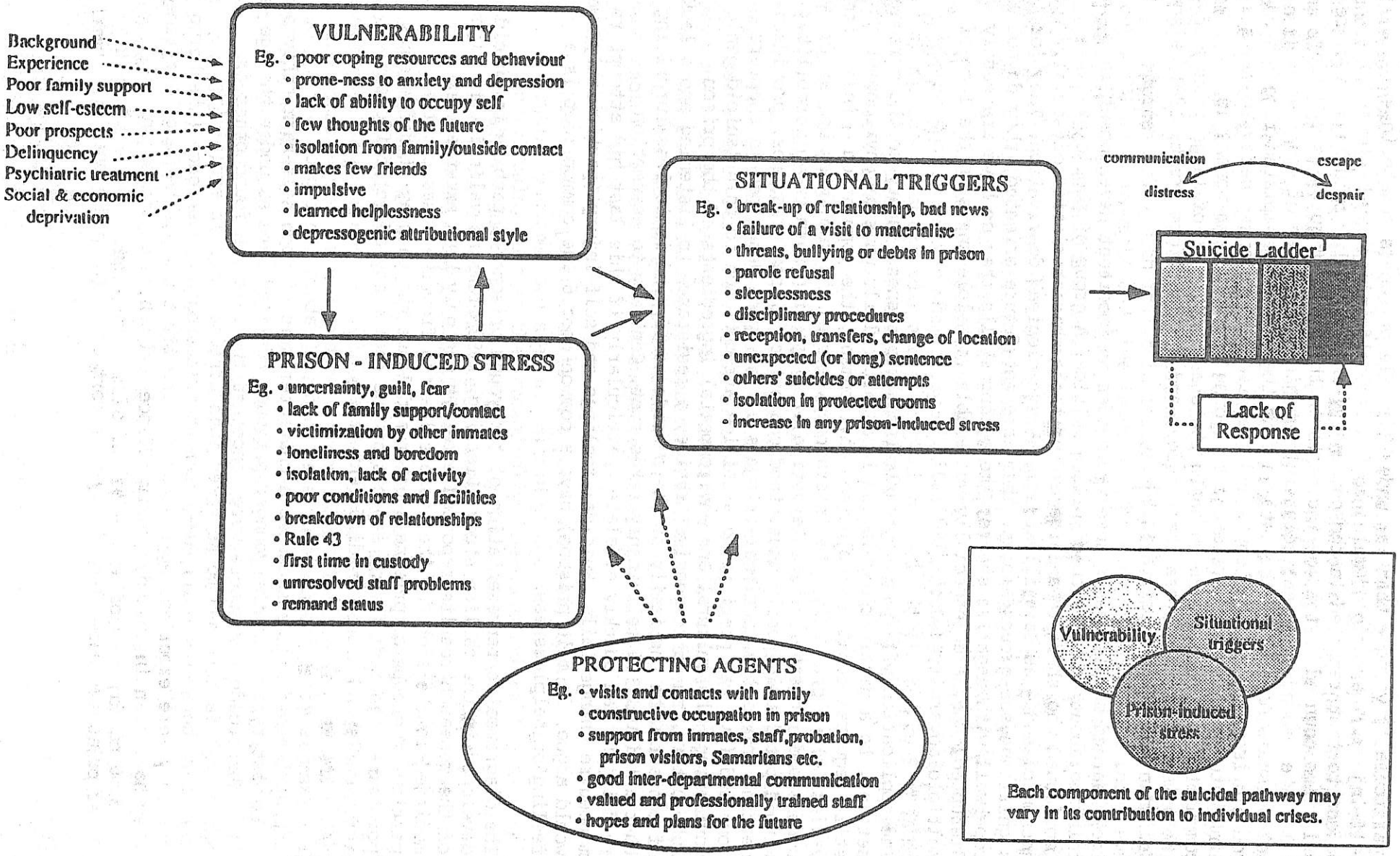
The application of a poor coping/learned helplessness theory to the prison setting, to a distinct population in a particularly unusual environment still requires caution. The prison environment, the population - in all its variety - and crucially, the interaction between the two, must be carefully understood. Together, the interaction of a specific form of vulnerability with a previously poorly understood context of prison pressures, provide a setting in which situational triggers of the types described in chapters four and five can precipitate a suicide attempt. Add to this 'suicidogenic' environment the cultural and environmental ingredients of the prison sub-culture, an 'unresponsive' regime, a resistance to listening and a lack of contact with the family or the outside world, and it is less surprising that a 'ritual' of self-injury takes root. Contrary to assumption, self-injury can quickly escalate, particularly if this last bid attempt to manoeuvre change fails. Suicidal feelings and self-injury (particularly, we would argue, in male prisons) have a common root.6 The common root is a feeling of helplessness.

The diagrammatic representation of the young prisoner's pathway to suicide developed in the earlier study (Liebling, 1992) remains valid in the light of the research results reported here. It has only been extended and modified in the light of the lessons learned from the research: that particular groups of prisoners enter and leave the pathway at different points, and that different aspects of the regime may affect different individuals and groups in different ways.

For example, the finding (discussed in detail above) that poor coping/learned helplessness is a characteristic of much self-harm behaviour - is most typical of the younger prisoner (defined here as under the age of 26). Where older prisoners were concerned the research found other or additional factors had to be taken into consideration in explaining self-harm behaviour - in particular their custodial experience (whether or not they were experiencing custody for the first time), the length of time they have been in custody, their offence and sentence, and so on.

Older prisoners were also likely to report other (or additional)

Figure 1 Diagrammatic representation of the prisoner's pathway to suicide



1. The 'Suicide Ladder ' (cp. Eldrid, 1988) indicates a pathway from feelings and thoughts of suicide, through self-injury and failed suicide attempts to completed suicide. The inmate may be propelled along the continuum of suicidal action by the (lack of) institutional response.

motivations for their self-harming behaviour. In particular they were more likely to report feelings of guilt about the offence as a motivating factor and feelings of frustration and anger.

The result is that the self-harm behaviour typical of an establishment - and therefore the suicide prevention procedures which are most appropriate to it - depend to a considerable extent on the population - or population groups - it caters for.

Some examples are given below - in each case, the sample is looked at in terms of a particular population characteristic and comparisons are made between the features of the self-harm group and the control group.

Type of Prisoner

(SG = Suicide Attempt Group; CG = General Population Group)

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1. The Young (under 26) N=68 33=SG 35=CG

For young offenders - defined here as those under the age of 26 - it is the prison situation which is particularly important. In comparison with older prisoners, young prisoner self-harmers are less likely to show evidence of psychiatric illness than other prison self-harmers. They are people in psychological distress, rather than people suffering from a mental disorder. Shame, guilt and mental disorder play a relatively minor role for the younger prisoner.

In general, young offenders will contain the largest proportion of poor 'copers' in the prison system. Consequently, as a group, the characteristics of the self-harmers in the population are more or less identical to those already noted above, ie they are more likely to have a history of being in care because of family problems or as a result of family breakdown (36 per cent SG cf. 6 per cent CG), to have a history of sexual abuse and to have been bullied at school. They are more likely to have witnessed parental violence or to have been hospitalised as a direct result of family violence.

Similarly, they will show greater vulnerability to the activity and coping variables, ie they were more likely than the comparison group to be vulnerable to boredom (76 per cent SG often bored), inactivity, bullying, poor facilities and lack of outside contact.

Their need for support is intense, and their reactions to distress impulsive. They are especially dependent on sustaining external resources, such as activity, structure and contact. They were more likely than the control group to be in custody for the first time (56 per cent cf. 24 per cent CG) and/or to be on Rule 43 (48 per cent SG cf. 16 per cent CG).

In many ways their predicament is most susceptible to intervention by staff and sympathetic regimes.

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2. Remand Prisoners N=65 32=SG 33=CG (22=under 21; 16=SG/6=CG)

Most completed suicides and most self-harm attempts occur during the remand stage - indeed, one third of the incidents examined by the study occurred within 7 days of arrival.

This is because the remand population contains all the vulnerable groups (the young, first timers, mentally disordered, etc) at the most stressful time of their custodial experience, ie during the time of initial impact of custody, when the uncertainties of conviction and sentence, of maintaining contact with the outside, are at their greatest, and when any feelings of remorse/guilt about the offence will also be at a maximum etc.

Within the remand population, 'self-harmers' tended to be younger than the general remand population, to report more 'family problems, and previous self-harm. They were likely to be first timers, to be more on their own and to report having difficulties with other prisoners. They were more likely to want help of a personal kind from staff.

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3. First Timers N=50 27=SG 23=CG (18=under 21 15=SG 3=CG $p<.05$)

A first custodial sentence is particularly stressful for any prisoner (54 per cent of both groups reported that they had been devastated by receiving a sentence- or the length of the sentence). However, amongst the 'first-timers', the subject group were significantly younger and rather less criminal than the comparison group (ie to have be fewer previous convictions or to be older at first conviction).

Their youth and inexperience also meant that they were particularly dependent upon (and therefore vulnerable to) outside contacts. For example, they were more affected by visits and contacts (wanting more, more depressed after, thinking of people outside all the time) and self-harm incidents were more likely to occur at the weekend (34 per cent cf. 8 per cent rest); ie after visits. Continuing the contact theme, self-harm episodes were more likely to be triggered by parole refusals or 'Dear John' letters. The subject group also seemed to be more 'depressed' - 50 per cent had received previous psychiatric treatment for depression and were more likely to have been transferred around the system for therapeutic reasons.

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4. Short and Medium Sentence Prisoners (<4yrs) N=29 10=SG 20=CG (3=under 21;all SG)

Older. 'Dear John''s, divorces and separations more significant for SG (eg. 30 per cent SG received 'Dear John' cf. 8 per cent CG). Family problems variables and use of alcohol and drugs significant for SG. 'Activity' variables significant for this group. Having no release plans important (44 per cent SG cf. 6 per cent CG). Highest use of 'protective custody'. 20 per cent SG not seen by doctor or hospital officer on reception. More referrals by wing staff. 20 per cent SG and 5 per cent CG never think about the long-term future. Higher proportion describe thoughts and attempts as 'serious'. More treatment required for injuries. Most likely to have tried

discussing their problems, but received no response (50 per cent). Planning, suicide notes, precautions more frequent. 83 per cent said incident did not alleviate their problems. 57 per cent said would repeat. Highest previous self-injury (50 per cent), 71 per cent SG thought about people on outside all the time.

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5. Long Sentence Prisoners (4yrs+) N=47 20=SG 27=CG (2=under 21;both SG)

Amongst long term prisoners the self-harm group were significantly more concerned about the importance of contact and communication than the control group (for example, they strongly wanted to receive and send more letters - 100 per cent of SG compared with 6 per cent of the CG). They were much more likely to be having 'morale-type' problems, for example they were much more likely to be seeing a psychiatrist (for depression, suicide risk and counselling -32 per cent SG cf. 4 per cent CG) and seemed to have difficulty in using their sentence to achieve anything constructive. They reported staff as less helpful and had more difficulties with them. The incidents tended to occur longer after arrival than those of other groups. They were less likely to have experienced previous custody. The self-harm episodes tended to be more serious and well thought out.

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6. Sex offenders/Rule 43 Prisoners N=35 24=SG 11=CG (12=under 21; 10 SG)

Clearly the sex offender/Rule 43 population is a highly vulnerable population, their protected status reflecting the particular pressures of the prison environment for this group. Within this population, the subject group were more likely than the comparison group to be young and to be on remand. They were also more likely to exhibit background deprivation factors, ie they were more likely to have truanted from school because of problems (eg. bullying) (53 per cent SG cf. 0 per cent CG), to have received previous previous psychiatric treatment (79 per cent SG cf. 46 per cent CG). and to have previously self-injured. They were more likely to report difficulties with staff and other inmates.

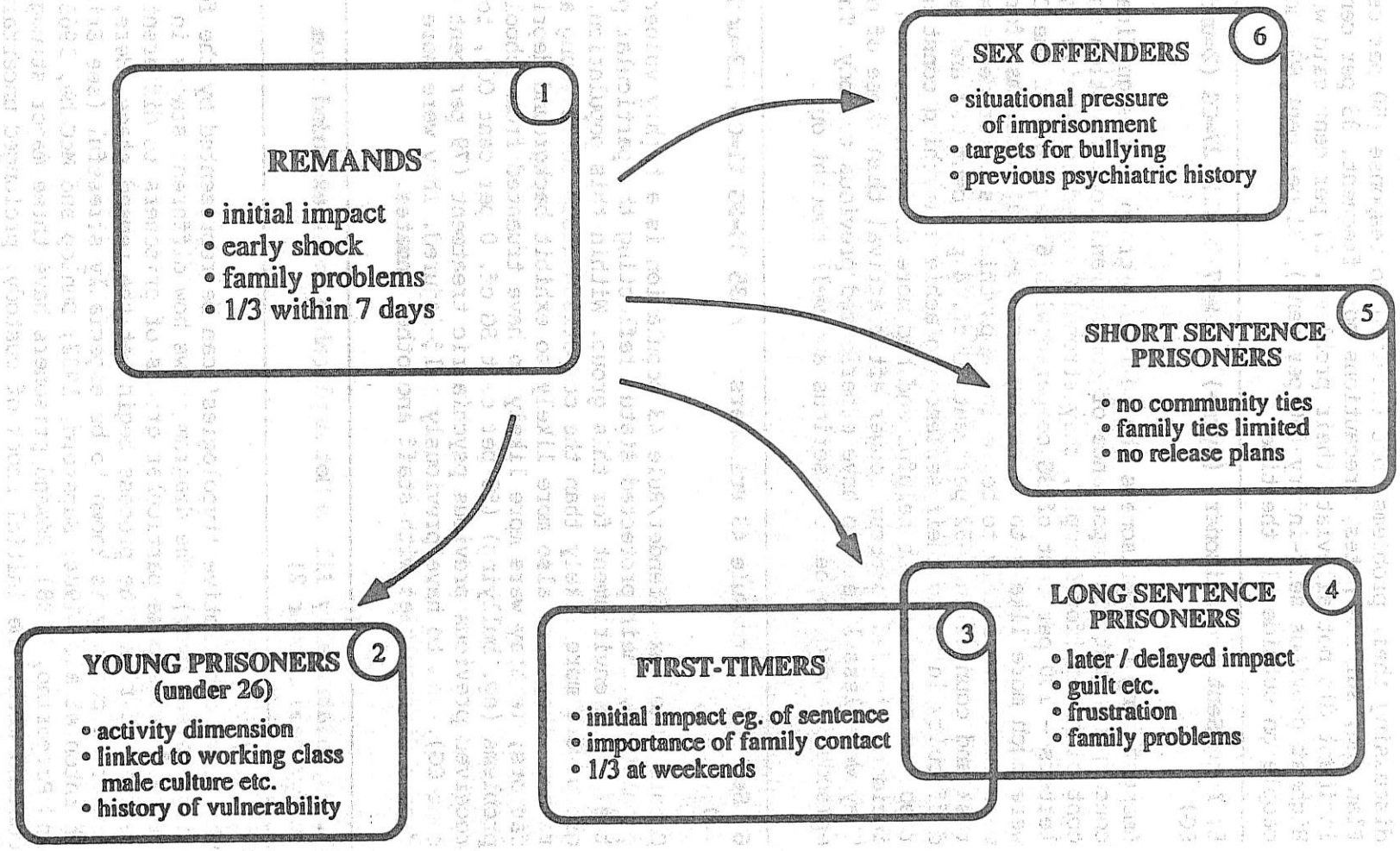
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7. Psychiatrically Ill N=Not Applicable (most excluded from study; see Chapter 2)

The above descriptive 'typologies' can be represented by the following diagram (see over). The diagram shows how different stages in the custodial process may expose particular groups of prisoners to different types and degrees of risk. The process begins at the remand stage. Here, the initial impact of custody is known to be especially stressful (see Ericson, 1975; Thornton et al., 1984; Sapsford, 1983; Dunlop and McCabe, 1965 and Zamble and Porporino, 1988). Remand prisoners have three major struggles to contend with: the initial shock of custody, prolonged uncertainty and frequently bad prison conditions. Studies outside the UK suggest that even where conditions (particularly overcrowding) are better, remand prisoners are still especially vulnerable to suicide (see Scott-Denoon, 1984).

Many prisoners share some vulnerability to depression, anxiety and suicidal feelings at this stage. Remanded prisoners may contain several significant

Figure 2 A differentiated model of prison suicide vulnerability



but distinct 'at risk' groups: a 'no previous custody' group, and the multiple, frequent custody (high vulnerability) group who spend very little time in the community between custody, long-term prisoners anticipating or having just received a sentence etc. suicide. These prisoners are still in distress, and they still have a higher then average risk of suicide; they have problems which require some response. The response they least need is isolation in 'protected conditions'.

Once through the remand stage, several paths diverge: for the young, arguably the 'poorest copers' in this setting, inactivity and a well-documented range of prison pressures may be a sufficient trigger to suicidal thought and action. Maltsberger shows how those at risk of suicide are especially dependent on sustaining external resources such as activity, structure and contact for support. This is also known to be true of the young, and of the lower social classes (see Willis, 1988; Porporino and Zamble, 1988). The sorts of prison pressures they are especially vulnerable to are boredom, inactivity, bullying, lack of contact from outside and poor facilities in prison.

First-time prisoners and long-sentence prisoners may share certain characteristics, which expose them to acute periods of risk at two different stages of the custodial process. They may be especially vulnerable to the immediate impact of imprisonment, (and) or they may show a later, delayed vulnerability, as the impact of their sentence becomes a reality and as family contacts become unreliable. Five of the long-term prisoners were serving life (two subject group and three comparison group prisoners). It is possible (but there were too few to explore) that long-termers are generally more at risk at the beginning of their sentences, but that lifers may be more of a risk later, as it dawns on them that their sentence is truly indeterminate.

Two further groups emerge from the results: prisoners on Rule 43, and short-sentence prisoners. Those on Rule 43 suffer from some of the worst 'situational pressures' that imprisonment has to offer. Their added vulnerability is apparent from the nature and extent of physical and sexual abuse, psychiatric contact and other 'problem variables' in their histories.

Finally, the case of short-sentence prisoners. It is important from the typology presented above that this remaining group display a particular set of characteristics relating to a lack of family and community ties. This group have few release plans, think very little about the future, and are most likely to have received a 'Dear John' letter or notice of an impending separation or divorce (see Haines, 1990 for the importance of these variables). This group were also differentiated on 'activity' variables which may reflect the large proportion of young (under 26) short sentence prisoners in this group. This additional group, not identified in any previous studies, completes the picture of the range and type of suicide risk potentially present in prison population.

Suicide and the Effects of Imprisonment

> The general perception of the prison environment as relatively benevolent is particularly evident among

> individuals whose exposure to the imprisonment experience is superficial and far removed from other life experiences. The reason for this is that the pain of modern imprisonment is more often psychological than physical. The effects of the modern prison are merely more subtle... In order to the subtle and personal nature of the prison experience there would have to be a careful documentation of what happens to offenders who experience various types and lengths of incarceration. (Haley, 1984: 494)

The diagram confirms the quite consistent (but often neglected) evidence of previous prison research of an initial stressful period of disorientation associated with imprisonment (see Backett, 1988, Sapsford, 1983; Ericson, 1975; Cohen and Taylor, 1981 and Dunlop and McCabe, 1965). This effect has been demonstrated by observational and sociological studies and also by empirical and psychological research. Its application to suicides in prison has been slow despite evidence of a marked over-representation of prison suicides early in custody (Topp, 1979; Dooley, 1990a). Historically studies on the effects of imprisonment have tended to concentrate on the prevalence or absence of particular long-term effects, or on the ways in which prisoners manage to cope with the demands imprisonment makes on them, both socially and psychologically (see in particular Bukstel and Kilmann, 1980; Walker, 1983 and 1987; Cohen and Taylor, 1981; Sykes, 1958; Goffman, 1961; Wheeler, 1961; Thomas, 1977, etc.).

Those who survive this initial stressful period - who 'manage to cope' - may still be at risk of suicidal feelings at later stages. At this stage, they can be differentiated into several distinct groups: the young, for whom activity is crucial; short-term prisoners, for whom community ties may be most significant, and long-term prisoners, for whom continuing uncertainty, the breakdown of relationships, and factors relating to the offence may be paramount. Other groups are Rule 43 prisoners - where characteristics and particular situation in prison make them a specific and vulnerable group, and the psychiatrically ill. First-time prisoners may be present amongst the remand population, or they may receive a custodial sentence without having first been remanded. They may 'appear' among several of these other groups, including long-term prisoners.

The 'poor coping' model of prisoners' lives (outlined in detail in Zamble and Porporino, 1988 and in Liebling, 1992) explains the apparent paradox that two separate groups of prisoners may be especially at risk of suicide: those with no previous custodial experience, and those with extensive prison experience. The no previous custody group may suffer the initial shock of custody described in many studies:

> In the initial stages of his sentence (ie. arrival and induction phases) the trainee undergoes a rapid and relatively intense process of adaptation to a new and strange environment. A fair degree of personal stress, insecurity and uncertainty is experienced at this time. This is reflected in his moods; in a certain inability to accept, comprehend or cope with the regime and its demands; confused and wary altitudes towards the staff, and a good deal of remorse coupled with 'motivation to change'. (Fuller and Reynolds, cited in Thornton et al., 1984: 171)

But the 'poor copers' tend to consist of people who are poor at coping in the community as well as in prison (see Zamble and Porporino, 1988). Thus while some prisoners do learn to adapt to the artificial environment of custody, there may be an identifiable group of 'poorest copers' who adapt least well to the conditions of imprisonment. This group may go on to become a high-risk group, due to their long-standing inability to cope well either in the community or in custody. This group may be especially at risk of suicide in custody because of their general social vulnerability. Increasing rates of suicide amongst young males from the lower social classes suggest that this group is increasing in size (see Introduction, and also Kinsey et al., 1991; Kreitman et al., 1991).

Zamble and Proporino also show how many prisoners have a limited understanding of their own behaviour - dealing poorly with problems, living without planning or direction and often leading themselves into greater difficulties (Zamble and Porporino, 1988: passim). At the same time, the prison environment removes many of the usual (if still destructive) outlets which this population tend to rely on in their normal lives. In particular it leaves few alternatives for avoidance - a preferred strategy for many people, but particularly for this group. Their infrequent thoughts of the future, their poor relationships and a inability to plan (in or out of the community) leave them open to casual and impulsive - destructive - behaviour. This behaviour is unlikely to resolve either their anxiety and depression or their offending behaviour.

These findings are confirmed by the present study and illustrate the potential importance of basic social skills training and education for these prisoners, which can be successful in modifying attitudes and developing insights into personal behaviour (see, for example, Shepherd, 1991).

Section III: The Staff

The role of prison staff in suicide prevention cannot be understood without some discussion of the role and nature of being a prison officer. Good suicide prevention means 'good custody' (Rowan, 1991; see also Dunbar, 1985). Their views about which aspects of their work are most valuable suggest that officers invest a great deal in their relationships with prisoners, and feel frustrated that there are so many constraints in this direction. They have a great interest in and knowledge of the sorts of (practical) problems prisoners encounter, and derive satisfaction from being able to contribute to the resolution of these problems. Prison officers are the group least likely to perceive a genuine conflict between their welfare and security responsibilities. Most believe that control and security flow from 'getting that relationship (between staff and prisoners) right' (cf. Control Review Committee, Home Office, 1984b) . They expressed mixed feelings about their role in suicide prevention, on the one hand recognising that they are closest to the ground in which such problems take root, but on the other, feeling ill-equipped in terms of time, training and support, to carry out the task confidently. Feeling unsupported themselves, their own abilities are under-played. Signs of improvement (largely due to increased and improved training, but also due to the development of 'staff care') were acknowledged. The particular operational problems encountered in overcrowded remand wings militated against much of this progress.

Hospital staff are becoming increasingly eager to share the responsibility for suicide prevention with others. This is a positive sign: inter-disciplinary co-operation is vital to an effective approach. Non-medical problems require non-medical solutions. At present, there are major problems of communication and co-operation between (particularly) hospital and discipline staff. There are similar problems between staff and higher management levels. If probation and prison staff can work together, then so can other types of staff. Where there is mutual cooperation, the benefits are obvious. Staff groups (but also individuals) need to understand the constraints, facilities and expertise each has to offer.

Training was still felt to be inadequate in several respects: it was not thorough enough, and needed to be related carefully to the day to day situations staff would encounter. The training described in chapter seven (the role of specialists) by a principal officer was well received: he trained his staff 'on the job', built up a team approach and co-ordinated other staff groups to provide support. Tackling staff sickness (morale) was an essential precursor to these changes. The recent document on 'Managing Sick Absence: Guidance to Line Managers' goes some way towards acknowledging this requirement (Home Office, 1992b).

Staff are well aware of suicide prevention procedures and how they operate locally. There is a tendency for staff to regard these instructions as 'all there is to do', and to feel defensive about their own responsibilities. This problem needs tackling. Staff should be able to feel that if they give a prisoner their support, they will not be at risk themselves. They may want to play a more meaningful role and many of them do. This is despite an element of 'risk' for themselves. That this 'risk' can be taken has only recently been acknowledged (Pilling, 1992).

Staff have problems and concerns of their own. The nature of their job is stressful, but the additional strain of dealing with self-injury and suicide may contribute to the development of a coping strategy which 'blocks out' others' distress. Acknowledging and responding to the pressures staff work under on a day to day basis (not just 'post-incident', most particularly, 'post security incident') should be part of a process of support officers feel convinced by. It may be that staff suffer from more 'organisational' stress than 'post-incident' stress, in terms of sheer numbers. The signs are that real and significant progress is being made. There are still gaps, however, and staff still argue that 'no-one cares about us'. It is often felt that those leaving the service, whether for retirement or on other grounds, should be encouraged to offer their thoughts and reflections to those with the power to move the service forward. Morale could be drastically improved - examples of recent developments at particular establishments provide sufficient guidelines as to how this can be achieved (again, see Pilling, 1992).

Staff need realistic and clearly defined goals, they need support, respect and training. They need 'face-to-face' consultation (cf. 'Communicating Priorities', Home Office, 1992a) - most of which is probably already known, but has only recently been acknowledged. The staff chapter simply provides the evidence, in as clear a form as possible. What it tries to do is draw in indelible ink the links between 'good suicide prevention', 'providing support for prisoners and staff' and 'good custody'.

It is important that prisoners and staff share a common world and that they

often talked about suicide and self-injury in similar terms. Many shared similar opinions about the problems of imprisonment and about the solutions. This finding was true of the Scottish Prison Service survey of staff and prisoners carried out in 1990 (SPS, 1991). There is little conflict between staff and prisoners in their views about ways forward. Staff and prisoners (but few researchers and managers) still talk in terms of rehabilitation, and still seek ways of helping prisoners change.

If staff are not supported, there may be a dangerous (if understandable) tendency for them to make quick intuitive decisions about how serious a suicide attempt is. These decisions are usually made on the basis of recent experience, the age of the prisoner and the method used. They may be wrong; they may not be justified by the evidence and they can result in a counter-productive escalation of distress, or increased efforts by prisoners to secure a response to their perceived plight. The words 'attention-seeking' and 'cry for help' are substitutes for explanation and understanding. So are the words 'manipulative' and 'inadequate'. Any establishment facing high numbers of self-injury should ask itself what it can do to provide alternative strategies for prisoners giving such clear signs of vulnerability. They should be encouraged to ask the prisoners what they are looking for, what they are escaping from, and what sort of help they need. Securing staff co-operation in providing some support for prisoners in distress may secure a commitment to playing a role in that process. Experience at Swansea, and increasingly, elsewhere, suggests that prisoners and staff need to be consulted, heard and respected in the planning of strategies aimed at reducing suicide. Above all, staff should be the first recipients of any information guiding their understanding about suicide risk in prison, its relationship to self-injury, the vulnerability of many prisoners and the sorts of situational factors which may contribute.

The Role of Specialists

The role of various specialist staff (and 'outsiders') has been developed in some areas (Samaritans and Boards of Visitors) but continues to be neglected in others. Raising awareness, and increasing inter-departmental communication is often all that is required. The potential role played by all specialist groups should not be under-estimated. With very little encouragement, the staff concerned will often work out a suitable role for themselves. It is important that this perceived role is shared and discussed with others. There was a relative absence of psychologists in the establishments in which the fieldwork took place. Where they do appear, they can play an essential and multiple role at both individual and management levels.

Any schemes to co-ordinate student and Prison Service interest in the sorts of research projects carried out by psychologists working in prisons and others (for MSC's, degrees, MPhil courses, etc.) should be encouraged. More could be done in facilitating and co-ordinating these sorts of arrangements, and perhaps providing some funding for the work carried out by non-prison students. Several of the short pieces of research required by Prison Service on suicide prevention procedures (monitoring the use of new forms, introducing and evaluating pilot schemes, etc.) and on bullying could be carried out by 'in post' graduate trainee psychologists or other students eager for the opportunity (and extra supervision) provided by establishment need. It is likely that long and detailed research projects

such as this will precipitate or coincide with change, innovation and development, particularly as they are normally commissioned and funded with these long-term aims in mind. One of the potentially powerful spin-off effects of such projects may be to link them to a continuing series of smaller evaluation projects which the psychological services are ideally placed to pursue. This is already happening in some establishments.

* *

Finally, a few comments should be made about the role of the researchers. The team were told on countless occasions by both staff and prisoners that they had been the only people who had shown sufficient interest or had sufficient time, to 'really listen'. That in itself was appreciated by both staff and prisoners, whatever the outcome of the research. Obviously all those involved in the fieldwork will test the validity of 'the research endeavour' by its eventual outcome in the field. That is the right test to use. There is also a hidden investment in research projects whatever the nature of the topic. People talk, reflect, share and co-operate, in a way which is more explicit than might otherwise be the case. That the researchers were so well received by both prisoners and staff throughout this project, suggests that they want, need and are certainly very able, to do just these things.

Footnotes

1. Depressogenic attributional style. An attributional style characterised by low expectations, an assumption of non-contingency between response and outcome (fatalism), non-strategic behaviour, avoidance, rumination on problems and low self-esteem. For example, an individual who attributes his failure in a test to internal and stable causes such as "low IQ" will not expect to improve on the next occasion, and is unlikely, therefore, to persist in his studies for re-sits. One who, on the other hand, makes an external, unstable attribution to "test difficulty", may well expect the next test to be easier and, being more inclined to expect success next time, will persist in his studies. Quite clearly, the former is a dysfunctional attitude to problems which undermines the skills of coping with them. (Jack, 1992:xv) In the case of prisoners, their coping style may be 'dysfunctional', but it may also be a rational and learned response to their life experiences, which tend to be 'unstable', 'externally unreliable' and adverse.

2. Despite this over-representation, commentators have neglected to address the significance of gender in their studies (Jack, 1992:3).

3. The seperate issue of self-injury by women has not been addressed in this research. See however, Liebling, 1992, for a discussion of suicide and self-injury amongst women.

4. The tight time-scale of the research did not allow the analysis to be carried out statistically, by clustering or factor analysis.

5. It may be significant that cell bells take longer to answer in remand prisons, due to the frequency of 'emergency' calls (which do not end up being emergencies). Suicides may be less likely to be prevented in local and remand centres, despite their lower and more immediate average level of intent.

6. The study by Willis on 'working class boys' contains an illuminating account of the sorts of pressure and victimization young boys subject each other to (see especially pp. 29-43: 'having a laugh' and 'boredom and excitement').

7. It is important to note that not all the long-term prisoners in the sample were in the training establishment. Only 28 of the 47 long-term group were there, two of these had actually made their suicide attempt in a previous establishment. Others were in local and remand centres, or special units. One was in police cells.

8. 'Cascading information' through line managers was not a popular or effective means of communication.

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Appendix I
Additional Prison Suicide Data

ADDITIONAL PRISON SUICIDE DATA

CATEGORY

	ADULT MALE	WOMEN	MALE UNDER 21	TOTAL
1988	28 (75%)	Nil	9 (25%)	37
1989	35 (73%)	2 (4%)	11 (23%)	48
1990	39 (78%)	1 (2%)	10 (20%)	50
1991	37 (88%)	Nil	5 (12%)	42

STATUS

	UNSENT-ENCED (INCL.YOs)	ADULT DETERM-INATE	ADULT LIFERS	HOSPITAL ORDER	SENTENC-ED YOs
1988	21 (57%)	12 (32%)	2 (5%)	Nil	2 (5%)
1989	28 (56%)	13 (27%)	3 (6%)	Nil	4 (10%)
1990	27 (54%)	12 (24%)	8 (16%)	1 (2%)	2 (4%)
1991	16 (38%)	15 (36%)	9 (21%)	Nil	2 (5%)

ESTABLISHMENT

	LOCAL PRISON &/OR REMAND CENTRE	TRAINING PRISON	DISPERSAL	YOI
1988	25 (68%)	7 (19%)	2 (5%)	3 (8%)
1989	36 (75%)	7 (15%)	3 (6%)	2 (4%)
1990	39 (78%)	6 (12%)	2 (4%)	3 (6%)
1991	23 (56%)	8 (20%)	6 (12%)	5 (12%)

From: Prison Service (1992) Caring for prisoners at risk of suicide and self injury

Appendix II
Suicide Prevention Procedures and Facilities in Sixteen Prisons

Appendix 2

Suicide Prevention Procedures and Facilities in Sixteen Prisons

Our sample of establishments included five local and remand centres, four closed training prisons, three closed young offender institutions, one open training prison, one open young offenders institution, one dispersal prison and one establishment with both local and remand and training facilities. We must qualify the following profiles with a reminder that the visits were short, and the period during which visits took place was April 1990 - September 1991.

Prison A: YOI Closed

This establishment consisted of two original sites, merged in 1986. It catered for long-term prisoners received from allocation centres in the Midlands and the South, and took some disciplinary transfers. The prison reported a high use of R46, OP and GOAD and a high rate of staff assaults. It housed a difficult and aggressive population, who sometimes formed gangs. Persistent bullying was a major problem. Staff were teaching 'assertiveness training' to inmates and 'dealing with aggressive inmates' to staff. There was some fear amongst new receptions, heightened by rumours about the establishment. There was no full-time medical cover, so the seriously suicidal would be tranferred out (usually to an adult establishment, as no YOI was able to take inmates serving over 5 years). Some special watches were carried out on the wings, in the segregation unit or on the landings. There was a large and very active psychology department involved in research, training, assessment, treatment, and policy and regime development. The establishment had a full-time probation department. It had an Induction Unit, provided sentence planning, and ran a personal officer system.

The population breakdown provided for us by psychology showed high ethnic minority figures - around 40%. A history of escapes (4) had led to increased security and staffing levels. Razor blades were no longer retained in cells (for security reasons). The size of their segregation unit had recently been increased from 7 to 18. There was very little unemployment (only 3 prisoners); 60 prisoners were on full-time education, a very active department - a key agent in the minimising of suicide attempts; there was good PE provision, up to eight hours per week, providing many courses and sports teams. Work provision was limited.

The establishment prided itself on its active and full regime ('the key is to keep the establishment busy, and modular; don't bore them, channel them'); association was provided every evening; there were high rates of temporary release, and many outside visitors, including the Samaritans, Chaplaincy groups, etc. Three recent serious suicide attempts were transferred out. A Hospital officer estimated that he would expect 30 incidents of ('serious') self-injury per year. When a recent spate of self-injury was mentioned by a hospital officer in front of the MO, she was not aware of these incidents. The hospital officer commented: 'Oh no, the doctor won't know; if she knew everything then she'd interfere!'. Two suicides had occurred at the establishment in the previous 15 years. Two officers had committed suicide, one recently, shortly after being suspended

from the service.

The staff felt there was a clear need for a psychiatric unit in the establishment, as they were dealing with a difficult population with many and varied unmet needs. At present, between 10 and 12 inmates per year were transferred out for help, either to hospital or therapeutic units. Even with a long-term population such as this, there was a feeling that the prison was 'containing' its population rather than helping them. The occupation rate was good, but little constructive work was being done. This was a lost opportunity, with a problem age group serving very long sentences. They were simply fulfilling minimal Home Office instructions. Rapid senior management changes at the establishment had left gaps and some confusion relating to SPMG, training, review of suicide prevention procedures, etc.

The hospital was a little 'bereft', particularly following the most recent change of governor; staff complained that there was no management interest in it's role or function at present? All the hospital really did was 'special sick', looking after specialists who came in, treatments and the upkeep of the hospital. There were 18 1997 referrals during the period of our research. An injury occurred during our second visit. The inmate concerned was a 'disciplinary problem' and received a mixed response from the staff. A check of the records suggested that only 1 incident had been missed. No records were available on this incident.

Prison B: Local and remand

A large, busy establishment; it had a large hospital with a psychiatric wing. Very little work or activity was available to prisoners. It was very much a 'short-stay' prison, prisoners were all on their way somewhere else. The establishment bemoaned the huge problem of a lack of recorded information, many records did not arrive with the prisoner. They estimated over a hundred incidents of self-injury each year. Many inmates repeatedly injured themselves. Some 1997 referrals were non-medical problems. The prison had received several 'lack of care' verdicts recently, most relating to death by natural causes. Staff (and doctors) were therefore feeling a little defensive. They were being blamed for problems which they could do little about. This was adding to staff frustration and anxiety. The POA had advised hospital officers not to complete 1996's.

Relationships between staff and prisoners were good, and our research was welcomed. The recording of information on self-injury was very poor.

About 15 of the 42 patients on the hospital were thought to be suicidal or depressed. 'Many of these problems should be tackled on the wings, but there is no time.' In the hospital, staff are busy getting inmates out to exercise, doing association, having visits, treatments, etc. so no real problem-solving time was available. Staff did refer to outside agencies, make phone-calls and the prison had developed links with outside organisations and hospitals. There was some reluctance to involve the Samaritans beyond attendance at the SPMG meetings, but this was being overcome and recently, Samaritan visitors had made referrals to the hospital.

The ward was not manned on a 24 hour basis, so few of the suicide risks could ever be placed in there. A placement scheme involving nurses from

local hospitals (and the RSU) spending part of their training course at the prison hospital was felt to be very successful, and served to break down barriers, enhance training and broaden experience in both directions, but there remained a problem within the community and amongst the public/in the media concerning attitudes and the rather unrealistic expectations of the sort of care the prison could provide. These problems were acute at inquests.

Prison C: Closed Training (Cat B)

A Cat B closed training prison with some Cat C prisoners. All adult male long-term prisoners, taken from locals or allocation units newly sentenced, or downgraded from higher security establishments. Some disciplinary transfers. Prisoners presenting a clear suicide risk would not be sent here. Suicide Prevention was low profile and took a long time to make any impact on the establishment in terms of procedures. Reception and Induction procedures had recently been improved in the light of criticisms made during an inspection. It tended to be assumed that inmates were already settled by the time they arrived here. A booklet had been produced, outlining facilities at the establishment and indicating the various sources of help to prisoners. A difficult prison for visitors to access; isolation in protected conditions resorted to for lack of any alternative. If an inmate was not fit for ordinary location, he would probably be transferred elsewhere. Level of staff involvement on the wings was high. Work, training and education facilities were good. Very little unemployment. There was a full probation department, and the officers seemed very well informed about the prisoners on their wings, and any problems they were having. We saw a probation officer drop into the wing offfice to chat to the senior officer about his client. Officers regularly contacted family, solicitors, probation, etc. on behalf of prisoners and passed information on to each other about potential 'risk'. 125 uniformed staff and about 400 prisoners; about 60 on each wing. They were slightly under their CNA in terms of occupancy. The prison had phases - sometimes a spate of 'at risk' prisoners, sometimes a spate of disruptive prisoners.

Several dormitories were available in the establishment, so 'at risk' prisoners could be placed in shared accommodation. Their most recent suicide risk ('a rare, genuine case') was a young prisoner now segregated on R43 GOAD, suffering from problems with his peer group. He was being treated medically, and the hospital were trying to find a new location for him. After a few days, if there are no visible signs of improvement, he would be transferred out. Often when they are transferred to a prison with full-time medical facilities, they return within two days, 'cured'. This phase of our research would omit the very real 'below the surface' activity, whereby threats, risks and depression came and went, with a considerable response from the staff, but no injury at the end of the day. 1997's were used, and usually elicited a good response from staff. We are monitoring the failure rather than the positive aspects of suicide prevention as it occurs? Staff did seem genuinely interested in prisoners here, had the time to respond to their problems and requests and were actively involved in 'suicide prevention' at its most fundamental - non-acute - level; ('if you get staffing and relationships right you won't need to worry about getting suicide prevention right').

High levels of staff stress, and poor facilities for them were being addressed, but were thought by the MO to contribute to inmate problems, in

all establishments. It was difficult to get staff to acknowledge their own stress. Very little suicide prevention training had taken place, due to shortages. Some of the prison service priorities were not 'people-oriented' at present. Too much energy was being expended on management and budgets, and the service was losing sight of its prisoners.

The hospital only had three cleaners in it, and was an out-patient centre, really. Later in the year it was actually closed as an in-patient resource. From our cross-checking with hospital records it seems we received incident forms for all cases, with the exception of one transfer out, and in that case we were sent a form from the receiving establishment. There were some problems of lack of continuity from the local general practice, different doctors coming in each day. It was also difficult to get a doctor to attend any suicide prevention management meetings. A part-time psychologist and psychiatrist visit once or twice a week. 'The quality of your structures are not an indication of the quality of care inmates receive.'

Prison D: Local and Remand

This small local prison was built in 1828. It had served a number of purposes. It reopened in 1980 as a YP Prison and became a local and remand prison in 1988, having been given six weeks to effect the transformation. At the time of first visit it held 420 inmates: 396 adults and 112 YPs, the majority of whom were housed two to a cell in 230 single cells.

It provided accommodation for remanded and convicted adult and young prisoners and had a large R43 population. At the time of our second visit the section of the main prison holding R43's was full, and as a result hospital accommodation was being used to house 10 non-medical R43's. This had resulted in a reduction in the hospital regime and an increase in the use of unfurnished accommodation for those thought to be at risk of suicide. YP's and adults were mixed together on wings which was felt to reduce tension. A personal officer scheme had just been started on an experimental basis for the prison's young lifer population.

Apart from the normal domestic tasks, there was little work available for inmates. There appeared to be a thriving Education Department, and one or two evening groups were running, e.g. AA.

The POA was in dispute with the prison management over manning levels and we received frequent complaints about staff shortages. The hospital was having to use agency staff to provide adequate cover. Four members of staff were known to be off sick with depressive illnesses and the issue of staff suicides was raised frequently on our tour round the prison. The hospital accommodation was very small and cramped and in poor condition. Patients were often kept in overcrowded conditions. There was one small protected room, again in poor condition, which were told was in more or less constant use.

The prison had had no suicides for over ten years. We were told by our liaison officer that self-injuries occurred in 'batches', maybe three or four over one weekend then nothing for a while. They estimated between 10 and 20 a month.

Because of the small size of the prison and it's local nature many staff we talked to felt that good, informal relationships existed between the

uniformed, hospital and specialist staff and between staff and prisoners. A lot of suicide prevention work appeared to go on on an informal basis, although we received a number of complaints about the demise of the 'F' marking system. Officers would make phone calls for inmates and there was a flow of information within the prison and with outside agencies.

The suicide prevention trainer estimated that approximately 50% of the staff had received suicide prevention training, but explained that it was difficult to arrange training sessions as staff were often withdrawn from courses at the last moment. Alternatively, the trainer would be asked to run a course for one or two people only. This was an insufficient number of people to form a group discussion, an important element of the training.

It is most unlikely that we have received all possible incident forms from this establishment despite the very best efforts of our liaison officer.

Prison E: Closed YOI

This large establishment consisted of two originally separate sites, and catered for a difficult and varied population of young remand and convicted prisoners. It provided a regional resource to the SE region for young offenders with previous sexual or arson offences, violence, frequent use of drugs or alcohol, or with a history of psychiatric problems. As such, it was perhaps surprising that the establishment had not experienced a single suicide until 1991/2, when four deaths by suicide within six months made it a media target. The number of suicide attempts was consistently high, so that we made several return trips to this establishment to catch up with information the hospital could not collect on our behalf. We also carried out several interviews. There was a high concentration of ethnic minority prisoners.

Bullying was a very serious problem in the establishment, on all units, and was frequently discussed in SPMG meetings. In two months, 23 inmates were admitted to the hospital as a result of self-injury, 28 were admitted as a result of threats, 12 were admitted from reception due to previous history of suicidal tendencies and eight were admitted on transfer from other establishments. This level of admission was placing tremendous pressure on a hospital that also had several other functions. The large hospital was a 50 bed facility, receiving inmates from two regions (and a third, temporarily, as one equivalent establishment's hospital in another area was having its hospital refurbished).

The establishment had been rebuilt on an American design, rather like a University campus, with 12 small units and long corridors sprawling over a vast area. Nine of the units held remand prisoners. There was a small officer-led therapeutic community, supported by two psychologists. The remand units took 64 inmates each, on two wings. There was a large probation department, and a very active Board of Visitors, who were particularly concerned about the number of suicide attempts. The establishment's design required a very staff-intensive arrangement, unfulfilled by present staffing levels, so that this intention did not seem to be reflected in either levels of activity or invlolvement, both of which were mixed/limited. No Induction procedure existed at the time of our first visit, in June 1990, and the reception process was cursory. About 60 new receptions per week were admitted to the remand units. The regime in both centres was severely criticised in a Chief Inspectors' Report (dated 1989).

There was a heavy reliance on television and video to occupy inmates. Staff and inmate morale was low.

There was some conflict at the prison - between two previously distinct branches of the POA, between hospital and discipline staff, about role-boundaries, and between officers on the therapeutic community and the rest of the discipline staff. The establishment, though 'beautifully landscaped' had a 'sad history' and was poorly integrated, particularly in terms of its Industrial Relations, through which 'warfare' the inmates had suffered unacceptably poor regimes.

Prison F: Local and Remand

An apparently small and cramped, very crowded and busy local and remand prison, containing an allocation unit, a large hospital (with particularly poor facilities, and rather dirty protected rooms) and a small female Category A unit. Most of the male prisoners were sharing cells with one or two other prisoners on one of five largely Victorian wings with narrow corridors. One landing housed sentenced young prisoners; they were quickly allocated elsewhere. Less than half of the prisoners were able to be employed. Recording of self-injury was poor and haphazard. There had been nine suicides between 1985 and 1990. An apparent young prisoner suicide in early 1990 became a murder trial when incitement was found to have occurred. Relationships between staff groups were a little frayed. A considerable resistance to Fresh Start was still being expressed. Some bullying was reported. Very little suicide prevention training had been possible. The physical environment was poor, facilities limited, there was no integral sanitation and remand prisoners suffered the worst of these conditions.

The staff were often long-serving and were described in an Inspectorate Report as 'traditional'. There was a large probation department, and some shared working; education facilities were good, but were geared towards convicted prisoners.

Prison G: Dispersal and Closed Training)

A large new prison with additional wings opening during the period of the research. It catered for long-term male prisoners and Category 'A's. One new wing had a large VPU and the prison housed a Special Security Unit and a small hospital. The prison from its opening suffered from persistent disturbances. There had been a long and controversial inquest following the prisons first suicide in January of 1991 (see Prison Service Journal, Summer 1991: Comment). The SPMG met after every serious incident. A post-incident stress group for staff had been established with the intention of dealing with the 'ordinary stresses of prison life' (particularly in a dispersal, where control was delicately maintained). There was some defensiveness about using the Samaritans in the prison lest staff deferred from acting upon potential suicide risks. We had a great deal of contact with staff in the hospital during the time of the inquest, and after a subsequent suicide, and they expressed concern and exasperation about their ordeal.

Prison H: Local and Remand

An apparently small but overcrowded local and remand centre catering for a

mixed population of about a third remands, some convicted, young and adult and a lifer wing . Most were in shared cells, some in threes. The establishment had been slightly disrupted by the arrival of groups of VPU or Rule 43 prisoners from two local establishments suffering from disturbances.

An exceptionally good liaison with the Samaritans was in place locally, with large groups participating in meetings, 'leaver's fairs', family visits and suicide prevention management meetings. We were invited by a probation officer to meet this group at one of their quarterly meetings during our visit. The arrangement had originally been facilitated by the Chaplain, who had used group discussions to communicate the potential role of the Samaritans to vulnerable prisoners. The Samaritans themselves were being very pro-active, stressing their availability and presenting a positive image of the work they could do.

There were poor relationships between staff on the hospital and the discipline staff.

Prison I: Closed Training (Cat C and D)

A large training establishment on two separate sites, with four living areas, each with a slightly different range of facilities and a different regime. Some Cat D's in the open quarter. Two new living blocks also under construction. High ethnic minority population and some deportees. A difficult prison to access so visits had been increased to 2 per month some time ago, and the length extended to one and a half hours. Most of the living accommodation was in two and four-man rooms.

The establishment ran an Induction programme (1 week) and there was talk of a personal officer scheme. Suicide Prevention training had recently been carried out, and these sessions were often followed by a spate of 1997 referrals, not all appropriate. Training was felt to improve communication between the hospital and the discipline staff. Despite the full staffing levels it was difficult to organise training courses for those who needed it most. Serious suicide risks would normally be transferred out. 'Borderline cases unsettle the staff - if he needs a 15 minute watch, it is assumed he requires transferring.' Some prisoners just need support.

One senior psychologist and 3 psychologists; fully staffed probation department. Psychiatrist visits monthly and when required. Prisoners could refer themselves to the psychology department, and the open-ness of the regime was felt to allow most of those with problems to find help or an outlet. The Samaritans had recently been involved in visiting prisoners and in training. Phones were only available in the open site at this time, but were planned for the rest of the prison shortly.

High unemployment (50%) on one of the sites. Elsewhere there were training courses and domestic and other work: a tailor's shop, light assembley workshop. Boredom and confinment were stll problems at the prison, particularly since the loss of hours introduced as a result of Fresh Start.

Cross-checking with hospital records assured us that we had received incident forms for almost all incidents, but data on three had to be retrieved ourselves. The staff had actually used our forms as the basis of a long interview with inmates who injured themselves, in order to obtain

the necessary information, and they found this procedure useful and interesting. They reported having learned quite a lot from this exercise already, and found it a useful guide to follow-up procedures. 'What's happened is that we've managed to find out what the problems were and we've actually managed to do something about solving them. This of course has told us something else. A lot of our incidents are really a result of neglect on the wings.' Their system of recording suicide risks was impressive. All 1997 referrals were recorded (16 during the last year). Many of these referrals were related to changes of location or unresolved problems ('manipulative'). All were from one site. They tended to occur in spates (they become seen as a legitimate way to manoeuvre a response). Problems between inmates or inmate groups led to pressure, which led to injuries.

During the same period there had been 19 suicide attempts and 17 serious injuries. There was a bullying problem, and debt problems, some violence. Most of the incidents were related to this.

We carried out an interview with the Principal Officer during our visit because of his particular interest in suicide prevention, training and monitoring. The staff produced excellent documents on 'Improvement Objectives' after SPMG meetings. The HPO had produced 'user-friendly' summaries of all the main reports and circulars on suicide prevention for the staff.

We attended the inquest of a recent suicide (a lifer) which had occurred shortly before our fieldwork start date, by invitation. It was held in the prison administration block. He had not been identified as being at risk and staff (and fellow prisoners) had been shocked by the death. This suicide was followed by a similar attempt; the prisoner was transferred to an establishment with full time medical cover.1 The officers felt that the reduction in censoring made it more difficult to be aware of inmates' outside problems.

Prison J: Open and Closed YOI

An isolated prison consisting of three units, a closed, a short term open (up to four weeks) and a long-term open. It was being refurbished and was well under-capacity in terms of its population. Employment was full and included farming and agricultural work, car mechanics and industrial cleaning courses, vegetable production and processing, etc. The establishment had phones. Receptions were received daily, and an Induction course was run for all newcomers.

The staff were currently being trained in suicide prevention, where this could be arranged. A GP practice of three acted as MO's to the prison, seeing all new receptions the day after arrival and doing sick parades twice daily. A personal officer scheme was being revived and officers felt they had time to talk to prisoners. Most of the 'suicide prevention' was carried out on the wings. Absconding was fairly common (about 90 per year). Serious or long-term suicide risks would be transferred out. Unfurnished accommodation was rarely used, as the establishment did not have full-time medical cover. The hospital was really only a sick-bay; most of the time they had no patients at all. A SPMG was under formation at the time of our first visit.

There were two probation liaison officers. The Samaritans could be called in onto the wings where this was requested. One hanging attempt occurred between our two visits. Checking with hospital records indicated that all incidents had been received.

Prison K: Local and Remand

A small, busy and crowded local prison, half of whose prisoners were on remand. The other half were short sentenced or long sentenced and lifers awaiting transfer or re-allocation to another prison. Some prisoners were received on disciplinary transfers from long-term prisons. The length of stay could vary from three days to three years. Most of the prisoners were located on one of three landings on a single large wing. There was a small Special Security Unit and a unit holding about 28 Rule 43 prisoners. There was no car park at the prison. We wondered how visitors travelling by car managed to park.

The full-time MO, who had a particular interest in and concern about suicide, was collecting information on the use of 1997's, and following up the cases to investigate the outcome. He was interested to discover whether or not the right people were being picked up as those needing extra attention. Two prisoners had recently swallowed razor blades. He thought that about seven suicide attempts had occurred during the last year. Of these, about four were 'genuinely suicidal'. The others might be looking for some kind of intervention, for example due to a domestic crisis. All suicidal cases would be kept on the hospital for at least a week, with regular reviews carried out either by the visiting psychiatrist or by the Medical Officer himself who, importantly, he felt, was psychiatrically trained. Suicide risk may persist even after discharge from the hospital back on to the wing, so cases would be followed up, ideally for up to six months.

The hospital had five single cells, two wards and an overflow landing on one of the wings. It was always full. A new hospital complex and reception areas was shortly to be built. One young lad considered to be at risk had been transferred to an RSU, where facilities for his care were felt to be more appropriate. Many of their at risk cases and razor blade swallowers (two recent cases) were under 25. Some had just been transferred from YOI's.

The SPMG met regularly and was felt to be a helpful means of sharing information. The use of protective cells for short periods of time was fairly high, for the psychotic, impulsive or disturbed prisoner. Location in these cells would normally be acompanied by counselling and support. The Samaritans were recently involved in the establishment and would visit following referral. Reasons given were lack of space and staffing reources to supervise visits.

Receptions had recently begun to take place from 2pm, allowing longer for the process to be completed. Some resistance to being 'responsible for the 1996' was expressed by reception staff.

A serious self-injury occurred the evening before our arrival, involving a transfer between dispersals. He had been waiting for his transfer for six weeks and had just discovered he was not being allocated to his expected establishment. He had slashed his stomach, requiring 18 stitches.

During our first visit we spent a considerable amount of time talking to senior mangement at a meeting. They complained of lack of support, information and consultation from above, suggesting to us that form-filling systems too easily became a substitute for 'the real care that is necessary':

> The only way you'll ever prevent suicides is, first of all you've got to mind that suicides occur at all; secondly you've got to recruit people who mind that suicides happen, and thirdly, training. You've got to pay for the training and put in the time and resources necessary. Then you've got to reward staff for caring, more than you reward them for not caring. If someone doesn't care, they can fill in forms until they are blue in the face and they'll not prevent any suicides.

Just before our return visit, four prisoners attempted suicide in one shared dormitory in the hospital. This incident was traumatic for the staff involved. Relationships and communication between hospital and discipline staff were generally good, assisted by the small size of the prison, When problems arose, 'divisions were forgotten and staff worked together'.

A submission to Tumim's Inquiry was shown to us. All the suggestions were regime oriented, and included a review of training, and of the applications procedure, the use and duration of use of special and protected cells, staff-inmate contact time, the treatment of Rule 43's, the number and nature of adjudications, and the special risks posed by the young (under 25's).

Prison L (Closed Training Prison Cat C)

A large Cat C training establishment with a Cat D unit. Originally a military establishment, most accommodation was in dormitories. It had been opened five years ago as a response to prison overcrowding. It had had a major disturbance and had a number of disciplinary problems, which staff felt was a result of unsuitable prisoners being downgraded from Cat B (where prisons were full) to Cat C where there was unused capacity. It had also had a suicide 22 months ago, when an inmate hanged himself, three days before release. A member of staff had also committed suicide recently.

The hospital was based in a separate block, it had a CNA of 18 and 11 patients at the time of the first visit. Staff comprised 1 SMO, 1 MO, 1 HPO, 1 HSO and 8 HOs and provided 24 hour cover.

The prison had a probation liaison officer scheme, an induction program which consisted of 4 day courses for new receptions, and staff also ran a pre-release course. One member of the hospital staff was a trained psychotherapist and was able to offer a counselling service to patients and the MO and the Psychologist were developing group work and counselling with the Life sentence prisoners. The MO was also running a joint research project with a local GP service comparing the use of medical services by a group of 500 patients in each community aged between 21 and 39.

The prison was unlocked through the day to 9 pm, with the exception of lunch and tea periods. In addition to 7 x 14 bed dormitories, each living

block also contained TV rooms (including Sky TV), pool and darts and we were told that officers and prisoners were encouraged to play these games together. As we have seen in other prisons, dormitory accommodation led to many problems for inmates, notably a total lack of privacy and a considerable amount of bullying which led to threats of self-harm and several incidents. We were told that there had been one serious suicide attempt, one attempt at wrist cutting and three 'minor' attempts in the last year. 1996s and 1997s were both used, though the hospital felt that in the latter case use was not always appropriate in some of the four or five they received weekly.

The prison also had 2 psychologists, and a Senior Probation officer and 10 probation officers, who supported and provided training for the probation liaison officers and worked with them on more complex cases. The probation department itself was heavily involved in throughcare work and in the provision of information about available services to prisoners.

The Psychology department had close working relationships with the hospital and were also responsible for organising staff training. Suicide prevention training had not been high on the list of the prison's priorities recently. In the aftermath of the Strangeways riot, much time had been given over to C & R training, but it was felt that despite this, suicide prevention training was up to target. Nearly 50 per cent of the uniformed grades had attended the half-day course.

Phones were available on the Cat D wing, but had yet to be installed in the rest of the prison. Hospital staff allowed prisoners to make phone calls.

Most prisoners threatening or attempting suicide were transferred to the nearest local and remand establishment as the hospital had few facilities for dealing with them. It was apparent that this establishment was not always to accept referrals. It had no protected room and prisoners had to be located in the segregation block for this purpose, which MOs and staff felt was unacceptable.

There was a SPMG meeting quarterly. It's membership comprised the SMO, the deputy governor, the Head of Inmate Services, Head of Residential, a Psychologist, the Chaplain and the Hospital Principal Officer although not all attended on a regular basis and the Probation Department had not been invited to attend. In addition, by the time of our second visit case conferences were being held on inmates who had injured themselves or attempted suicide and the establishment was using these as a basis for on-going evaluation of their procedures.

Some contact with the Samaritans was available through the Chaplain though the extent of this contact was unclear. On our second visit we were told that a phone line to the Samaritans was to be installed and that they currently visited the prison when required.

The unemployment rate was very low, with most inmates being either employed or on education, though staff felt that most work offered to inmates was boring.

During the course of the research there were several staff changes (including a change of SMO) and it became clear on our second visit that we had not received information on all the incidents that had occurred. We

made considerable efforts to check through all available data via the case conference notes, 213 records, and hospital occurence book, and now have a record of the majority of attempts. Food refusers and self-injuries not requiring treatment have probably been missed.

This establishment certainly provided better facilities for its inmates than many of the local establishments they were allocated from but it felt dispirited and there was conflict between some of the staff and specialist groups. There was no feeling of a team working in one direction, but there were certainly a number of people concerned to care for inmates and their needs.

Prison M (Cat B training prison)

A Cat B training prison with a lot of Cat C prisoners awaiting realloction. It had a VPU for R43 prisoners and a Lifer wing. ADP 545, CNA 550. The establishment had single cell accommodation; integral sanitation work was in progress. It provided a hospital facility for other prisons. The SMO was responsible for 8 other prison hospitals in his area, a high load. His staff at the prison comprised 1 Ft and 1 Pt MO, 1 HPO, 1 HSO and 5 HOs together with a number of visiting specialists. Agency nurses regularly provided night cover. A psychiatrist held sessions three times a week. The hospital was a rather large, rambling building which was due to be redeveloped. Patients were located either in the 10 bedded ward or in one of the single rooms. The ward was used if the doctor felt an inmate was at risk of harming himself. All 1996 and 1997 referrals were seen quickly. They were used regularly. The SMO felt many 1997s were used inappropriately but that they were all taken seriously. He completed 220s for all self-injuries regardless of intent since he felt that an inmate who had injured himself however trivially had to be taken seriously. There were some reports of bullying and self-injuries to avoid transfer to other less popular prisons. There had been one suicide within the last two years. 31% of the prisoners were from ethnic minority groups.

The prison had a Probation department, with 1 probation officer on each wing and a Psychology department. It received 5/6 new receptions weekly. There was a lifer support group and a young prisoner group. There was also a wing-based induction programme.

The SMO had used the SPMG to institute practical steps to prevent suicides. A suicide awareness card was issued to all staff, special scissors were kept on the wings for cutting inmates down and Brookes Airways were available on all wings. The SPMG also reviewed all cases of self-harm regularly. Self-harm and attempted suicide were not considered major problems because of the quality of the regime and of staff/inmate relationships. Employment and education were available for all inmates, a Personal Case Officer scheme was working well, the psychology department and the psychiatrist were available for counselling, psychotherapy and support.

Many prisoners were thought to appreciate being in this prison because it was easy for visitors to access and frequent visits were allowed.

On the occasion of our first visit, involvement of the Samaritans in the prison was being actively resisted. By the time we paid a revisit, discussions had started with the local branch and it was anticipated that

they would be invited in to hold sessions on a regular basis.

The prison hospital had on three occasions during our research year employed an agency nurse to 'special' an actively suicidal patient, funding this out of their agency nurse budget. They had also ordered steel gates to be fitted to two cells so that 'special' nursing (continuous support and care) could be more easily facilitated.

This prison had a large, very busy hospital, with record keeping that was a considerable improvement on many others we had seen. A check through the 1997 index suggested that we have not received forms for 3 incidents in the 12 month period. Our liaison officer had done his best to complete forms for all cases he could, but in his absence, these three appear to have been missed.

Concern was expressed by staff about staff suicides and the lack of counselling/support for staff.

Suicide prevention training was run by members of the Probation service and a hospital officer. Two sessions were run last year and one during 1991. The feeling was that the vast majority of staff were now trained. We checked through the Protected Room sheets; it had been used 12 times during the research period, for short periods only. Hospital staff were reluctant to use it, preferring to place inmates in either the 10 bedded ward or one of the 5 single rooms.

Staff felt that the prison had few problems in regard to attempted suicide and self-injury as it had a settled and active regime and the fact that it held a more mature long-stay population meant that inmates and staff got on well and staff were aware of the need to get to know their inmates. The prison also ran a personal officer scheme and a social skills course.

Prison N: Local and Remand; Closed Training

A combined prison with three distinct sites, one housing category C and D prisoners serving short, medium and long sentences and offering a training regime, the main prison housing remand and short sentenced prisoners, and a young offender remand centre. The main prison was severely overcrowded. There was a high proportion of Rule 43 prisoners (between 50 and 70). The full-time hospital acted as a resource to other prisons in the area, so this establishment often received prisoners requiring full-time medical cover on transfer from other prisons in our research.

The hospital had 44 beds at maximum capacity. Its population fluctuated from 25 to 32. There were no manned wards, and therefore seclusion was sometimes resorted to in the case of suicide risk. There were serious staff shortages on the hospital, resulting in a reduction in staff training. Often, inmates were placed in a dormitory with other inmates and a TV. The last suicide was in 1991. During 1989 there had been eight attempts, five of which had resulted in a F220, referral to a psychiatrist and hospital treatment. A suicide occurred during the period of our fieldwork. Staff were keen to discuss this case with us and the full written details were subsequently sent to us. The prisoner was 34, serving the last three months of an 18 month sentence. The only thing the staff could think of which may have contributed to his suicide was that he had just been sacked from the kitchen. His father had died a year ago. He had made several 'superficial

scratches' on his wrist just prior to the hanging. He had not gone to the hospital for treatment for these. The suicide occurred in the training prison annex where there were open dormitories and where these problems are difficult to pick out. There had been alcohol in his blood. Staff talked about the tendency to resort to black humour as a way of coping with feelings of guilt and self-recrimination.

A recent change of medical officer was felt to have radically changed the response to suicide risk and had reduced the use of seclusion. Training had also contributed to these changes, allowing the staff more of a role and increasing their confidence and interest in potentially at risk prisoners.

We carried out a long and detailed interview with the hospital principal officer during our second visit, at his request. This officer was our liaison officer; he was a suicide prevention trainer and had completed an impressive programme of training both locally and at satellite establishments and this was felt to have increased awareness and interest. He was transferred to one of our qualitative research prisons during the fieldwork period and took up these roles again on arrival. As a result of these local training sessions and subsequent discussions, a local team was set up to address staff welfare issues and support.

The average age of the suicide attempters in the adult section of the establishment was 26. Peer group pressure, such as verbal and physical bullying was thought to contribute to the number of incidents. The frequency of self-injury was largely attributable to the high number of receptions, and the mixed population. Problems with visits was a contributor.

In the receptions area of the young offender remand unit we were told that 1996's had proved unworkable. 'We prefer the contact to the paperwork'. A recent change to the reception procedure included giving newcomers a cup of tea. This changed the atmosphere completely, helping them to relax. The 1997 was felt to be useful. ('It's a bit like research, we like it when there's an answer at the end of it and we get something back'). The hospital felt this form was 'over-used', for prisoners with disciplinary problems.

The Samaritans were involved in the establishment's SPMG and participated in training for staff. Telephones were shortly to be installed. A 'listeners scheme' was being introduced on a joint staff/inmate basis. A recent officer suicide had concentrated concern on the problem of suicide risk and had precipitated some important discussions in training sessions.

Relationships between staff and prisoners and between different departments within the establishment were good, particularly over suicide prevention procedures. The only problem related to the use of the hospital for 'disciplinary' problems which were difficult to resolve in the cramped main prison, where wing and cell changes were virtually impossible.

We were warned during our first visit that we were likely only to receive 60% of the forms on incidents occurring ('You have to appreciate that what happens is you get half way down a form, then you get called away. You get back, someone has put some more paper on your desk and you've forgotten all about it'.)

Prison O: Closed YOI

A large closed YOI and centre, where prisoners were 'swapped' on their way to other establishments. Here they would be fed, their movements recorded and property exchanged in the meantime. A new wing was shortly to be opened. At the time of our visit three wings out of seven had integral sanitation. There was a separate juvenile wing holding 75 under 18 year olds accommodated two to a cell.

Ninety six of the staff had been trained in suicide prevention at the time of our first visit. Several regional trainers had ended up with postings here, so facilities were excellent. Pride in this area of work was obvious. There was a recently revamped personal officer scheme and an induction and pre-release scheme. The regime was active; prisoners dined in association. Phones were being installed. A PO was looking into the problem of bullying which, as elsewhere, was rife. Education facilities were excellent. Staff were eager to show us their facilities and developments, and continually complained that we would not be present for long enough to see their good work. Rule 46 was used as infrequently as possible ('after all, being in here is all about training'..). The pride and enthusiasm we saw here was refreshing.

This establishment sent us comprehensive information well beyond the completion of our incident forms, also enclosing copies of the completed 1997's and other reports on each incident. They also included information about threats (which we excluded from our main analysis, but looked at separately). Most of the form-filling was done by a hospital senior officer, who took a particular interest in our research. Specially prepared reports and copies of the minutes of SPMG meetings were forwarded to us. The SPMG met quarterly and had additional special meetings where required. There was a high level of awareness of suicide and its prevention, although phases occurred where meetings were postponed and the level of 1997 referrals tailed off. The BOV were very active and involved in the establishment, and the Samaritans were making arrangements to be involved. All the procedures were followed, and each wing had a 'suicide prevention pack' including training materials and a box with scissors and a knife ('We do things properly. I don't want to end up in a coroner's court').

Acute suicide risks were transferred to a nearby YOI with a larger hospital. Self-injury may result in 'refuge' in the segregation unit, which confused staff and prisoners and confused the medical and disciplinary aspects of the problem. There was some evidence that prisoners were put on report for 'wasting staff time'. 'The mechanics sometimes mitigate against dealing with the actual problem'. Juveniles were taken directly from court, and this was felt to have increased their problems:

> Juveniles are quite a problem to us. We've got a young lad here who was depressed and crying for his mum. He's doing 42 days. He'll probably serve about 21. He is only 14 years old.

This YOI had a high disciplinary record and acknowledged its strict reputation. A stress course for prisoners was being run and an assertiveness training course was under consideration.

There was a fully staffed probation department (unusually), and working

relationships between prison officers and probation officers were good. Training had been arranged by the local probation department, which was appreciated by the prison staff. Staff had one hour per week 'personal development time'. Staff described themselves as largely very happy. There were some mixed feelings expressed to us about a management change, which had 'lowered the standard of discipline' and therefore made the job 'even more demanding', the loss of a suicide prevention trainer to another establishment and some staff shortages. Relationships between the hospital and discipline staff were also good.

Most of their self-injury occurred in 'spates' and was related to taxing and bullying. Staff were trying to tackle this, providing wing changes in exchange for names of perpetrators. 1997 referrals were frequent (mainly for 'depression' and coping problems), but they had only completed one F220 'attempted suicide' form in a year. A recent suicide attempt had been their most serious to date, a hanging attempt resulting in loss of consciousness in the segragation unit. The officer who found this inmate had received regular support and counselling. Other officers had been reprimanded for teasing this young officer about his reaction to the attempt. The inmate had attempted suicide the week before, on induction, and was on a 15 minute watch. The officer was visiting his cell two minutes' earlier and returned when he heard a noise. He only checked the inmate because 'he knew he was at risk, and I'd been asked to keep an eye on him. Ordinarily, I might not have got up'. The brush with death was so close, the officer suffered days later from guilt, fear and depression and required professional counselling.

Perhaps surprisingly, for an establishment of this size, there was no full-time hospital, and no continuity of Medical Officer ('Our hospital is really used for sporting injuries. We're really just a glorified first-aid station'). Transfers could be a problem, 'particularly if they think they are on the way to open, and we have to tell them the open won't have them.'

A cross-check with hospital records suggested that we may have missed a number of incidents, despite the best efforts of the staff to be comprehensive. Very mild injuries not requiring any treatment at all would probably not be recorded.

At the end of a recent Inspectorate visit in 1990 the Governor was congratulated for the manner in which staff were confronting the problem of suicide prevention.

Prison P: Open Training

A medium sized adult open prison for 65 lifers and for long-termers coming to the end of their sentences, with an educational annexe holding an additional 98 prisoners. This annexe had recently been used for six months to hold illegal immigrants, but it was normally used for prisoners taking full-time education courses. Prisoners could be transferred from other establishments to this annex on referral.

In the main prison, which had won an award for its beautiful gardens, accommodation was mainly in large dormitories of 40 prisoners each. This resulted in some problems of theft, pressure and bullying. Self-injury was infrequent, perhaps two or three incidents per year. Several borderline cases were encountered. Any serious risks would be transferred quickly to

another establishment with full-time medical cover. 'Rule 43' type problems could occasionally be transferred to the annex, but it would not be officially documented in that way. The 'suicide risk' boundary is not always easy to place. Absconding was much more of a problem, and seemed to be on the increase. In 1990, three attempted suicides were transferred to the nearest local prison. The recent well publicised case [R v Birmingham and Solihul Coroner] illustrating the problems transfers may create was discussed as an example. Since this case, staff responded more cautiously to potential risk, and the paper-work was more thorough. Home leave was the trickiest time, often bringing serious re-assessments of expectations on release.

Most of the prisoners were employed. Suicide prevention procedures remained informal. 1996's were not used at the time of our first visit, and 1997's were often raised to alert staff to problems, but were not exclusively used for suicide risk. The SPMG met fairly regularly, but had been cancelled on the last two occasions. The group comprised a governor, a chaplain, two SWIP officers, the Senior Probation Officer, the Industrial Manager and the Security Officer. They had no links with the Samaritans at the time of our first visit, but by the time of our second they were attending at the establishment one evening per month. Payphones were in use throughout the establishment. Staff training in suicide prevention had been carried out. There was a sense that counselling and support was not necessary (see SPMG minutes), as prisoners with urgent needs were transferred elsewhere, and that suicide risk was not a major problem here.

Some problems of staff shortages (particularly in the hospital and on reception) were discussed with us, and also some prisoner dissatisfaction over conditions in the dormitories, lack of privacy, queuing required for meals, mail and canteen. The hospital was small and minimally staffed; it was facing imminent closure, which was badly affecting staff morale:

> Depression has really set in amongst the staff; morale is very low. There's more chance of an officer committing suicide just now than there is of inmates. Throughout, there is no care and there's no support.

Several changes of staff at senior mangement level was also affecting staff morale, and procedures, many of which had lapsed. There was a full probation department.

A cross check with hospital records and a chance encounter with a particular hospital officer indicated that there had been three incidents during our research year (despite repeated denials from our liaison officer), none of which required stitches and all of which had led to transfers out. One incident had involved a swallowed razor blade. Two other prisoners had threatened to commit suicide on return from absconds. A more serious incident had occurred since the completion of our data collection period.

Appendix III
Profiles of Four Prisons

Appendix III

Profiles of Sample 1 Prisons

Prison 1: Category C Training

The first establishment was an adult male Category C training prison. It was set in a rural location. It was built during the 1980's and received its first prisoners in February 1988. At that time it had a CNA of 484. The building of an additional wing has since increased this figure by 100. During the six weeks of the research the average population of the prison was 520.

Most of the prisoners were housed in one of the four main wings (A-D) in single cells with integral sanitation, arranged on corridor type landings or spurs of 28 cells each. Each wing also contains offices for discipline staff and probation, TV rooms, quiet room, association areas, kitchen, servery and interviewing rooms. One wing was a Vulnerable Prisoner Unit, not named as such, but receiving prisoners on referral from other establishments on the basis of the nature of their offence, the risks they faced from other prisoners and their suitability for the regime. Prisoners had to 'come off the Rule' before being accepted at the prison. The regime offered therapeutic group sessions run by prison staff, with the assistance of a psychologist.

Since the prison had opened an additional wing, E, had been built. Its design differed from the rest of the prison; it was of the new gallery type and was planned to provide accommodation for 100 prisoners in double cells. A number of problems were experienced once the accommodation was occupied; dissatisfaction was expressed by prisoners on this wing who were sharing cells in a prison where the majority were in single accommodation. Work was therefore set in hand to adapt the wing to single cell accommodation for 50 prisoners. This work was nearing completion during the fieldwork period.

A fifth wing, accommodated approximately 40 long-term and lifer prisoners in single rooms. These rooms did not have integral sanitation but prisoners had 'free' access to these facilities. The wing was originally designated a Pre-Release Unit but inadequate numbers of prisoners meant such a plan was not viable. The wing operated as a 'privilege' unit and prisoners applied to be located there from other wings in the prison. Prisoners in this wing had their own room keys and dined in association.

The Gate area included a visits room, a children's creche and offices for the Governor and administrative staff. The two-story 'spine' or central core of the prison comprised Reception, a Clothing Store, Shop, Kitchen, Gymnasium, Chapel, Education, Library and a further suite of management and administration offices. It was linked at first floor level to wings A-D and the Hospital.

The first floor of the hospital functioned as an out-patients' department and contained surgeries, offices and the waiting area. The ground floor or in-patient area contained a 5 bedded ward and 9 rooms, some with integral sanitation and a TV/association room. It also had access to the hospital exercise area. The protected room had a number of design faults and had

been placed out of use by the SMO. Staffed for 24 hours a day, the hospital acted as a resource for other prisons in the area in addition to serving its own population.

The segregation block was situated to the rear of the central 'spine'. Separate accommodation within the perimeter fence housed the workshops, VT and bricklaying courses. The prison also had an outside works area, a farm and a large sportsfield.

The establishment was a training prison and it was expected that the majority of prisoners would spend their time either in one of the workshops, or attending a vocational course, or in full time education or employed on domestic duties around the prison. Their first week was spent on an Induction Course. During the research period, an average of 24 prisoners per week (4%) were unoccupied. Both Education and the PE department offered a well-attended range of daytime and evening activities; the PE department also ran Community Service activities.

Movement to and from labour and activities around the prison was unescorted and use was made of the tannoy system to call prisoners to visits, appointments etc. The prisoners were unlocked at approximately 8 am. They were locked up for 1« hours at lunch and again at tea and they were locked up for the night at 8.30pm six days a week after evening association. Initially, association was available every night, this was reduced to 6 evenings and was likely to be reduced to five as overtime hours were reduced under the Fresh Start agreement. The lunch time lock up was extended by 1 hour on Tuesdays for staff development (training, education, P.E. etc).

There were many attractive flower beds and grassed areas within the prison and the grounds were clean and tidy; the absence of the usual 'prison smell' was often commented on by staff and prisoners.

The prison was designed to accommodate adults serving sentences of over 18 months in length, including approximately 40 life-sentenced prisoners. The table below gives sentencing information for the population at the time of the research, together with a breakdown by age and ethnicity.

Table A3.1

Prison 1 Population November 1990

Sentence Length	No.	%
Up to 18 months	6	1.1
18 months up to 4 years	161	29.8
Over 4 years	309	57.1
Life	65	12.0
Total	541	100.0
Ethnic Origin*		
European	470	86.9
West Indian/Guyanese	46	8.5
Indian	5	0.9
Pakistani	8	1.5
African	3	0.6
Arabian	2	0.4
Mixed	7	1.3
Total	541	100.1**
Age		
21-30 years	239	44.0
31-39 years	151	28.0
41-50 years	91	17.0
51-60 years	37	7.0
61+ years	23	4.0
Total	541	100.0

* Using the classification in Prison Service Statistics for England & Wales, 1988, London: HMSO

** Rounding errors mean figures do not exactly total 100%

Research in Prison 1

Interviews: The Comparison Group

We obtained a copy of the alphabetical roll of the 541 prisoners in the prison on 6.11.90. This included the name, number, location, offence, sentence, PED and EDR of all the inmates. We deleted from this list 14 who would be discharged during the fieldwork period. We then selected a random sample of 23 prisoners, using a 1/23 sampling fraction, with the aim of achieving 20 interviews. Checking this result, we discovered that we had not drawn a prisoner from F wing, the small privilege unit. We were anxious that the sample should represent each of the main units of the prison and, therefore, randomly selected one prisoner from F wing to include in the sample. We compared the main offences of the comparison group with those of the total prisoner population with the following results:

Table A3.2

Main Offence for Comparison Group and Total Prisoner Population

Main Offence	Comparison Group		Total Population	
Murder/Manslaughter	4	(16.7%)	77	(14.2%)
Violence	5	(20.8%)	43	(8.0%)
Sexual	10	(41.7%)	187	(34.6%)
Burglary	2	(8.3%)	52	(9.6%)
Robbery	1	(4.2%)	65	(2.0%)
Theft/handling	0		9	(1.7%)
Fraud/Forgery	1	(4.2%)	8	(1.5%)
Criminal Damage	0		4	(0.7%)
Arson	0		11	(2.0%)
Drugs	1	(4.2%)	38	(7.0%)
Other	0		47	(8.7%)
TOTAL	24	(100.1)*	541	(100.0%)

*Rounding errors mean figure does not exactly total 100%

The comparison group was representative of the total prisoner population or most offence groups.

From the pool of 24 comparison group prisoners we achieved interviews with 21. One prisoner refused; one had been temporarily moved to another prison one was transferred to another prison at short notice and two had to be transferred to the subject group.

Subject Group

The initial contacts with this establishment and the introductory tour round the prison had suggested that we might have difficulty finding a sufficient number of subjects for the research. We had hoped that this group would comprise prisoners who had attempted suicide, deliberately injured themselves or who had seriously considered suicide within one month

of the fieldwork start date or during the fieldwork period. This definition would have resulted in a very small group. We therefore extended the definition to include prisoners who had attempted suicide, deliberately injured themselves or seriously considered suicide within the past 12 months. We traced prisoners by consulting staff, and wing and hospital records. In total, we interviewed 14 subjects.

Staff

At the time of the research the prison comprised the following:-

1 Governor II, 2 Governor IV,4 Governor V, 7 Principal Officers, 21 Senior Officers, 90 Prison Officers; 1 Principal Officer Training, 1 Principal Officer PEI, 1 Senior Officer PEI, 4 PEI Officers, 1 Principal Officer Catering, 1 Senior Officer Catering, 4 Catering Officers, 1 Works Manager, 2 Principal Officers Works, 2 Senior Officers Works, 7 Works Officers, 10 Night Patrol Officers; 1 Senior Medical Officer, 1 Visiting GP, 1 Visiting Psychiatrist, 1 Hospital Principal Officer, 1 Hospital Senior Officer, 8 Hospital Officers; 1 Church of England Chaplain, 1 Senior Probation Officer, 5 Probation Officers, 1 Senior Education Officer, 8 Full Time Education Officers, 25 Part Time Education Officers, 2 Library Officers, 1 Part Time County Librarian

In addition to the above there was a number of Industrial Craftsmen, Farm Specialists, Administrative staff and stores staff, visiting specialists and ministers of other religious denominations.

We aimed to achieve 30 interviews from staff, concentrating upon discipline and hospital staff and particular key individuals (The Governor, The Governor chairing the Suicide Prevention Management Group Meeting, the Senior Medical Officer, the visiting psychiatrist, the Chaplain and the officer responsible for suicide prevention training). We completed interviews with 29 staff members. We were unable to interview the Senior Medical Officer as he was transferred to another prison during the fieldwork period; the Chaplain was reluctant to be interviewed.

Suicide Prevention Mangement Group

We attended two meetings, one shortly before the fieldwork, and the second at the end of the fieldwork. The meetings were chaired by a Governor IV and attended by:

Meeting 1	Meeting 2
Senior Probation Officer	Principal Officer
Samaritans' Representative	Hospital PO
Senior Officer	Education Officer
Chaplain	Senior Officer
	Chaplain

The group discussed self-injury figures and incidents for the period, the appropriate use of referral forms, the proper role of the hospital and the wings in 'containing' the problem; the use of Samaritans, including problems of confidentiality; the role of the Chaplain (in relation to who might be the most appropriate source of help); the role of medication, and of special watches and procedures for the 'low-risk' inmate. Much of this

discussion was felt to be geared towards our interest. During the second meeting, we thanked the staff for their co-operation with our research. They replied with thanks to us for 'focusing their minds', and for being sounding boards.

Suicide Prevention Training

Suicide Prevention Training in the prison was carried out by a Senior Officer who arranged courses at the request of the Principal Training Officer; he also acted as a Regional Trainer for nearby establishments. At the time of our research 36% of all the staff in the prison had received suicide prevention training, although different staff groups had received considerably more:

Night Patrols	100%
Wing based discipline staff	58%
Instructors	63%
Operations and IAS discipline staff	46%.

Prison 2: Local and Remand Centre

This local and remand prison opened in 1872. A number of other buildings had been added since that date; the latest, a new visits and administration block, came into use during the course of our fieldwork.

We quickly learnt from both staff and prisoners that the prison had changed considerably during the last two years. The regime had been improved out of all recognition; work and education were available for both remand and convicted prisoners, an active regime had been developed for the hospital, stress counselling had started; a scheme was being developed to encourage prison officers to take a more active role in the Education department; pre-release and induction courses were in place and improvements in the reception and visits areas would be possible once the new accommodation was fully operational. A SWIP officer scheme was in operation. Prison officers designated as SWIP officers were trained and supported by the Prison Probation Department and undertook most of the day to day welfare work of the prison. As a result the Probation Department was able to take a more proactive role in running groups for offenders.

Most of the staff we spoke to welcomed these changes and many told us that the impetus to change started with the appointment of a new Governor who anticipated change rather than waiting for it to be introduced at department level. Some staff, however, felt that change had come too quickly, that the prison was destablized as a result and needed time to settle; others were more openly resentful and others again felt that the changes had not been fully implemented and were to some extent 'tokenism'. The pre-release and induction courses, for example, were frequently cancelled as staff were redeployed.

Our impression was that, whilst some of the new schemes were suffering from staff shortages or withdrawals at short notice, the efforts that had been made to improve daily life for inmates were considerable and approximately two-thirds of prisoners were engaged in some activity during the day.

The prison had a CNA of 391; the daily population during the fieldwork

period fluctuated around 560 and the prison was receiving approximately 70 new receptions per week from a wide surrounding area. Consequently inmates lived in overcrowded conditions two or three to a cell.

A wing held the YPs, the R43s and the short-term convicted prisoners

B wing held the long term convicted

C wing help the adult remands

An additional block, D wing, held the Special Unit and the Segregation Unit.

The Hospital

The hospital was able to accommodate 34 in a 7 bedded ward, a 3 bedded ward, a number of single rooms and 3 protected rooms. We were told that it usually held about 20-25 patients. The hospital also ran a treatment room on the main prison, and arranged clinics staffed by outside specialists. The prison itself was conveniently situated very near a large local general hospital and exchange placements were arranged with NHS colleagues.

At the time of our fieldwork the hospital was staffed by 1 Senior Medical Officer, 1 Medical Officer, 1 Part-time Medical Officer, 1 Principal Officer, 4 Senior Officers and 15 Basic Grade Officers. The staff were arranged in groups: the externals, treatments, and in-patient teams.

The hospital had been without a Principal Officer and 4 nurses for some time and staff felt overstretched. Despite this, the hospital regime had been considerably improved and a variety of activities were available to patients on a regular basis. A care-plan system of treating patients was being developed along with a personal officer scheme.

Like the rest of the prison, the hospital had clearly changed over the last two years and further changes and improvements for both staff and patients were being planned. These changes had certainly improved the situation of patients in the hospital. We felt that some staff, however, felt under-valued and unsupported during the process of change.

The prison's direct telephone line to the Samaritans was located on the hospital. Prisoners located on normal accommodation who wished to use it had to be brought over from the main prison to do so.

Education

The Education department was run by an Education Officer with a staff of 4 full-time teachers, 2 half-time teachers and about 40 sessional workers. It organized classes covering all levels from Basic Education to Post-graduate studies and arranged for distance learning material to be available for in-cell study. We were told that it was the Governor's policy to prioritise on prisoners remanded in custody. Consequently over 30 of those on full-time education were remands, the remaining 20 places were filled by YPs and and 20 adults on a half-day basis. A wide range of classes was also available three nights a week and classes were run on the hospital.

The Education department arranged for us to talk to two groups of prisoners. One of the major complaints centred around the issue of visits. Prisoners felt they rarely received their permitted time on visits, the visits area was badly sited vis a vis the rest of the prison and their visitors were harassed from a distance by other prisoners, and conditions and facilities for visitors were poor. As a result visits were seen as times of considerable tension for all and problems could be exacerbated.

Kit issue, lack of hygiene and overcrowding were also seen as major problems by prisoners. It was pointed out to us that while it was often preferable to be two in a cell because prisoners could talk and support each other, three to a cell was counter-productive and led to stress and possible bullying.

Work

In addition to usual prison domestic parties, the prison also ran three workshops, located in a separate three-storey building and employing both sentenced and remanded prisoners. One workshop employed the R43 prisoners who came over first and return to the wings last and spend their day on the workshop. Showers had been installed for the prisoners and classrooms and interviewing rooms were available for Education and Probation officers. Staff in the shop and staff in other areas of the prison all told us how much this iniative had improved life for the R43s and of the changes that had taken place in their behaviour and attitudes as a result. They were no longer considered to be as seriously at risk of suicide and self-injury as they had been in the past.

Interviews: The Comparison Group

We obtained a copy of the alphabetical rolls of the prison on 2.4. and again on 15.4 (561 and 575 respectively) and using a sampling fraction of 1/37 selected two samples for interview, each of 15. We decided to sample twice as it had become clear during our first week that the high prison turnover meant we would be unable to contact a lot of prisoners in the comparison group if we selected them all at the beginning. We achieved interviews with 25 comparison group prisoners. Table 1 below shows a comparison of their age and status with those of the prison population in general:

Table A3.3

Prison 2 Population

Status	Prison Population %	Comparison Group %
Sentenced	44	44
Remanded, unsentenced etc	54	56
Other	2	0
Total	100	100

Table A3.3 (cont.)

Age		
17-20 years	15	16
21-30 years	55	64
31-40 years	19	20
41-50 years	7	-
51-60 years	3	-
61+ years	1	-
Total	100	100

Subject Group

We included in this group any prisoner who had attempted suicide or injured himself or had been seriously considered at risk of suicide within one month of our arrival at the prison. Altogether we interviewed 20 prisoners out of a possible 21. One was transferred out before we were able to speak to him.

Staff

This establishment had a staff of approximately 275. We achieved interviews with 33 staff members.

Suicide Prevention Management Group

The SPMG usually met monthly; we attended the meeting scheduled for April. The Group was chaired jointly by the SMO and the Head of Inmate Activities (check this) and participants on this occasion included representatives from Probation, Education, the Samaritans, the Hospital, and discipline staff. Neither the Chaplaincy nor the Board of Visitors were present though formally part of the group.

The group was in the process of ordering Resusiaide Packs for the prison, to be paid for out of the medical budget, was arranging for plastic cards outlining suicide prevention procedures to be issued to all staff and for new Samaritan Posters to be displayed in the prison.

Statistics presented for the last month (March 1991) showed that 4 1997s had been completed and that 14 prisoners had been placed in the protected room (2 for over 24 hours), usually because the hospital did not have adequate night cover available to monitor them.

The Samaritan representative reported that there had been no letters or phone calls from prisoners during the last month but that one prisoner had been visited. Unfortunately this visit had been made by a volunteer new to the prison who had failed to make arrangements for a follow-up visit. The issue of inmate representation on the group was considered and it was suggested that the idea of an Inmate sub-committee should be explored with a number of inmates to see what they thought.

At the suggestion of the Governor, the group was asked to draw up

contingency plans for contacting and informing relatives when an inmate attempted suicide. This was an issue which had been raised graphically at the Deaths in Custody Conference which members the establishment had attended and we found it impressive that although they had been upset by this section of the conference they had quickly responded to the message.

Suicide prevention training

Suicide Prevention Training in the prison was carried out by two trained Senior Officers. The prison target was to have trained all staff by the end of 1990. 'Senior staff and those in key positions will receive the long, all day course and other members of staff will receive the shorter package' (Annual review of suicide prevention strategy. At the time of our fieldwork the following staff had received training:

Short course:	BGO	40
	Prison Auxillaries	2
Long course:	HPO	1
	HSO	4
	HO	15

In total, 26% of the staff had been trained. The two tutors explained that they experienced the usual difficulties in running courses; the last two having been cancelled at short notice due to staff redeployment.

Prison 3: Local and Remand Centre

This establishment became a local prison in 1986, after having been (in reverse order) a dispersal, a Borstal and a training prison for 17, 10 and 9 years respectively. It was opened in 1870 as a local prison and is located close to the city centre, in Hedon. Its CNA was 440; its ADP varied between 620 and 640. At the time of our research, it was locking out any higher numbers, and staff were therefore responsible for prisoners kept in police containers in several areas. This liaison task took up most of the Head of Custody's time. In particular, arranging receptions each day was a time-consuming operation, involving several phone-calls to courts and police cells to negotiate numbers and spaces. A slight sense of chaos reigned. There had only had two suicides since the establishment had become a local prison. The most recent of these was in Sept 1990 when a young remand prisoner on a (child) murder charge hanged himself. He had been in the prison for five months and was in the hospital on protection from other R43 prisoners.

The adult prisoners were house in one of the three radial wings of the prison, while the young prisoners were located in a separate block (known as B wing) built within the prison perimeter. Accommodation was divided as follows:

A Wing - Special Unit (CNA 16, ADP 8)

B Wing (the separate remand block) - Young Prisoners (remands, trials, convicted and sentenced, JR's and civils) (CNA 100, ADP 144)

C Wing - Adult Remands (CNA 160, ADP 245-55)

D Wing - Adult Sentenced/Allocation (CNA 142, ADP 190)

B Wing. This wing was particularly cramped, having four landings with three spurs each but no visibility between either landings or spurs. This made the wing structurally difficult to control. The fourth landing housed those YP's segregated for good order and discipline on one side, and those segregated for their own protection on the other. These inmates watched video's in a recess on one end of a spur as there was no space elsewhere in the wing to fit 12 prisoners. The numbers on B Wing had recently fallen. Sentenced Young Prisoners were transferred to a neighbouring establishment for allocation under a local tactical management agreement between the two Governors to reduce the pressure on B Wing. Most of the young prisoners were therefore remands and trials. The R43 inmates were harder to relocate, as there was nowhere for them to go. They could only go to the neighbouring YOI if they came 'off the Rule'.

Staff maintained that they could cope, providing the roll was below 150. Above this figure, problems of bullying, self-injury and vandalism escalated. Increased efforts had been made to engineer activity for the YP's, including education classes, association, stress-management groups and video's. Despite these efforts there was little structured work or activity going on. Cleaning, PE, education, association, games and showers were the only available activities. There was no evening association. Staff had recently been encouraged to make phone calls on behalf of inmates, where necessary, to diffuse anxiety. Serious efforts were being made to keep the number of under 16 year olds to a minimum. At the time of the fieldwork there were four. Staff were liaising with social services to find alternative accommodation for them.

B wing was noisy, and had a small interview room next to the association area on the ground floor. Interviews were difficult to carry out in this room due to the noise, the lack of privacy (and the flies!). Several inmates referred to the distress caused by shouting and taunting that went on at night through cell windows. At the time of our arrival, arrangements were in hand to transfer the YP's out to a new YOI by the end of August and to refurbish B Wing, changing its function. The disturbance caused by the first young prisoners to be transferred there delayed the move, so that no changes took place during the time of our stay.

All accommodation throughout the prison was shared, some three to a cell. C wing housed the (63) adult Rule 43's, three to a cell. This meant that two separate regimes had to be run, staggering unlocking, feeding, exercise and so on throughout the day. Cell bells rang all day long, and were rarely answered - staff were always on their feet, in and out of the office, answering the phone or queries at the door and carrying out basic duties. The cells themselves were long and narrow, small and cramped, very dirty with very high windows. Most sentenced prisoners on D Wing were housed two to a cell. The prison was dirty and cramped throughout and shortages of kit, knives and forks, and other essentials were constantly noted. A special unit on A wing was exempt from these conditions. It was large and clean, with good facilities.

The hospital was housed in a separate building, connecting underground to the central corridors of the rest of the prison. Its functions were to accommodate those inmates for whom court reports were required, murder charges, suicide risks and self-injurers, the physically ill and the

mentally ill. There was a shortage of accomodation on the hospital, a situation exacerbated by the difficulties experienced in moving (5) psychiatric patients out to hospitals. There were 23 beds available, 13 in single rooms. 2 of these had integral sanitation and were used for VIR cases. There was a 4 bed ward, for cleaners, and a 7 bed ward. This ward was comfortable, open and had shower facilities and a television. 2 protective cells were often used simply for accommodation, as an extra room. They were occasionally used for seclusion. They were in very bad condition, were unclean and small. Problems associated with mixing particular prisoners exacerbated the problem of shortage of space. Decisions had to be made about the degree of risk, only the most difficult cases were able to be accommodated in the hospital at all. Special watches were carried out on the wings, those inmates felt to be vulnerable by the SMO being marked for Communal Cell. Productions to court occasionally left these inmates without a cell-mate during the day, but staff were alert to this and tried to re-arrange accommodation accordingly.

Probation

The Probation department consisted of 1 Senior Probation Officer and 7 main grade officers. The large open plan office from which the team worked was set apart from the wings, in the administrative area of the prison. The team shared most responsibilities, only 2 of the officers having a part-time designated function, on the Special Unit. The whole team dealt with new receptions, applications and requests as they were made. The Department arranged interviews with an Alcohol and Drugs Advisory Service, with Citizens Advice, provided counselling, a parole information group and other groups, periodically. Most of their time was taken up responding to immediate requests.

Education and Work

The Education Department was physically small but played a major role in the occupation of young and adult inmates, and those on R43. A new and very enthusiastic Senior Education Officer was in post and was keen to expand the role of the department even further, beyond the 'occupation' of prisoners to a meaningful programme of education. It was difficult to target those inmates most in need or wanting Education, as many were 'creamed off' for work or cleaning in the prison. The work consisted of textiles and tailoring shops, domestics (cleaning, kitchens) and gardens

Receptions

Prison 3 received over 100 new receptions each week. The reception area was small and very crowded. It had been intended to be temporary, but no new reception area had been built. There were no private interviewing areas, and it was difficult to segregate different groups of inmates. Interviews were cursory, by necessity.

Chaplaincy

The Chaplaincy team (1« + assistant) were fully involved in the prison, providing support to both prisoners and staff, making themselves available to new receptions and trying to be as visible as possible on the wings. They were a well-used resource in the prison, staff referring inmates to them when they felt that this was appropriate. They co-ordinated prison

visitors but felt that there were not enough to respond to demand. They also ran several groups.

Our impression of this establishment was of a friendly, open and co-operative prison for us to work in, but on the whole, the staff were unhappy and busy getting through the days, always short of the basic necessities and always struggling to fit bodies into available spaces. Efforts were being made in many quarters, but particularly on B Wing, to occupy and placate bored, disgruntled and sometimes disruptive prisoners. The hospital facilities were simply inadequate to deal with the sorts of problems presented by the population. Staff were eager to help us with our research, and to talk to us in detail about the problems they faced. Inmates thought the prison was friendly, but lacking basic facilities. Staff-prisoner relationships seemed relaxed and familiar. Many inmates commented that they preferred this to other locals.

Table A3.4

Prison 3 Population July 1991

Status	Remand No. (%)	Sentenced No. (%)	Total No. (%)
Young Prisoners	130	14	144 (23)
Adults	229	252	481 (77)
Total	359 (57)	266 (43)	625 (100)

Interviews: The Comparison Group

We obtained a copy of the alphabetical roll of the 625 prisoners in the prison on 1.7.91 and 15.7.91. This included the name, number, location, offence, sentence, PED and EDR of all the inmates. We selected a random sample of 10 prisoners at two stages of our fieldwork, to avoid losing short stay remand prisoners, using a 1/50 sampling fraction, with the aim of achieving 20 interviews in total. Our second selection were weighted slightly towards remand prisoners, to rectify a potential imbalance in the composition of the total group. Comparisons of their age and status with those of the prison population showed the following:

Table A3.5

Prison 3 Population July 1991 with Comparison Group

Status	Prison Population %	Comparison Group %
Sentenced	43	28
Remanded, unsentenced etc.	57	72
Total	100	100

Table A3.5 (cont.)

Age		
under 17	1	-
17 - 20	22	17
21 - 30	51	61
31 - 40	18	22
41 and over	8	-
Total	100	100

From the pool of 20 comparison group prisoners we achieved interviews with 18.

Subject Group

We included amongst the Subject Group any prisoner who had attempted suicide, deliberately injured themselves or who had seriously considered suicide within one month prior to our fieldwork start date or during the fieldwork period. This definition resulted in a substantial group. We traced prisoners by consulting staff, the daily roll board and wing and hospital records. In total, we interviewed 20 subjects. 16 of the subjects were YP's. (3 of the Comparison Group were YP's). Many of them had injured themselves as a result of bullying on the wing.

The Probation Department kept a record of all incidents of self-injury occurring at the prison. From 1 January - 1 June 1991 54 incidents were recorded. 38 (70%) of these were amongst YP's. In only 10 cases was a 220 raised.

Staff

At the time of our research the prison comprised 271 staff members (9 Governor grades, 16 PO's, 36 SO's, 4 night patrols, 226 officers, 17 prison auxiliaries, 26 industrial staff, 1 SMO, 1 MO, 1 HEO, 3 EO's, 3 Instructors, 3 Chaplains, 4 storemen, 3 p/t cleaners, 14 AO's, 2 typists and 1« psychologists). We completed interviews with 29 staff members.

During one of our group discussions a number of incidents of self-injury were discussed. The groups agreed that 'bang-up' was the main problem here, that there were only 20 jobs in the prison to go round, for B Wing, and that this aspect of life 'gets to you'. The top job was cleaning, not least because it attracted the top wage of £3.60. They discussed discrepancies between courts regarding visits: in two local courts, you couldn't have vists from your families in the magistrates' courts. The police and magistrates argued that they don't have the time to man them. This was felt to be unfair, as court visits were often easier for families than travelling to a prison. Visits to court were less demanding on families, who could squeeze them in during the day, rather than spend the entire day travelling and waiting around. They all thought one in particular was great - the police let you have your visits just sitting on a bench outside your cells. We asked what they would do to reduce self-injury. They said reduce bang-up, introduce more compassionate staff,

who have more time for you. There should be more association, phones, and - a constant theme - there should be rehabilitation in prisons. The use of 'strips' was no help at all. They talked about the harshness of the YP culture. Anyone who slashed up got really badly teased, and egged on. 'No slasher gets a proper night's sleep in here'. They were shouted at and taunted, told that they are just looking for sympathy. They don't get it from other inmates. The trouble for some inmates is they just don't get their 'normal privileges'. They've no visits, no cigarettes, they can't work, they get no letters...

The groups thought that JR's were particularly badly off, because they were transferred under a local agreement to an establishment where they would be unable to work for up to six weeks: 'it's lke a morgue'.

They talked about the difficulties in passing the time. Reading was difficult for some, and for those who could, often the books were torn or pages missing. 30 inmates could go on education. The R43's worked on textiles. Apart from that, they could play games and watch video's every three days in the afternoon. The improved regime was still sorely limited. They contrasted their experience at the prison with a booklet inmates received when they came in, telling them all about the prison and what they would do there. The two versions were unrelated. One of the difficulties revolved around the overcrowding. This meant that officers had to hurry inmates through basic tasks such as showers, collecting food, slopping out, etc. Officers had mentioned this problem to us. Inmates perceived this pressure as aggravating, making relationships between staff and prisoners more difficult. Even getting a shower before an appearance at court was unlikely.

The group were boisterous, but very earnest and helpful. They were so eager for something to do; they were reluctant to draw the discussion to an end. It was clear that a struggle to 'stay on top' themselves resulted in harsh treatment towards weaknesses shown by others. Psychological bullying was rife.

A Chaplain's group we attended was excellent, led by a part-time Chaplain's assistant who related well to the inmates and provided a great deal of support. He also challenged their behaviour and tried to offer alternatives. Unfortunately the group - which was popular - clashed with exercise. Some inmates chose not to go on exercise in the compound for fear of bullying.

Suicide Prevention Management Group

A SPMG Meeting was convened, largely for our benefit, during the course of our fieldwork. The meetings had lapsed before our arrival, and had in any case been informal and irregular, with no agenda. A decision was taken to reconstitute the group, under a tighter brief. The meeting was chaired by a Governor and attended by:

Senior Probation Officer
Samaritans' representative
D Wing Senior Officer
Chaplain
Senior Medical Officer
2 B Wing Officers

2 Governors
BOV Representative

The group decided to run on less ad-hoc lines and to have an agenda. Training was an important area of concern, particularly the question of who should get training as a priority. The group decided to monitor progress between meetings. They discussed the issue of prisoner representation on the group. This was felt to be a good idea in principle, but there were problems of consistency, due to the high turnover.

The group felt that probation should follow through all cases of self-injury in order to find out what sort of pressures such inmates are subject to. Perhaps self-help groups or discussion groups should be run. The prison had a full-time and part-time psychologist in post, but at present they had an uncertain role, and were not used as a resource for self-injury. The group should review all recent cases of self-injury, concentrating somehow on eliciting information from inmates who did make suicide attempts or injure themselves. They anticipated fewer problems in the future, as the B Wing inmates were due to be transferred to out within a few weeks. At present, the BOV occasionally talked to inmates about self-injury, but the information was not put to any use. There was a feeling that the establishment tended to deal with the issue quite coldly as a 'reportable incident', and follow-up was poor. The group discussed ways around the problem of confidentiality. Perhaps if inmates were encouraged to write their reasons down and talk in terms of general problems the group could learn more about the internal and external pressures inmates were subject to. Information recorded on forms (213) was unhelpful, these forms only recorded physical details. A local form should be developed.

The issue of communication was raised. The hospital did not send enough information back to the wings on the 1997, or quickly enough. Staff complained about the number of inmates who came back to the wings when some degree of risk was still felt to be present. The wings would prefer a plan, or more direction from the hospital as to what to do with the inmate concerned once he left the hospital.

The group discussed the potential for building on the present 'stress' course for inmates, perhaps involving MIND, or more officer time, combining the functions of 'pre-release', induction, sentence planning, suicide prevention and other groups in some way. The potential for staff involvement, particularly given the experience accumulated amongst staff during their time as a dispersal prison, was great.

Phones were to be introduced shortly. The group discussed the pro's and cons of the various methods and their implications for ease of access to the Samaritans.

The last item to be discussed was the important issue of how to turn suicide prevention into a 'dynamic activity' - ie. something which occurred between meetings, and not just at them.

Suicide Prevention Training

Twenty one uniformed officers had been trained in suicide prevention during 1988. Since then, the trainer had been off on long-term sick leave.

Prison 4: Local and Remand Centre

The establishment was built in 1847; the design of its facade was modelled on Windsor Castle. It is a classic Victorian prison with four four-storey wings radiating from a central tower block. Each wing had been painted in a theme colour and the inside of the prison was quite bright and light. Over time other buildings had been added, including a visits block, and an education department. A new staff mess and a new works department had been built outside the walls. The Governor's office, those of most of his colleagues and of the administrative staff were all located in a separate block outside the prison gate. A visitors centre was located nearby.

The prison had a CNA of 642; during the course of our fieldwork numbers fluctuated from just below 900 to around 915, despite the fact that the young prisoners had recently been transferred to a new centre. The majority of prisoners were located two to a cell; Category A and E men usually had single cells, and on each wing there were some cells for 3. The cells were small, cramped and well-worn and many inmates had to spend most of their day in them. We heard a number of complaints about infestations of ants and of problems with pigeons and there was evidence of large amounts of debris being thrown from cell windows.

A wing held remands and R43s OP. There were 150 of the latter, most of whom were convicted. The R43 population on the wing had spread beyond their allocated protected area and a number had to be housed on ordinary location, causing added stress to them and to staff. The wing population on 18/9 was 284. B wing was the old YP wing. It's future had yet to be decided but at the time of our fieldwork it was being used to house 173 convicted and trials. C wing held 207 convicted prisoners. D wing held a mixture of remands, trials and convicted prisoners, 155 in total on 18/9.

Hospital

The prison hospital was located at the end of D wing and was staffed by an SMO, 3 MOs, 1 Part-time GP, a Governor V, 2 Principal officers, 4 Senior officers, 21 Hospital officers, a part-time Pharmacist and drew on the services of a number of visiting specialists.

The hospital was large, with accommodation for 63 in-patients. It had one protective room, which was in a poor state, two interconnected wards which held a total of 17 beds, and a mental observation wing on the floor above, all single cells, some unfurnished. It also had a VIR room with integral facilities.

In addition to this accommodation, there was an area of D wing known as the Upper Hospital which was used to house overspill hospital patients and prisoners who did not need to be in hospital but who would have difficulty surviving in the main prison. This upper hospital was not staffed by hospital officers but by D wing staff, a situation which was unsatisfactory to all concerned. A new hospital for the prison was due to be opened in 1993 and a new Hospital Governor was due to take up his post in mid-October. A teacher from the Education Department ran classes in the ward each afternoon, in term-time, and the hospital also had a TV and a number of board games for patients' use.

Probation

The prison had a probation team of 11 Probation officers led by two Senior Probation Officers. Each probation officer had a designated task and some were located in wing based offices. They played an active role in the prison and were responsible for most aspects of prisoners' welfare. Several groups were run in collaboration with prison officers, and working relationships with the department were good. The probation team had played a very active role in suicide prevention procedures and contributed enormously to the SPMG meetings and Case Conferences.

Education and work

The Education department had been able to operate for 41 weeks during the last year. They had aimed for 43-44 weeks but lack of officer cover had precluded this. They offered classes to all sections of the prison population: R43s in the morning, convicted men in the evenings and unconvicted in the afternoons but were only able to cater for 70 prisoners at a time in the department. In addition, they ran classes in the hospital ward and had a classroom on the R43 landing. Applicants were picked up on reception interview, via cell visits, and when they attened an interview at the Observation, classification and allocation unit. Unfortunately, we were told up to 40% of applications were rejected on security grounds. One explanation for this that we were given was that the Education Department is built of concrete blocks and is not considered a secure area, also that the prison did not have enough discipline staff available to provide adequate cover (these issues are also mentioned in a recent Inspectorate report). The department offered a wide range of subjects including crafts, remedial subjects, examination subjects and were able to provide a number of Open Learning Packs for individual study.

The prison also had four workshops, three of which were producing textiles. The remaining shop was a light assembly shop which could provide work suitable for unskilled labour and thus for short-term employees. In addition other prisoners were employed on the normal prison work duties, e.g. cleaners, kitchen assistants, outside parties, etc. Information extracted from the nominal roll of the prison on 18/9/91 showed that 117 prisoners (13%) were involved in education and 389 prisoners (43%) were in employment.

Chaplaincy

The prison chaplaincy was staffed by 2 Church of England vicars and 1 Roman Catholic priest, together with a Church Army Sister and several visiting ministers. The Church Army sister had been heavily involved with the B wing YPs. She left during the course of our fieldwork to join the new young prisoners' centre and continue her work with the YPs.

The Prison had a most attractive Chapel and a small Mosque. The Chapel was also used for film shows. While the Chaplains did not object to this, some inmates felt that it was an inappropriate venue.

Interviews

Within a short time of our arrival we were warned that staff might be suspicious of our research as they had been subject to a number of

pressures and strains in recent months. Not only had they had to cope with several suicides and a spate of self injuries which left staff anxious and fearful especially on night duty, the prison had also been the focus of a sustained and hostile local press campaign which staff felt had been particularly biased and unfair and against which they had little redress. Four of the staff had recently been involved in criminal proceedings concerning alleged assaults against inmates which had resulted in one member receiving a custodial sentence. The prison hospital had recently been the subject of a Prison Department internal enquiry and its staff were currently the focus of an investigation by the Police as a result of complaints laid against them by an ex colleague concerning their treatment of patients.

However, we found that once staff realized that we were anxious to understand their problems and concerns as well as those of inmates we were given excellent co-operation and most staff did all they could to facilitate our research. The recent departure of the young prisoners also meant that by the time we arrived, many of the staff were feeling much less pressurized, though still very busy, and were able to find time to talk to us and to reflect on their recent experiences.

The Comparison Group

We obtained a copy of the alphabetical roll of the prison on 5/9/91 (903 inmates) and again on 18/9/91 (914 inmates). From each of these we selected a random sample of 19 prisoners using a sampling fraction of 1/90 and 1/100 respectively. We oversampled by three to allow for refusals, discharges etc and obtained interviews with 16 prisoners. Comparisons of their age and status with those of the prison population showed the following:

Table A3.6

Prison 4 and Comparison Group Populations September 1991

Status	Prison Population %	Comparison Group %
Sentenced	55	56
Remanded, unsentenced etc.	45	44
Total	100	100
Age		
21-30	61	69
31-40	22	13
41-50	10	19
51-60	4	-
61 and over	2	-
Total	100	100

Subject Group

We included in the subject group any prisoner who had attempted suicide,

deliberately injured himself or who had seriously considered suicide within one month of our arrival at the prison. In total we interviewed 8 subjects from a possible pool of 11. Of the three that we lost, one was a 3-to-unlock prisoner and it was not possible to interview him confidentially; one was a diagnosed schizophrenic and could not respond to questions; the third was attending court for the week following his injury, which was our last week in the prison.

Staff

At the time of our research the prison had a staff of 540, 407 of whom were unified grades. These included 12 governor grades, 21 principal officers, 51 senior officers and 310 officers. We completed interviews with 37 staff members.

Suicide prevention management group

This group was well established in the prison and met monthly; we attended the September meeting. In response to its self-harm and suicide problem, the establishment had set up its own system of monitoring and classifying incidents; all incidents were reported to the SPMG with the more serious and those considered to be 'genuine' being discussed in full.

The meeting we attended was chaired by the Head of Custody and attended by the SMO, the Hospital Governor, the Acting Head of Residential, the Senior Probation Officer and a Visiting Psychiatrist and the HEO Training. Plans were forthing to include a representative of the local Samaritans and a prisoner representative on the group. September's meeting was not attended by a member of the uniform staff nor the Chaplain, though we understand that this is not the usual situation.

Staff in the prison appeared to be well-informed about suicide prevention procedures. 1997s were completed and returned to wings, where they were kept in a file in the wing office. Wing occurrence books were frequently used to draw colleagues' attention to inmates who were causing concern and a 1997 file was kept on the LIDS computer data base listing all inmates who had been referred on a 1997 together with comments about their 'treatment', e.g. communal cell, locate flat.

The prison had also recently set up a counselling team to act as a resource to staff. This team included the Head of Custody, the Hospital Governor, the Chaplain and the Senior Probation Officer and we were told that all staff were contacted after any incident to see what support they required.

Suicide prevention training

Three members of the prison staff were suicide prevention trainers. Training had to be abandoned during the summer leave period; it had been hoped to resume training during September but this had not been possible due to staff shortages and it therefore had to be postponed until October/November. The training records showed that 258 (48%) members of the prison staff had received training in suicide prevention; these figures were unlikely to be up-to-date because of recent staff movements, but they were felt to reflect an approximate picture for the prison. All staff had recently been issued with suicide prevention cards.

Appendix IV
Tables

TABLES FOR CHAPTER 2

Table 2.1 Sample 1 prisons - breakdown of population as at 31.12.89*

Establishment	CNA	Total Occ	Under 21						Adults					Civils
			Untried and convicted unsentenced	Up to and incl. 4 months	Over 4 months up to 18 months	Over 18 months up to 3 years	Over 3 years	Fine Default	Untried and convicted unsentenced	Up to and incl. 18 months	Over 18 months up to 4 years	Over 4 years	Fine Default	
LOCAL AND REMAND														
B	571	905	2	-	26	10	7	1	362	199	172	106	8	12
D	244	338	55	-	4	2	14	-	163	39	35	23	1	2
E	689	912	-	-	16	10	18	-	292	175	256	135	8	2
H	200	274	-	-	1	1	-	-	59	73	94	44	-	2
K	205	316	-	-	-	-	-	-	178	36	45	52	4	1
N+	605	435	44	-	7	-	-	4	121	77	120	57	2	3
CLOSED TRAINING (CATEGORY)														
C (B)	405	405	-	-	-	-	-	-	-	3	87	315	-	-
N++ (C)	200	179	-	-	-	-	-	-	-	97	66	14	2	-
C (Disperal)	432	429	-	-	-	-	-	-	-	-	2	427	-	-
I (C & D)	754	710	-	-	-	-	-	-	-	165	350	195	-	-
L (C)	1001	778	-	-	-	-	-	-	-	316	389	73	-	-
M (B)	549	551	-	-	-	-	-	-	-	4	12	535	-	-
OPEN TRAINING														
P	526	518	-	-	-	-	-	-	-	189	169	160	-	-
CLOSED YOI														
A	296	271	-	-	-	4	267	-	-	-	-	-	-	-
F	846	706	351	33	156	111	48	7	-	-	-	-	-	-
O	412	334	-	-	159	150	25	-	-	-	-	-	-	-
OPEN YOI														
Q	288	135	-	-	116	18	1	-	-	-	-	-	-	-
SAMPLE TOTALS		8196	452	33	485	306	380	12	1175	1373	1797	2136	25	22
%		100	5.5	>1	5.9	3.7	4.6	>1	14.3	16.7	21.9	26.0	>1	>1
TOTAL PRISON POPULATION		44281	2613	332	2857	2026	1294	50	6466	6646	10341	11285	211	160
%		100	5.9	>1	6.4	4.5	2.9	>1	14.6	15.0	23.3	25.4	>1	>1
ADDED 1.8.90														
J (Open)	357	138	-	49	57	25	4	3	-	-	-	-	-	-
ADJUSTED TOTAL		8334	452	82	542	331	384	15	1175	1373	1797	2136	25	22
%		100	5.4	>1	6.5	4.0	4.6	>1	14.0	16.5	21.6	25.6	>1	>1
J (Open & Closed)	542	319	-	50	122	106	38	3	-	-	-	-	-	-
ADJUSTED TOTAL		8515	452	83	607	412	418	15	1175	1373	1797	2136	25	22
%		100	5.3	>1	7.1	4.8	4.9	>1	13.8	16.1	21.1	25.1	>1	>1

Notes: * Source: Occupation of Prisons, Remand Centres and Young Offender Institutions, and Police Cells on 31 Dec 1989. Compiled by Home Office Statistical Department from information supplied on F.1032 revised, F.752 revised and F.
+ See also N below.
++ Part of N but listed separately.

Table 2.2 Population in fieldwork prisons by status and age compared with comparison groups (%)

Status*	Remand & Convicted Unsentenced %		Sentenced %	
	Pop.	CG	Pop.	CG
Prison 1	-	-	100	100
Prison 2	54	56	44	44
Prison 3	57	72	43	28
Prison 4	45	44	55	56

* Excludes small numbers of 'other' prisoners, eg civil prisoners

Age	under 21 %		21-30 %		31-40 %		41-50 %		51-61 %		Over 60 %	
	Pop.	CG	Pop.	CG	Pop.	CG	Pop.	CG	Pop.	CG	Pop.	CG
Prison 1	-	-	44	38	28	24	17	29	7	9	4	0
Prison 2	15	16	55	64	19	20	7	0	3	0	1	0
Prison 3	23	11	51	67	18	22	6	0	1	0	1	0
Prison 4	-	-	61	69	22	13	10	19	4	0	2	0

Table 2.3 Male Prison Population 1990

a) Remand population[1]: Annual Receptions and Average Daily Population (ADP) 1990

	Receptions		ADP	
	No.	%	No.	%
Adults	36,687	(65)	6,239	(69)
Young prisoners	19,757	(35)	2,816	(31)
TOTAL	56,444	(100)	9,055	(100)

b) Sentenced population: Annual Receptions and Average Daily Population (ADP) 1990

	Receptions		ADP	
	No.	%	No.	%
Adults	47,191	(73)	28,201	(82)
YPs	17,359	(27)	6,121	(18)
TOTAL	64,550	(100)	34,322	(100)

c) Total population: Annual Receptions and Average Daily Population (ADP) 1990

	Receptions		ADP	
	No.	%	No.	%
Adults	83,878	(69)	34,440	(79)
YPs	37,116	(31)	8,937	(21)
TOTAL	120,994	(100)	43,377	(100)

1 includes untried and convicted but unsentenced

Note: excludes 447 in police cells and 197 non-criminal prisoners
excludes female prison population

Prison Statistics England and Wales 1990 Cm.1800, London, HMSO, 1992

TABLES FOR CHAPTER THREE

Table 3.1 Number of incident forms received from each prison

Prison	Type	No.	%
A	Closed YOI	8	(3)
B	Local & Remand	26	(9)
C	Closed training	2	(1)
D	Local & Remand	29	(10)
E	Local & Remand	50	(16)
E	Closed & Remand YP	47	(15)
G	Dispersal	17	(6)
H	Local & Remand	23	(8)
I	Closed training	7	(2)
J	Closed & Open YOI	6	(2)
K	Local & Remand	36	(12)
L	Closed training	9	(3)
M	Closed training	7	(2)
N	Local & Remand	15	(5)
O	Closed YOI	23	(8)
P	Open	0	(0)
TOTAL		305	(102)*

* Due to rounding errors

Table 3.2 Number of incident forms received per prisoner

Number	No.	%
1	248	(81)
2	37	(12)
3	12	(4)
4	3	(1)
5	2	(1)
6	2	(1)
7	1	(-)
TOTAL	305	(100)

Table 3.3 Number of forms received by type of prison

Type of Prison	No.	%
Local and Remand	179	(59)
Closed training Adult	42	(14)
Closed YOIs	84	(28)
Open Prison Adult	0	(0)
Open Prison YOI	0	(0)
TOTAL	305	(101)*

* Rounding errors

Table 3.4 Status of respondent completing form

Respondent	No.	%
Medical Officer	23	(8)
Governor Grade	12	(4)
Hospital Principal Officer	20	(7)
Hospital Senior Officer	75	(25)
Hospital Officer	123	(40)
Researcher	25	(8)
Not Known	27	(9)
TOTAL	305	(101)*

* Rounding errors

Table 3.5 Time between date of incident and completion of incident form (days)

Days	No.	%
On the same day	55	(18)
Within 1 day	68	(22)
Within 2 days	29	(10)
Between 3 & 7 days	27	(9)
Over 7 up to 28 days	43	(14)
Over 28 days	40	(13)
Not Known	43	(14)
TOTAL	305	(100)

Table 3.6 Age of prisoner (years)

Age	No.	%	
		Sample	Prison population
14 - 16	20	(8)	(0.8)
17 - 20	86	(35)	(16.0)
21 -24	57	(23)	(22.0)
25 - 29	35	(14)	(22.1)
30 - 39	33	(13)	(23.2)
40 - 49	6	(2)	(10.9)
50+	5	(2)	(4.9)
Not Known	6	(2)	
TOTAL	248	(100)	(100.0)

Table 3.7 Status

Status	No.	%	
		Sample	Prison population
Unconvicted	98	(40)	(16.4)
Convicted, unsentenced	19	(8)	(4.0)
Sentenced	130	(52)	(79.6)
Not Known	1	-	
TOTAL	248	(100)	(100.0)

Table 3.8 Length of sentence (prisoner data only)

Sentence (Months)	No.	%	
		Sample	Prison population
Up to 4 months	10	(8)	(3.8)
Over 4 months to 18 months	38	(29)	(25.7)
Over 18 months to 4 years	44	(34)	(34.6)
Over 4 years	28	(22)	(27.9)
Life/HMP	8	(6)	(8.0)
Not Known	2	(2)	-
TOTAL	130	(100)	(100.0)

Table 3.9 Offences and charges

i.Convicted prisoners: main offence

Type of offence	No.	%	
		Sample	Prison Pop under sentence 30/6/90 %
Murder/manslaughter/att murder	8	(5)	} (22.7)
Violence against the person	27	(18)	
Sexual offences	9	(6)	(9.0)
Robbery	24	(16)	(12.1)
Burglary	38	(26)	(17.6)
Theft and Handling	19	(13)	} (11.4)
Fraud and Forgery	1	(1)	
Arson	6	(4)	(1.5)
Criminal Damage	4	(3)	(1.2)
Other	13	(9)	(15.5)
Not recorded	–	(–)	(9.5)
TOTAL	149	(101)*	(100.0)

From Prison Statistics, 1991

ii. Remand prisoners: main charge

Type of offence	No.	%
Murder/manslaughter/att murder	8	(8)
Violence against the person	13	(13)
Sexual offences	9	(9)
Robbery	16	(16)
Burglary	22	(23)
Theft and Handling	8	(8)
Fraud and Forgery	2	(2)
Arson	5	(5)
Criminal Damage	6	(6)
Other	9	(9)
Not recorded	–	(–)
TOTAL	98	(99)*

*Rounding error

Table 3.10 Transfers

	Prisoners		Incidents	
	No.	%	No.	%
Yes	65	(26)	86	(28)
No	160	(65)	194	(64)
Not known	23	(9)	25	(8)
TOTAL	248	(100)	305	(100)

Table 3.11 Reasons for transfer

Reason	Prisoners		Incidents	
	No.	%	No.	%
Suicide Risk	12	(18)	21	(24)
Disciplinary	12	(18)	14	(16)
Administrative	37	(51)	39	(45)
Not known	8	(12)	12	(14)
TOTAL	65	(101)	86	(100)

Table 3.12 Form F1996 completed

	Prisoners		Incidents	
	No.	%	No.	%
Yes	65	(26)	87	(24)
No	94	(38)	114	(37)
Not known	89	(36)	104	(34)
TOTAL	248	(100)	305	(100)

Table 3.13 Methods used to attempt suicide or self-harm (N=305)

Method	Prisoners (N=248)		Incidents (N=305)	
	No.	%	No.	%
Hanging/self-strangulation	42	(17)	54	(18)
Cutting neck	8	(3)	9	(3)
Cutting wrists (length)	17	(7)	20	(7)
Cutting wrists (across)	102	(41)	117	(38)
Other cuts	72	(29)	88	(29)
Setting fire	5	(2)	9	(3)
Drug overdose/poison	16	(7)	19	(6)
Swallowing razor blades	6	(2)	6	(2)
Food refusal	9	(4)	14	(5)
Other methods	18	(7)	9	(3)

NOTE: A number of prisoners used a combination of methods

Table 3.14 Day of week of incident

Day	No.	%
Sunday	41	(13)
Monday	47	(16)
Tuesday	42	(14)
Wednesday	43	(14)
Thursday	45	(15)
Friday	44	(15)
Saturday	42	(14)
Not known	1	(-)
TOTAL	305	(101)*

*Rounding errors

Table 3.15 Time of day of incident

Time of day	No.	Hourly rate	%
24:00 to 07:59	39	4.9	(13)
08:00 to 11:59	28	7.0	(9)
12:00 to 13:59	24	12.0	(8)
14:00 to 16:59	38	12.7	(12)
17:00 to 19:59	51	17.0	(17)
20:00 to 23:59	76	19.0	(25)
Not known	49	-	(16)
TOTAL	305		(100)

Table 3.16 Distribution of incidents by month

Month	No.	%
January	22	(7)
February	17	(6)
March	17	(6)
April	27	(9)
May	28	(9)
June	26	(9)
July	36	(12)
August	35	(12)
September	25	(8)
October	25	(8)
November	28	(9)
December	19	(6)
TOTAL	305	(100)

Table 3.17 Time between date of incident and date of sentence (months)

Months	No.	Average per month	%
Up to 3 months pre-sentence	4	1.3	(3)
Up to 1 month post-sentence	29	29.0	(22)
Over 1 month up to 2 months	18	18.0	(14)
Over 2 months up to 3	11	11.0	(8)
Over 3 months up to 6	16	5.3	(12)
Over 6 months up to 8	10	5.0	(8)
Over 8 months up to 12	12	3.0	(9)
Over 12 months up to 24	19	1.6	(15)
Over 24 months	5	-	(4)
Not known	6		(5)
TOTAL	130		(100)

Table 3.18 Time between date of incident and Earliest Date of Release (months)

Months	No.	%
Within 2 months of EDR	17	(13)
Over 2 months up to 4	16	(12)
Over 4 months up to 6	7	(5)
Over 6 months up to 12	20	(15)
Over 12 months up to 24	19	(15)
Over 24 months up to 36	14	(11)
Over 36 months	10	(8)
Up to 12 months post EDR	2	(2)
Not known	25	(19)
TOTAL	130	(100)

Table 3.19 Time between date of incident and Parole Eligibility Date (PED) (months)

Months	No.	%
Up to 2 before PED	9	(16)
Over 2 months up to 6	12	(21)
Over 6 up to 12 months	14	(25)
Over 12 months before PED	8	(14)
Up to 18 months post PED	13	(23)
TOTAL	56*	(99)**

* Where applicable and known. ** Rounding errors

Table 3.20 Time between date of incident and date of arrival in establishment (weeks)

Weeks	No.	Weekly rate of sample	%
Up to and incl 1 week	54	54	(18)
Over 1 week up to 2	23	23	(8)
Over 2 weeks up to 3	16	16	(5)
Over 3 weeks up to 4	13	13	(4)
Over 4 weeks up to 12	82	10.3	(27)
Over 12 weeks up to 52	70	1.8	(23)
Over 52 weeks	16	-	(5)
Not known	31		(10)
TOTALS	305		(101)*

*Rounding errors

Table 3.21 Location of incident

Location	No.	%
'Normal location' - single cell	102	(34)
'Normal location' - shared cell	124	(41)
Hospital	44	(15)
Segregation block	19	(6)
Other locations	15	(5)
Not known	1	(-)
TOTAL	305	(101)*

*Rounding errors

Table 3.22 Submission of Form F1997

	Prisoners		Incidents	
Yes	114	(46)	138	(45)
No	80	(32)	98	(32)
Not known	54	(22)	69	(23)
TOTALS	248	(100)	305	(100)

Table 3.23 Type of treatment administered (for incidents)

Treatment	No.	%	N
None/minimal	139	(48)	288
Plaster only	43	(15)	288
Steri-strip	52	(18)	287
Sutures	37	(13)	286
Transfer to prison with full medical cover	14	(5)	287
Outside hospitalization	24	(8)	287

Table 3.24 Action taken

Type of action taken	No.	%	N
Located in seclusion/unfurnished room	132	(45)	291
Referal to psychiatrist	87	(29)	291
Located in hospital room	67	(23)	291
Placed on special watch	46	(16)	296
Placed in shared accommodation	28	(9)	296
Located in hospital ward	27	(9)	290

Table 3.25 Any previous attempts or incidents?

	Prisoners	
	No.	%
Yes	111	(45)
No	112	(45)
Not known	25	(10)
TOTAL	248	(100)

Table 3.26 Number of previous incidents

	Prisoners	
	No.	%
Single	19	(17)
Multiple	50	(45)
Not known	42	(38)
TOTAL	111	(100)

Table 3.27 Previous incident in custody

	Prisoners	
	No.	%
Yes	72	(65)
No	22	(20)
Not known	17	(15)
TOTAL	111	(100)

Table 3.28 Time between current and most recent previous incident

Time interval	Prisoners		Incidents	
	No.	%	No.	%
Up to and including 7 days	10	(14)	27	(22)
Over 1 up to 4 weeks	10	(14)	24	(19)
Over 4 up to 12 weeks	14	(19)	26	(21)
Over 12 weeks	20	(28)	23	(19)
Not known	18	(25)	24	(19)
TOTAL	72	(100)	124	(100)

Table 3.29 In receipt of medical/psychiatric treatment at time of incident

	Prisoners		Incidents	
	No.	%	No.	%
Yes	83	(34)	119	(39)
No	119	(48)	137	(45)
Not known	46	(19)	49	(16)
TOTAL	248	(101)	305	(100)

Table 3.30 Time between date of incident and visit to Medical Officer (days

Days	Prisoners		Incidents	
	No.	%	No.	%
Within last 7 days	78	(32)	101	(33)
8 - 28 days	31	(13)	36	(12)
Over 28 days	19	(8)	24	(8)
Not known	120	(48)	144	(47)
TOTAL	248	(101)	305	(100)

Table 3.31 Brief details of medical history considered relevant

Items	Prisoners(N=248)		Incidents(N=305)	
	No.	%	No.	%
Previous self injury/ suicide attempts/threats	85	(34)	107	(35)
Current psychiatric illness/ possible illness	35	(14)	53	(17)
Previous psychiatric history	38	(15)	53	(17)
Personality disorders or inadequacies	28	(11)	34	(11)
Other possible risk indicators	29	(12)	34	(11)
Current serious/chronic medical illness	15	(16)	22	(7)
Drug/alcohol abuse/addiction	17	(7)	21	(7)

Table 3.32 Reasons for incident*

	Incidents (n=305)				Prisoners (n=248)			
	Prisoner		Staff		Prisoner		Staff	
	No.	%	No.	%	No.	%	No.	%
Domestic								
Break-up/threatened break-up of relationship	29	(10)	24	(8)	27	(11)	20	(8)
Domestic problems	21	(7)	15	(5)	18	(7)	13	(5)
Contact problems	20	(7)	18	(6)	18	(7)	14	(6)
Bereavement/serious family illness	6	(2)	8	(3)	6	(2)	8	(3)
Situational								
Relating to charges/offences	15	(5)	19	(6)	14	(6)	16	(6)
System frustrations	50	(16)	64	(21)	41	(17)	57	(23)
Upset at being in prison	13	(4)	12	(4)	11	(4)	10	(4)
Pressure/victimization/bullying	45	(15)	42	(14)	40	(16)	36	(15)
Unable to cope	23	(8)	25	(8)	15	(6)	19	(8)
Strategic								
Regime frustrations	29	(10)	17	(6)	24	(10)	16	(7)
Relating to changes in location	25	(9)	56	(20)	19	(8)	47	(19)
Wants practical help	5	(2)	4	(1)	5	(2)	4	(2)
Attention seeking behaviour	4	(1)	33	(12)	3	(1)	25	(10)
Manipulative	2	(-)	51	(18)	2	(1)	38	(15)
Emotional								
Seeking sympathy/care/support	1	(-)	6	(2)	-	(-)	5	(2)
Depressed/fed up	56	(18)	30	(10)	52	(21)	26	(11)
Frustration/anger/tension	22	(7)	27	(9)	18	(7)	22	(9)
Communicating distress/ cry for help	2	(-)	15	(5)	2	(1)	10	(4)
Emotional relief	2	(-)	5	(2)	1	(-)	3	(1)
Fear	9	(3)	8	(3)	9	(4)	8	(3)
Medical								
Mental illness	12	(4)	24	(8)	9	(4)	18	(7)
Drug/alcohol related	8	(3)	10	(3)	7	(3)	8	(3)
Medical problems	9	(3)	9	(3)	6	(2)	6	(2)

Table 3.32 (Cont.)

Other								
Wanted to die	27	(9)	12	(4)	21	(9)	9	(4)
Personal inadequacies	3	(1)	45	(15)	3	(1)	34	(14)
Other1	20	(7)	20	(7)	15	(6)	16	(6)
Don't know/denies/ no reason given	33	(11)	11	(4)	24	(10)	11	(4)

* Missing in 22 incident cases and 18 prisoner cases. 1. Very small numbers = boredom, guilt, lack of support/attention, and 'other'

Table 3.33 Respondent's risk assessment of incident

Degree of risk	Prisoners		Incidents	
	No.	%	No.	%
Risk of suicide	54	(22)	68	(22)
Possible risk	111	(45)	138	(45)
No risk	75	(30)	90	(30)
Not known	8	(3)	9	(3)
TOTAL	248	(100)	305	(100)

TABLES FOR CHAPTER FOUR

Table 4.1 Age

	subject group		comparison group	
	No.	%	No.	%
16 - 17 years	7	(11)	1	(1)
18 - 20 years	14	(23)	5	(6)
21 - 25 years	12	(19)	29	(36)
26 - 36 years	19	(31)	30	(38)
37 years and over	10	(16)	15	(19)
TOTAL	62	(100)	80	(100)

Chi-square=17.28 df=4 p<.002

Table 4.2 Age: young prisoners and adults

	subject group		comparison group	
	No.	%	No.	%
Young Prisoners	21	(34)	6	(8)
Adults	41	(66)	74	(92)
TOTAL	62	(100)	80	(100)

Chi-square=14.10 df=1 p<.0002
(with Yates' correction)

Table 4.3 Ethnic origin

	subject group		comparison group	
	No.	%	No.	%
White British	57	(92)	64	(81)
Black British	0	-	5	(6)
Other Black	2	(3)	3	(4)
Other White	3	(5)	7	(9)
TOTAL	62	(100)	79	(100)

Chi-square=5.23 df=3 n.sig.

1 missing

Table 4.4 Status of interviewee

	subject group		comparison group	
	No.	%	No.	%
Remanded	30	(48)	30	(38)
Convicted awaiting sentence	2	(3)	4	(5)
Sentenced	30	(48)	46	(58)
TOTAL	62	(99)	80	(101)
	Chi-square=1.78 df=2 n.sig.			

Table 4.5 Number of charges/offences

	subject group		comparison group	
	No.	%	No.	%
1	14	(23)	17	(21)
2	16	(26)	26	(33)
3-5	22	(36)	22	(28)
6+	9	(15)	15	(19)
TOTAL	61	(100)	80	(101)
	Chi-square=1.64 df=3 n.sig.			

1 missing observation

Table 4.6 Main charge/offence type

	subject group		comparison group	
	No.	%	No.	%
Murder	5	(8)	3	(4)
Manslaughter	1	(2)	3	(4)
Violence	14	(23)	21	(26)
Sexual	18	(29)	18	(23)
Robbery	5	(8)	11	(14)
Burglary	12	(19)	12	(15)
Theft	3	(5)	7	(9)
Fraud	0	–	1	(1)
Arson	4	(7)	0	–
Drug offences	0	–	2	(3)
Other offences	0	–	2	(3)
TOTAL	62	(101)	80	(101)

Chi-square=13.69 df=10 n.sig.

Table 4.7 Main charge/offence type: adults only

	subject group		comparison group	
	No.	%	No.	%
Murder	4	(10)	3	(4)
Manslaughter	1	(2)	3	(4)
Violence	9	(22)	19	(26)
Sexual	16	(39)	16	(22)
Robbery	1	(2)	11	(15)
Burglary	8	(20)	11	(15)
Theft	0	–	6	(8)
Fraud	0	–	1	(1)
Arson	2	(5)	0	–
Drug offences	0	–	2	(3)
Other offences	0	–	2	(3)
TOTAL	41	(100)	74	(101)

Chi-square=18.58 df=10 p<.05

Table 4.8 Pleas (remanded and convicted awaiting sentence interviewees)

	subject group		comparison group	
	No.	%	No.	%
Guilty	14	(44)	16	(47)
Not guilty	8	(25)	7	(21)
Both	9	(28)	11	(32)
Other	1	(3)	0	-
TOTAL	32	(100)	34	(100)
	Chi-square=1.34 df=3 n.sig.			

Table 4.9 Court

	subject group		comparison group	
	No.	%	No.	%
Crown court	45	(73)	53	(66)
Magistrates	7	(11)	7	(9)
Both	9	(15)	19	(24)
Other	1	(2)	1	(2)
TOTAL	62	(101)	80	(101)
	Chi-square=1.97 df=3 n.sig.			

Table 4.10 Why Crown Court*

	subject group		comparison group	
	No.	%	No.	%
Nature of charge	42	(78)	49	(67)
Magistrates direction	9	(17)	16	(22)
Own choice, more lenient	3	(6)	5	(7)
Other	0	-	3	(4)
TOTAL	54	(101)	73	(100)
1 missing	Chi-square=3.23 df=3 n.sig.			

* Excludes 14 who had or were only appearing in Magistrates Court

Table 4.11 Alcohol consumption or drug usage within 24 hrs of charge/offence

	subject group		comparison group	
	No.	%	No.	%
Alcohol:				
No	35	(58)	37	(48)
Yes, no effect	3	(5)	6	(8)
Yes, affected	22	(37)	34	(44)
TOTAL	60	(100)	77	(100)
	Chi-square=1.54 df=2 n.sig.			
Drugs:				
No	35	(58)	62	(81)
Yes, no effect	4	(7)	2	(3)
Yes, affected	20	(33)	13	(17)
Other	1	(2)	0	-
TOTAL	60	(100)	77	(101)
	Chi-square=8.69 df=3 p<.05			

5 missing

Table 4.12 Alcohol consumption or drug usage within 24 hrs of charge/offence: young prisoners

	subject group		comparison group	
	No.	%	No.	%
Alcohol:				
No	11	(52)	2	(33)
Yes, no effect	1	(5)	0	(-)
Yes, affected	9	(43)	4	(67)
TOTAL	21	(100)	6	(100)
	Chi-square=1.19 df=2 n.sig.			
Drugs:				
No	10	(48)	5	(83)
Yes, no effect	1	(5)	0	-
Yes, affected	10	(48)	1	(17)
TOTAL	21	(101)	6	(100)
	Chi-square=2.45 df=2 n.sig.			

Table 4.13 Alcohol consumption or drug usage within 24 hrs of charge/offence: adults

	subject group		comparison group	
	No.	%	No.	%
Alcohol:				
No	24	(62)	35	(49)
Yes, no effect	2	(5)	6	(9)
Yes, affected	13	(33)	30	(42)
TOTAL	39	(100)	71	(100)
	Chi-square=1.60 df=2 n.sig.			
Drugs:				
No	25	(64)	57	(80)
Yes, no effect	3	(8)	2	(3)
Yes, affected	10	(25)	12	(17)
Other	1	(2)	0	-
TOTAL	39	(99)	71	(100)
5 missing	Chi-square=4.98 df=3 n.sig.			

Table 4.14 Days in police custody

	subject group		comparison group	
	No.	%	No.	%
None	4	(7)	6	(8)
1-3 days	39	(63)	46	(58)
4+ days	19	(31)	27	(34)
TOTAL	62	(101)	79	(100)

Chi-square=0.32 df=2 n.sig.

1 missing

Table 4.15 Opinion of police custody*

	subject group		comparison group	
	No.	%	No.	%
No opinion	0	-	1	(1)
Negative:				
conditions	6	(11)	13	(18)
emotions	13	(23)	9	(13)
treatment	8	(14)	10	(14)
other	12	(21)	13	(18)
Neutral/indifferent	15	(26)	21	(29)
Positive	2	(4)	5	(7)
Other	1	(2)	0	-
TOTAL	57	(101)	72	(100)

Chi-square=6.19 df=7 n.sig.

* Excludes 10 who had not spent time in police custody
3 missing

Table 4.16 Any bail

	subject group		comparison group	
	No.	%	No.	%
No	34	(55)	37	(46)
Yes	28	(45)	40	(50)
Other	0	-	3	(4)
TOTAL	62	(100)	80	(100)
	Chi-square=3.01 df=2 n.sig.			

Table 4.17 Why remanded in custody*

	subject group		comparison group	
	No.	%	No.	%
Police	6	(11)	16	(26)
Psychiatric reports	1	(2)	2	(3)
No hostel available	1	(2)	0	-
Re-offended on bail	19	(33)	14	(23)
Nature of offence	20	(35)	22	(35)
Other	10	(18)	8	(13)
TOTAL	57	(101)	62	(100)
	Chi-square=6.76 df=5 n.sig.			

* Excludes 21 who were not remanded in custody
2 missing

Table 4.18 Number of remand centres

	subject group		comparison group	
	No.	%	No.	%
None	4	(7)	17	(22)
One	48	(77)	52	(66)
Two+	10	(16)	10	(13)
TOTAL	62	(100)	79	(101)
	Chi-square=6.25 df=2 p<0.05			

1 missing

Table 4.19 Number of remand centres: young prisoners

	subject group		comparison group	
	No.	%	No.	%
None	1	(5)	0	-
One	19	(90)	6	(100)
Two+	1	(5)	0	-
TOTAL	21	(100)	6	(100)
	Chi-square=0.62 df=2 n.sig.			

Table 4.20 Number of remand centres: adults

	subject group		comparison group	
	No.	%	No.	%
None	3	(7)	17	(24)
One	29	(71)	46	(63)
Two+	9	(22)	10	(14)
TOTAL	41	(100)	73	(101)
	Chi-square=5.13 df=2 p<0.10			

Table 4.21 Why transferred on remand

	subject group		comparison group	
	No.	%	No.	%
Administrative	5	(50)	8	(80)
Full hospital cover	2	(20)	0	-
Other	3	(30)	2	(20)
TOTAL	10	(100)	10	(100)
	Chi-square=2.89 df=2 n.sig.			

Table 4.22 Length of time on remand*

	subject group		comparison group	
	No.	%	No.	%
None	2	(7)	9	(20)
Up to 12 weeks	9	(30)	15	(33)
13-24 weeks	13	(43)	11	(24)
25+ weeks	6	(20)	11	(24)
TOTAL	30	(100)	46	(101)
	Chi-square=4.42 df=3 n.sig.			

* Only asked of sentenced prisoners

Table 4.23 Opinion of remand*

	subject group		comparison group	
	No.	%	No.	%
Devastating	5	(19)	2	(7)
Difficult	13	(50)	14	(47)
OK/indifferent	8	(31)	14	(47)
TOTAL	26	(100)	30	(101)
	Chi-square=2.69 df=2 n.sig.			

* Only asked of sentenced prisoners who had spent time on remand
9 missing

Table 4.24 Any contact with probation, solicitor or police*

	subject group		comparison group	
	No.	%	No.	%
None	6	(19)	9	(26)
Probation	3	(10)	5	(15)
Solicitor	12	(39)	5	(15)
Probation+Solicitor	7	(23)	10	(29)
Police+Solicitor	2	(6)	3	(9)
All	1	(3)	1	(3)
Other	0	-	1	(3)
TOTAL	31	(100)	34	(100)

Chi-square=5.59 df=6 n.sig.

* Only asked of 66 on remand or convicted awaiting sentence
1 missing

Table 4.25 Has any of that contact been useful*

	subject group		comparison group	
	No.	%	No.	%
No	6	(24)	6	(24)
Yes-practical legal	10	(40)	15	(60)
Yes-welfare, support, counselling	5	(20)	2	(8)
Yes-mixture of welfare support, counselling and practical family help	4	(16)	2	(8)
TOTAL	25	(100)	25	(100)

Chi-square=2.95 df=3 n.sig.

* Only asked of those who had had any contact

Table 4.26 Sentence/outcome expected*

	subject group		comparison group	
	No.	%	No.	%
CSO	1	(3)	1	(3)
Probation	0	-	2	(6)
Custody	23	(70)	22	(67)
Walk out-technical	0	-	1	(3)
Walk out- no sentence	1	(3)	3	(9)
Hospital	2	(6)	0	-
Other	1	(3)	2	(6)
Don't know	5	(15)	2	(6)
TOTAL	33	(100)	33	100)
	Chi-square=7.64 df=7 n.sig.			

* Only asked of remands and convicted and awaiting sentence

Table 4.27 Length of sentence expected*

	subject group		comparison group	
	No.	%	No.	%
>1 - <4 years	13	(62)	11	(52)
>4 years	6	(29)	9	(43)
Life/HMP	2	(10)	1	(5)
TOTAL	21	(101)	21	(100)
	Chi-square=1.1 df=2 n.sig.			

* Only asked of the 45 expecting custody
3 missing

Table 4.28 How would you feel about that*

	subject group		comparison group	
	No.	%	No.	%
Devastated	7	(30)	6	(27)
Upset	7	(30)	5	(23)
Indifferent	8	(35)	8	(36)
Positive	0	–	1	(5)
Mixed	0	–	2	(9)
Other	1	(4)	0	–
TOTAL	23	(99)	22	(100)

Chi-square=4.39 df=5 n.sig.

* Only asked of those expecting custody

Table 4.29 Length of sentence received*

	subject group		comparison group	
	No.	%	No.	%
<12 months	2	(7)	6	(13)
>1 - <4 years	8	(27)	13	(28)
>4 years	18	(60)	24	(52)
Life/HMP	2	(7)	3	(7)
TOTAL	30	(101)	46	(100)

Chi-square=.92 df=3 n.sig.

Table 4.30 Reaction to sentence

	subject group		comparison group	
	No.	%	No.	%
Shock, devastated	13	(43)	18	(38)
Harder than expected	5	(17)	10	(21)
Expected	4	(13)	11	(23)
Lenient	6	(20)	6	(13)
Other	2	(7)	2	(4)
TOTAL	30	(100)	47	(99)
	Chi-square=2.09 df=4 n.sig			

Table 4.31 Prefer sentenced or prefer remand

	subject group		comparison group	
	No.	%	No.	%
No preference	7	(27)	6	(20)
Prefer remand	9	(35)	9	(30)
Prefer sentenced	10	(38)	15	(50)
TOTAL	26	(100)	30	(100)
	Chi-square=0.81 df=2 n.sig.			

Only asked of sentenced prisoners not all of whom had been remanded

Table 4.32 Reasons for preference

	subject group		comparison group	
	No.	%	No.	%
Know where you are	7	(37)	9	(35)
Less bang up	0	-	2	(8)
Facilities	5	(26)	11	(42)
Mixture	1	(5)	4	(15)
Other	6	(32)	0	-
TOTAL	19	(100)	26	(100)
	Chi-square=11.49 df=4 p<0.05			

Table 4.33 Uncertainties of sentence

	subject group		comparison group	
	No.	%	No.	%
Parole?*				
None	9	(36)	28	(68)
1 refusal	8	(32)	4	(10)
2 refusals	0	–	1	(2)
Not heard	6	(24)	5	(12)
Other	2	(8)	3	(7)
TOTAL	25	(100)	41	(99)
	Chi-square=9.033 df=4 p<0.10			
*Asked of 66 eligible for parole				
Outstanding charges				
None	47	(80)	68	(87)
Yes	11	(19)	8	(10)
Other	1	(2)	2	(3)
TOTAL	59	(101)	78	(100)
	Chi-square=2.05 df=2 n.sig.			
5 missing				
Appeal				
No appeal	22	(73)	23	(50)
Yes-successful	2	(7)	3	(7)
Yes-refused	2	(7)	10	(22)
Not heard	2	(7)	6	(13)
Other	2	(7)	4	(9)
TOTAL	30	(101)	46	(101)
	Chi-square=5.08 df=4 n.sig.			

Table 4.37 Reasons for preferring particular prison

	subject group		comparison group	
	No.	%	No.	%
Close to home	2	(12)	2	(7)
Facilities	5	(29)	18	(58)
Prefer staff attitude	2	(12)	1	(3)
Mixture	6	(35)	7	(23)
Other	2	(12)	3	(10)
TOTAL	17	(100)	31	(101)

Chi-square=4.24 df=4 n.sig.

Table 4.38 Previous convictions and sentences

		subject group		comparison group	
		No.	%	No.	%
Previous convictions?	None	7	(13)	6	(8)
	1-5	16	(29)	15	(20)
	6-10	4	(7)	9	(12)
	11+	28	(51)	45	(60)
	TOTAL	55	(100)	75	(100)

Chi-square=2.98 df=3 n.sig.

Previous custodial sentences?	None	27	(44)	23	(29)
	One	7	(12)	9	(11)
	Two	3	(5)	11	(14)
	Three+	24	(39)	36	(46)
	TOTAL	61	(100)	79	(100)

Chi-square=5.32 df=3 n.sig.

2 missing

Table 4.39 Age at first conviction

	subject group		comparison group	
	No.	%	No.	%
8-12 years	9	(17)	11	(15)
13-17 years	33	(61)	43	(61)
18+ years	12	(22)	17	(24)
TOTAL	54	(100)	71	(100)

Chi-square=0.07 df=2 n.sig.

Table 4.40 Age at first caution

	subject group		comparison group	
	No.	%	No.	%
7 years	1	(3)	0	–
8–12 years	15	(50)	20	(51)
13–17 years	12	(40)	15	(39)
18+ years	2	(7)	4	(10)
TOTAL	30	(100)	39	(100)
	Chi-square=1.57 df=3 n.sig.			

Excludes 73 no cautions, don't know
1 missing

Table 4.41 Number of cautions

	subject group		comparison group	
	No.	%	No.	%
None	27	(49)	32	(44)
1–2	9	(16)	32	(44)
3+	19	(35)	8	(11)
TOTAL	55	(100)	72	(99)
	Chi-square=15.82 df=2 p<0.0005			

Excludes 13 don't know
2 missing

Table 4.42 Number of cautions YPs

	subject group		comparison group	
	No.	%	No.	%
None	4	(24)	2	(33)
1–2	4	(24)	2	(33)
3+	9	(53)	2	(33)
TOTAL	17	(101)	6	(99)
	Chi-square=0.68 df=2 n.sig.			

Table 4.43 Number of cautions adults

	subject group		comparison group	
	No.	%	No.	%
None	23	(61)	30	(45)
1-2	5	(13)	30	(45)
3+	10	(26)	6	(9)
TOTAL	38	(100)	66	(99)

Chi-square=13.20 df=2 p<0.002

Table 4.44 Previous main offence type

	subject group		comparison group	
	No.	%	No.	%
Violence	21	(42)	39	(52)
Sexual	9	(18)	7	(9)
Robbery	3	(6)	3	(4)
Burglary	14	(28)	15	(20)
Theft	3	(6)	7	(9)
Fraud	0	-	2	(3)
Arson	0	-	1	(1)
Criminal Damage	0	-	1	(1)
TOTAL	50	(100)	75	(99)

Chi-square=6.55 df=7 n.sig.

Table 4.45 Time at liberty since last sentence*

	subject group		comparison group	
	No.	%	No.	%
0	1	(3)	0	-
1-3 mths	10	(27)	7	(12)
4-12 mths	11	(30)	22	(38)
13+ mths	15	(41)	29	(50)
TOTAL	37	(101)	58	(100)

Chi-square=5.27 df=3 n.sig.

* Excludes those who had not been in custody

Table 4.46 Schooling

		subject group		comparison group	
		No.	%	No.	%
How old were you when you left school?	<15	5	(8)	9	(11)
	15	25	(41)	27	(34)
	16	24	(39)	33	(41)
	17+	4	(7)	4	(5)
	Other	3	(5)	7	(9)
	TOTAL	61	(100)	80	(100)
		Chi-square=1.71 df=4 n.sig.			
1 missing					
Were you ever expelled or excluded?	No	31	(51)	48	(60)
	Yes	23	(38)	28	(35)
	Other	7	(11)	4	(5)
	TOTAL	61	(100)	80	(100)
		Chi-square=2.45 df=2 n.sig.			
Note: 67% SG and 33% CG YPs expelled or excluded cf 23% SG and 35% CG adults					
1 missing					
Qualifications?	None	44	(72)	61	(77)
	CSEs (only)	8	(13)	6	(8)
	<5 O's(+CSEs)	5	(8)	4	(5)
	5+ O's	0	-	3	(4)
	A levels	2	(3)	3	(4)
	Other	2	(3)	2	(3)
	TOTAL	61	(99)	79	(101)
		Chi-square=4.10 df=5 n.sig.			
2 missing					
Any qualifications since leaving school?	No	36	(59)	38	(48)
	Yes	25	(41)	42	(52)
	TOTAL	61	(100)	80	(100)
		Chi-square=1.84 df=1 n.sig.			
1 missing					

Table 4.46 (Cont.)

Truancy?	None	18 (30)	19 (24)
	Less than 10 days	9 (15)	7 (9)
	Less than 4 weeks	3 (5)	7 (9)
	More than 4 weeks	31 (51)	42 (53)
	Other	0 -	5 (6)
	TOTAL	61 (101)	80(101)

Chi-square=6.08 df=4 n.sig.

Note: 68% YPs cf 48% adults truanted more than 4 weeks per year

1 missing

Reasons?	Bored	15 (36)	33 (58)
	Friends	2 (5)	7 (12)
	Both	3 (7)	2 (4)
	Problems	19 (45)	8 (14)
	Other	3 (7)	7 (12)
	TOTAL *	42 (100)	57(100)

Chi-square=13.85 df=4 p=<0.01

Note: There was no significant difference between the YP groups

Excludes 37 who didn't truant
5 missing

Adults only Reasons?	Bored	9 (33)	30 (59)
	Friends	2 (7)	6 (12)
	Both	2 (7)	2 (4)
	Problems	12 (44)	7 (14)
	Other	2 (7)	6 (12)
	TOTAL	27 (99)	51(101)

Chi-square=10.21 df=4 p=<0.05

Table 4.47 Experience of violence at school

	subject group		comparison group	
	No.	%	No.	%
None	18	(30)	32	(40)
Minor (fights)	6	(10)	19	(24)
Bullied	19	(32)	8	(10)
Picked fights	12	(20)	13	(16)
Both bullied and fights	5	(8)	6	(8)
Other	0	-	2	(3)
TOTAL	60	(100)	80	(101)

Chi-square=14.74 df=5 p<0.02

Note: 24% of SG and 50% CG YPs answered no to this question there was no significant difference overall between the two groups

1 missing

Violence at school: adults only

None	13	(33)	29	(39)
Minor (fights)	4	(10)	38	(24)
Bullied	13	(33)	7	(10)
Picked fights	6	(15)	13	(18)
Both bullied and fights	3	(8)	5	(7)
Other	0	-	2	(3)
TOTAL	39	(99)	74	(101)

Chi-square=12.21 df=5 p<0.05

Table 4.48 Local authority care

		subject group		comparison group	
		No.	%	No.	%
Any local authority care?	None	30	(48)	49	(61)
	Yes	32	(52)	31	(39)
	TOTAL	62	(100)	80	(100)
		Chi-square=2.34 df=1 n.sig.			
YPs only: Any local authority care?	None	8	(38)	4	(67)
	Yes	13	(62)	2	(33)
	TOTAL	21	(100)	6	(100)
		Chi-square=1.54 df=1 n.sig.			
Adults only: Any local authority care?	None	22	(54)	45	(61)
	Yes	19	(46)	29	(39)
	TOTAL	31	(100)	74	(100)
		Chi-square=0.55 df=1 n.sig.			
Reasons given?	Criminal behaviour	3	(9)	10	(32)
	Family problems	17	(53)	5	(16)
	Behavioural	5	(16)	7	(23)
	Mixture	3	(9)	9	(29)
	Other	3	(9)	0	-
	Don't Know	1	(3)	0	-
	TOTAL	32	(99)	31	(100)
		Chi-square=17.64 df=5 p<0.01			

Table 4.49 Employment and unemployment

		subject group		comparison group	
		No.	%	No.	%
How many jobs in last two years?	None	8	(13)	7	(9)
	One	17	(28)	19	(24)
	Two	3	(5)	5	(6)
	Three	6	(10)	2	(3)
	Several	12	(20)	13	(17)
	Not out for 2 years no work	3	(5)	10	(13)
	Not out for 2 years some work	7	(12)	21	(27)
	Other	5	(8)	1	(1)
	TOTAL	61	(101)	78	(100)
		Chi-square=14.29 df=7 p<0.05			
3 missing					
Types of jobs?	Managerial/professional	2	(4)	2	(3)
	Skilled manual	6	(11)	9	(14)
	Semi/unskilled manual	25	(47)	24	(38)
	Sales/services	6	(11)	6	(9)
	Self-employed	0	-	2	(3)
	YTS	6	(11)	4	(6)
	Casual	4	(8)	14	(22)
	Other	4	(8)	3	(6)
	TOTAL*	53	(100)	64	(101)
		Chi-square=7.75 df=7 n.sig.			
* Excludes those who hadn't worked in last two years					
How much unemployment in last two years?	None	13	(22)	11	(15)
	All the time	8	(14)	14	(18)
	<Half the time	15	(26)	16	(21)
	Half the time	6	(10)	9	(12)
	>Half the time	9	(16)	18	(24)
	Other	7	(12)	8	(11)
	TOTALS	58	(100)	76	(101)
		Chi-square=3.14 df=5 n.sig.			
8 missing					

Table 4.49 (Cont.)

What were you doing when you came in here?	Unemployed	31 (50)	45 (58)
	School	0 –	2 (3)
	Employed	17 (27)	23 (30)
	Scheme	3 (5)	1 (1)
	Other	11 (18)	7 (9)
	TOTAL	62 (100)	78 (101)
		Chi-square=5.61 df=4 n.sig.	

2 missing

Table 4.50 Accommodation

		subject group		comparison group	
		No.	%	No.	%
Where were you living before prison	N.F.A.	4	(7)	4	(5)
	Own home	23	(37)	42	(53)
	Parent(s)	16	(26)	13	(17)
	Siblings	1	(2)	3	(4)
	Friend(s)	7	(11)	5	(6)
	Relatives	2	(3)	3	(4)
	Lodgings/ Hostel	6	(10)	6	(8)
	Other	3	(5)	3	(4)
	TOTAL	62	(101)	79	(101)
		Chi-square=5.43 df=7 n.sig.			

Note: No YPs living in their own home, 56% were living with their parents
57% adults living in their own home, 12% with parents

1 missing

How far away is that from here?	0–50 miles	36 (58)	49 (61)
	51–100 miles	12 (20)	18 (23)
	101–150 miles	6 (10)	4 (5)
	151–200 miles	2 (3)	2 (3)
	200+	4 (7)	7 (9)
	Other	2 (3)	0 –
	TOTAL	62 (101)	80 (101)
		Chi-square=4.19 df=5 n.sig.	

Note: 67% SG YPs and 83% CG YPs living within 50 miles of home cf 54% SG and 60% CG adults

Table 4.50 (Cont.)

How long lived at previous address?	<3 mths.	16 (26)	17 (22)
	>3 mths. <6 mths.	8 (13)	11 (14)
	>6 mths. <1 year	5 (8)	13 (17)
	>1 year <3 years	9 (15)	16 (20)
	3-5 years	6 (10)	6 (8)
	5-10 years	7 (11)	4 (5)
	10+ years	5 (8)	4 (5)
	All life	6 (10)	8 (10)
	TOTAL	62 (101)	79 (101)
		Chi-square=.26 df=7 n.sig.	

Note: 22% YPs cf 7% adults had lived at previous address All Life

1 missing

How long lived in same area?	<3 years	6 (10)	20 (25)
	>3 years <life	16 (26)	23 (29)
	All life	40 (65)	37 (46)
	TOTAL	62 (101)	80 (100)
		Chi-square=6.74 df=2 p<0.05	

Note: 85% YPs cf 47% adults had lived in area All Life

Address going out to?	Same	18 (29)	30 (38)
	Different	11 (18)	15 (19)
	Hostel	3 (5)	5 (6)
	NFA	18 (29)	22 (28)
	DK/Decision not made yet	12 (19)	8 (10)
	TOTAL	62 (100)	80 (101)
		Chi-square=3.08 df=4 n.sig.	

Who are you going to live with?	No-one	13 (21)	20 (25)
	Parents	17 (27)	14 (18)
	Girlfriend	8 (13)	12 (15)
	Relatives	2 (3)	5 (6)
	Wife (and children)	4 (7)	5 (6)
	Friends	2 (3)	3 (4)
	Don't know	10 (16)	20 (25)
	Other	6 (10)	1 (1)
	TOTAL	62 (100)	80 (99)
		Chi-square=8.94 df=7 n.sig.	

Table 4.51 Family situation

		subject group		comparison group	
		No.	%	No.	%
Marital status?	Single	36	(58)	28	(35)
	Married	9	(15)	13	(17)
	Cohabiting	8	(13)	20	(25)
	Separated	0	–	4	(5)
	Divorced	4	(6)	10	(13)
	Widowed	1	(2)	0	–
	Other	4	(6)	4	(5)
	TOTAL	62	(100)	79	(100)

Chi-square=12.57 df=6 p<0.10

Note: 89% of the YPs were single cf 35% of the adults

1 missing

Any change of status since custody?	None	44	(71)	58	(73)
	Separated	7	(11)	10	(13)
	Divorced/ing	7	(11)	9	(11)
	Widowed	2	(3)	0	–
	Married	0	–	1	(1)
	Other	2	(3)	1	(1)
	TOTAL	62	(99)	79	(99)

Chi-square=3.75 df=5 n.sig.

1 missing

Do you have any children?	Yes	32	(52)	47	(59)
	No	30	(48)	33	(41)
	TOTAL	62	(100)	80	(100)

Chi-square=.72 df=1 n.sig.

Note: 70% of YPs had no children cf 38% adults

How old are your children?	All under 10	20	(63)	33	(70)
	>10 - <18	4	(13)	1	(2)
	Both	2	(6)	4	(9)
	18+	2	(6)	4	(9)
	Mixed	3	(9)	4	(9)
	Other	1	(3)	1	(2)
	TOTAL	32	(100)	47	(101)

Chi-square=3.75 df=5 n.sig.

Table 4.51 (Cont.)

Do you have a girlfriend?	No	34	(55)	44	(55)
	Had but Dear John	12	(19)	7	(9)
	Yes	11	(18)	28	(35)
	Homosexual	1	(2)	0	-
	Other	4	(7)	1	(1)
	TOTAL	62	(101)	80	(100)
	Chi-square=10.70 df=4 p<0.05				
Do you still have contact with your mother?	Yes	38	(62)	46	(58)
	Yes, but remote	12	(20)	19	(24)
	Deceased before age of 16	1	(2)	6	(8)
	Deceased	7	(12)	7	(9)
	No contact	3	(5)	1	(1)
	TOTAL	61	(101)	79	(100)
	Chi-square=4.68 df=4 n.sig.				
2 missing					
With your Father?	Yes	23	(38)	42	(53)
	Yes, but remote	24	(39)	21	(26)
	Deceased before age of 16	3	(5)	7	(9)
	Deceased	7	(12)	8	(10)
	No contact	4	(7)	2	(3)
	TOTAL	61	(101)	80	(101)
	Chi-square=5.63 df=4 n.sig.				
1 missing					
Number of siblings?	None	11	(18)	9	(12)
	One	8	(13)	10	(13)
	Two	13	(22)	21	(27)
	Three	10	(17)	13	(17)
	Four-Five	11	(18)	12	(15)
	Six-Seven	5	(8)	8	(10)
	Eight or more	2	(3)	5	(6)
	TOTAL	60	(99)	78	(100)
	Chi-square=2.41 df=6 n.sig.				
4 missing					

Table 4.51 (Cont.)

Any other relatives you have contact with?	Yes	18	(30)	23	(29)
	Yes, but remote	0	–	5	(6)
	No	42	(70)	52	(65)
	TOTALS	60	(100)	80	(100)
		Chi-square=3.90 df=2 n.sig.			
2 missing					
Do you have a stepmother?	No	53	(88)	65	(81)
	Yes	2	(3)	8	(10)
	Yes, but remote	5	(8)	7	(9)
	TOTAL	60	(99)	80	(100)
		Chi-square=2.34 df=2 n.sig.			
2 missing					
Do you have a stepfather?	No	41	(68)	56	(70)
	Yes	10	(17)	14	(18)
	Yes, but remote	7	(12)	8	(10)
	Deceased	2	(3)	2	(3)
	TOTAL	60	(100)	80	(101)
		Chi-square=0.20 df=3 n.sig.			
2 missing					
Family? separation	Divorced/sep	32	(52)	45	(56)
	Together	26	(43)	34	(43)
	Other	3	(5)	1	(1)
	TOTAL	61	(100)	80	(100)
		Chi-square=1.73 df=2 n.sig.			

Note: 67% of SG and 50% CG YPs had divorced or separated parents cf 40% SG and 54% CG adults

1 missing					
How old were you when they separated?	Birth to 8	22	(67)	25	(57)
	9-16	9	(27)	14	(32)
	17+	2	(6)	5	(11)
	TOTAL	33	(100)	44	(100)
		Chi-square=1.01 df=2 n.sig.			

Table 4.51 (Cont.)

What happened to you?	Stayed with mother	15	(43)	20	(44)
	Stayed with father	2	(6)	8	(18)
	Other relatives	3	(9)	3	(7)
	Care	12	(34)	6	(13)
	Other	3	(9)	8	(18)
	TOTAL	35	(101)	45	(100)
		Chi-square=7.45 df=4 n.sig.			

Table 4.52 Parental violence

		subject group		comparison group	
		No.	%	No.	%
Witnessed violence between parents?	None	24	(41)	46	(58)
	Minor	13	(22)	17	(21)
	Repeated	22	(37)	17	(21)
	TOTAL	59	(100)	80	(100)
		Chi-square=5.03 df=2 p<0.10			

Note: 38% of SG and 50% CG YPs had not witnessed violence between their parents cf 42% SG and 58% CG adults

3 Missing

Hospitalization required?	None	21	(62)	25	(74)
	Yes	13	(38)	9	(26)
	TOTAL	34	(100)	34	(100)
		Chi-square=1.08 df=1 n.sig.			

4 Missing

Were your parents violent towards you?	None	21	(34)	39	(49)
	Minor	14	(23)	17	(21)
	Repeated	26	(43)	24	(30)
	TOTAL	61	(100)	80	(100)
		Chi-square=3.30 df=2 n.sig.			

Note: 66% YPs had experienced violence from their parents cf 55% adults

1 missing

Table 4.52 (Cont.)

Hospitalization required?	None	30	(73)	39	(83)
	Yes	9	(22)	6	(13)
	Other	2	(5)	2	(4)
	TOTAL	41	(100)	47	(100)
		Chi-square=1.37 df=2 n.sig.			

Note: 36% SG and 0% CG YPs had needed hospitalization as a result cf 15% SG and 14% CG adults

Which parent was violent towards you?	Mother	3	(7)	4	(10)
	Father	25	(61)	26	(62)
	Both	8	(20)	5	(12)
	Step-parent	4	(10)	5	(12)
	Other	1	(2)	2	(5)
	TOTAL	41	(100)	42	(101)
		Chi-square=1.29 df=4 n.sig.			

Were you sexually abused as a child?	No	39	(64)	75	(94)
	Yes, by family	2	(3)	1	(1)
	Yes, by others	18	(30)	1	(1)
	Other	2	(4)	3	(4)
	TOTAL	61	(101)	80	(101)
		Chi-square=25.01 df=3 p<0.0001			

Note: 86% of SG and 100% CG YPs responded No to this question

Chi-square=0.96 df=2 n.sig.

1 missing

Adults only: Were you sexually abused as a child?	No	21	(53)	69	(93)
	Yes, by family	2	(5)	1	(1)
	Yes, by others	16	(40)	1	(1)
	Other	1	(3)	3	(4)
	TOTAL	40	(101)	74	(99)
		Chi-square=32.96 df=3 p<0.0001			

Table 4.53 Family history

		subject group		comparison group	
		No.	%	No.	%
Family psychiatric treatment?	None	39	(64)	54	(68)
	Mother	4	(7)	6	(8)
	Father	2	(3)	4	(5)
	Many	2	(3)	4	(5)
	Other	6	(10)	12	(15)
	Don't know	8	(13)	0	-
	TOTAL	61	(100)	80	(101)

Chi-square=11.81 df=5 p<0.05

Note: For YPs only there is no significant difference between subject and control groups. For adults only level of significance p=0.02

1 missing

Why did they have treatment?	Suicide attempt	1	(6)	2	(8)
	Depression	7	(41)	9	(36)
	Mental illness	7	(41)	5	(20)
	Addiction	0	-	4	(16)
	Other/DK	2	(12)	5	(20)
	TOTAL	17	(100)	25	(100)

Chi-square=4.85 df=4 n.sig.

6 missing

Family suicide attempt?	None	36	(59)	58	(73)
	Yes	17	(28)	19	(24)
	Don't know	8	(13)	3	(4)
	TOTAL	61	(100)	80	(101)

Chi-square=5.06 df=2 p<0.10

Note: 24% SG and 0% CG YPs had family members who had made a suicide attempt cf 30% SG and 26% CG adults

1 missing

Table 4.53 (Cont.)

Family suicide?	None	47 (80)	68 (87)
	Yes	3 (5)	3 (4)
	Don't know	9 (15)	7 (9)
	TOTAL	59 (100)	78 (100)

Chi-square=1.48 df=2 n.sig.

Note: No YPs had experienced a family suicide, though 40% replied Don't know to this question cf 5% adults who answered Yes and 5% Don't know

5 missing

Table 4.54 Previous psychiatric history

		subject group		comparison group	
		No.	%	No.	%
Any previous psychiatric treatment	None	13	(21)	33	(43)
	Yes	46	(75)	41	(54)
	Other	2	(3)	2	(3)
	TOTAL	61	(100)	76	(101)

Chi-square=7.43 df=2 p<0.05

Note: 76% SG and 20% CG YPs answered Yes p=0.029 cf 75% SG and 56% CG adults, not significant

5 missing

Reason for previous psychiatric treatment	Don't know	2	(4)	2	(5)
	Suicide attempt	2	(12)	4	(9)
	Depression	11	(22)	1	(2)
	Formal mental illness	2	(4)	3	(7)
	Addiction(s)	4	(8)	1	(2)
	Behavioural problems	12	(25)	14	(32)
	Offending behaviour	8	(17)	8	(18)
	Other	1	(2)	6	(14)
	Mixture	3	(6)	5	(11)
	TOTAL	45	(100)	44	(100)

Chi-square=15.22 df=8 p<0.10

Note: There was no significant difference on this table for YPs only

Table 4.54 (Cont.)

Adults only: Reason for previous psychiatric treatment	Don't know	2 (6)	2 (5)
	Suicide attempt	5 (16)	4 (9)
	Depression	8 (25)	1 (2)
	Formal mental illness	1 (3)	3 (7)
	Addiction(s)	4 (13)	1 (2)
	Behavioural problems	5 (16)	14 (33)
	Offending behaviour	5 (16)	7 (16)
	Other	0 (-)	6 (14)
	Mixture	2 (6)	5 (12)
	TOTAL	32 (101)	43 (100)
		Chi-square=19.03 df=8 p<0.02	

Table 4.55 Role of drugs and alcohol

		subject group		comparison group	
		No.	%	No.	%
Report alcohol problems?	None	37	(62)	43	(54)
	Minor	2	(3)	6	(8)
	Major	20	(33)	24	(30)
	Erratic	1	(2)	5	(6)
	Other	0	-	2	(3)
	TOTAL	60	(100)	80	(101)
		Chi-square=4.72 df=4 n.sig.			

Note: 48% SG and 17% CG YPs report drinking more than 3 pints a week cf 18% SG and 29% CG adults

2 missing

Report drug problems?	None	27	(44)	39	(49)
	Minor	24	(39)	29	(36)
	Major	9	(15)	10	(13)
	Prison only	1	(2)	2	(3)
	TOTAL	61	(100)	80	(101)
		Chi-square=0.49 df=3 n.sig.			

Note: 29% SG and 50% CG YPs report no drug problem cf 53% SG and 49% CG adults
33% YPs report no drug usage cf 50% adults

1 missing

Table 4.56 Previous self-injury

		subject group		comparison group	
		No.	%	No.	%
Previous self-inflicted injury?	None	22	(36)	58	(73)
	Yes, once	11	(18)	9	(11)
	Several	27	(44)	10	(13)
	Other	2	(3)	3	(4)
	TOTAL	62	(101)	80	(101)
		Chi-square=22.49 df=3 p<.0001			
YPs only					
Previous self-inflicted injury?	None	5	(24)	3	(50)
	Yes, once	4	(19)	1	(17)
	Several	11	(52)	0	(-)
	Other	1	(5)	2	(33)
	TOTAL	21	(100)	6	(100)
		Chi-square=7.67 df=3 p<0.10			
Adults only					
Previous self-inflicted injury?	None	17	(42)	55	(74)
	Yes, once	7	(17)	8	(11)
	Several	16	(39)	10	(14)
	Other	1	(2)	1	(1)
	TOTALS	41	(100)	74	(100)
		Chi-square=13.12 df= 3 p=<.004			
Previous self-injury in custody?	Custodial	3	(8)	1	(5)
	Other institution	4	(10)	0	-
	Non-custodial	25	(64)	16	(80)
	Mixture	7	(18)	3	(15)
	TOTAL	39	(100)	20	(100)
		Chi-square=2.74 df=3 n.sig.			
3 missing					
Number of previous self-injuries	One	7	(18)	9	(47)
	Several	31	(82)	10	(53)
	TOTAL	38	(100)	19	(100)
		Chi-square=5.26 df=1 p<0.05			

Table 4.56 (Cont.)

Intention?	Suicide attempt	15 (40)	7 (32)
	Cry for help	3 (8)	2 (9)
	Avoidance/escape	0 -	1 (5)
	Distress/despair	6 (16)	4 (18)
	Mixture	11 (29)	5 (23)
	Other	3 (8)	3 (14)
	TOTAL	38 (101)	22 (101)
		Chi-square=2.68 df=5 n.sig.	

2 missing

Table 4.57 Current location

	subject group		comparison group	
	No.	%	No.	%
single cell	10	(16)	25	(31)
shared cell	23	(37)	49	(61)
dormitory	0	-	1	(1)
hospital room	14	(23)	4	(5)
hospital ward	9	(15)	1	(1)
hospital unfurnished	3	(5)	0	-
segregation block	3	(5)	0	-
TOTAL	62	(101)	80	(99)
prefer single	22	(36)	40	(50)
prefer share	26	(42)	23	(29)
not sure	14	(23)	17	(21)
TOTAL	62	(101)	80	(100)
	Chi-square=3.47 df=2 n.sig.			

Table 4.58 Employment in prison

		subject group		comparison group	
		No.	%	No.	%
Do you have a job in prison?	No	41	(66)	34	(43)
	Yes	19	(31)	45	(56)
	Some, irregular	2	(3)	1	(1)
	TOTAL	62	(100)	80	(100)
		Chi-square=9.42 df=2 p<0.01			
Would you prefer to be working?	No	13	(28)	14	(28)
	Yes	34	(72)	33	(65)
		0	-	4	(8)
	TOTAL	47	(100)	51	(101)
		Chi-square=3.90 df=2 n.sig.			
Do you enjoy the work?	Enjoy	12	(55)	20	(44)
	Dislike	5	(23)	13	(28)
	It's O.K.	5	(23)	12	(26)
	Other	0	-	1	(2)
	TOTAL	22	(101)	46	(100)
		Chi-square=1.11 df=3 n.sig.			
Does work help you to do your time?	Yes	21	(91)	35	(76)
	Some	1	(4)	4	(9)
	No	1	(4)	6	(13)
	Other	0	-	1	(2)
	TOTAL	23	(99)	46	(100)
		Chi-square=2.48 df=3 n.sig.			
Do you spend enough time working?	Enough	8	(35)	18	(39)
	Too much	0	-	10	(22)
	Not enough	12	(52)	14	(30)
	Other	3	(13)	4	(9)
	TOTAL	23	(100)	46	(100)
		Chi-square=7.29 df=3 p<0.10			

Table 4.58 (Cont.)

Do you get anything else out of work?	No	8	(37)	15	(33)
	Money	0	–	5	(11)
	Experience	6	(27)	4	(9)
	Satisfaction	4	(18)	9	(20)
	Company	2	(9)	6	(13)
	Other	2	(9)	7	(15)
	TOTAL	22	(100)	46	(101)
		Chi-square=6.58 df=5 n.sig.			
How much pay do you get?	<190 pence	14	(23)	11	(14)
	190–290 pence	31	(50)	27	(34)
	290–390 pence	4	(6)	19	(24)
	390+ pence	6	(10)	20	(25)
	None/don't know	7	(11)	3	(4)
	TOTAL	62	(100)	80	(101)
		Chi-square=17.56 df=4 p<0.01			

Table 4.59 Prison education

		subject group		comparison group	
		No.	%	No.	%
Are you doing any education in prison?	None	34	(55)	48	(60)
	Full time	8	(13)	3	(4)
	Part time	7	(11)	9	(11)
	Evenings only	4	(7)	7	(9)
	Mixture	0	–	2	(3)
	Other	9	(15)	11	(14)
	TOTAL	62	(101)	80	(101)
		Chi-square=5.74 df=5 n.sig.			
Would you prefer to do education in prison?	No	15	(34)	22	(41)
	Yes	28	(64)	28	(52)
	Other	1	(2)	4	(7)
	TOTAL	44	(100)	54	(100)
		Chi-square=2.13 df=2 n.sig.			

Table 4.59 (Cont.)

Do you enjoy your classes?	Enjoy	18	(75)	20	(87)
	Dislike	1	(4)	1	(4)
	O.K.	5	(21)	2	(9)
	TOTAL	24	(100)	23	(100)
		Chi-square=1.37 df=2 n.sig.			
Does education help pass the time?	Yes	19	(76)	18	(75)
	Some	2	(8)	1	(4)
	No	4	(16)	3	(13)
	Other	0	-	2	(8)
	TOTAL	26	(100)	24	(100)
		Chi-square=2.48 df=3 n.sig.			
Do you get anything else from education?	No	5	(20)	9	(39)
	Yes	20	(80)	14	(61)
	TOTAL	25	(100)	23	(100)
		Chi-square=1.30 df=1 n.sig.			
Do you spend enough time on education?	Enough	5	(20)	11	(46)
	Too much	0	-	2	(8)
	Not enough	17	(68)	8	(33)
	Other	3	(12)	3	(13)
	TOTAL	25	(100)	24	(100)
		Chi-square=7.47 df=3 p<0.10			

Table 4.60 Physical education

	subject group		comparison group	
	No.	%	No.	%
None	36	(58)	34	(44)
Yes, enjoy	15	(24)	30	(39)
Yes, dislike	1	(2)	1	(1)
Limited availability	1	(2)	8	(11)
Other	9	(15)	5	(6)
TOTAL	62	(101)	78	(101)
	Chi-square=9.95 df=4 p<0.05			

2 missing

Table 4.61 How do you spend your time in your cell?

	subject group		comparison group	
	No.	%	No.	%
Nothing	10	(16)	1	(1)
Read	7	(12)	16	(20)
Write	5	(8)	5	(6)
Draw	3	(5)	0	-
Music	0	-	6	(8)
Sleep	7	(12)	0	-
Mixture	24	(39)	43	(54)
Other	5	(8)	8	(10)
TOTAL	61	(100)	79	(99)

Chi-square=31.17 df=7 p<0.0001

2 missing

Table 4.62 Special variable: active in cell

	subject group		comparison group	
	No.	%	No.	%
Active	35	(57)	74	(95)
Bored	17	(28)	1	(1)
Other	9	(15)	3	(4)
TOTAL	61	(100)	78	(100)

Chi-square=29.54 df=2 p<0.001

3 missing

Table 4.63 Length of time in cell

		subject group		comparison group	
		No.	%	No.	%
Weekdays:	up to 12 hours	4	(7)	8	(10)
	13-20 hours	21	(36)	43	(56)
	21-22 hours	8	(14)	7	(9)
	23-24 hours	24	(41)	16	(21)
	Other	2	(3)	3	(4)
	TOTAL	59	(101)	77	(100)
		Chi-square=8.53 df=4 p<0.10			
Weekends:	up to 12 hours	3	(5)	3	(4)
	13-20 hours	8	(14)	22	(29)
	21-22 hours	14	(24)	11	(14)
	23-24 hours	27	(46)	31	(40)
	Other	7	(12)	10	(13)
	TOTAL	59	(101)	77	(100)
		Chi-square=5.41 df=4 n.sig.			

4 missing

Table 4.64 Are you ever bored?

		subject group		comparison group	
		No.	%	No.	%
Weekdays:	Seldom	7	(12)	8	(10)
	Some	16	(26)	36	(46)
	Often	38	(62)	35	(44)
	TOTAL	61	(100)	79	(100)
		Chi-square=5.66 df=2 p<0.10			

2 missing

Weekends:	Seldom	6	(10)	11	(14)
	Some	10	(17)	27	(34)
	Often	44	(73)	41	(52)
	TOTAL	60	(100)	79	(100)
		Chi-square=6.92 df=2 p<0.05			

3 missing

Table 4.65 Is there anything you can do about the boredom?

	subject group		comparison group	
	No.	%	No.	%
Nothing	29	(53)	15	(22)
Positive	16	(29)	45	(65)
Negative	8	(15)	4	(6)
Other	2	(4)	5	(7)
TOTAL	55	(101)	69	(99)

Chi-square=19.53 df=3 p<0.0002

18 missing

Table 4.66 Are there rewarding things to do in this prison?

	subject group		comparison group	
	No.	%	No.	%
No	17	(30)	22	(28)
Limited	22	(39)	22	(28)
Yes	16	(28)	33	(42)
Other	2	(4)	1	(1)
TOTAL	57	(101)	78	(99)

Chi-square=3.70 df=3 n.sig.

7 missing

Table 4.67 Do you have a sentence plan/did anyone discuss how you would spend your time?

	subject group		comparison group	
	No.	%	No.	%
No	56	(92)	69	(89)
Yes	3	(5)	7	(9)
Other	2	(3)	2	(3)
TOTAL	61	(100)	78	(101)

Chi-square=0.89 df=2 n.sig.

3 missing

Table 4.68 Do you have a personal/group officer?

	subject group		comparison group	
	No.	%	No.	%
No	44	(72)	58	(73)
Yes	15	(25)	16	(20)
Other	2	(3)	5	(6)
TOTAL	61	(100)	79	(99)

Chi-square=0.94 df=2 n.sig.

2 missing

Table 4.69 How much contact (i.e. visits) do you have with your family?

	subject group		comparison group	
	No.	%	No.	%
None	23	(37)	23	(29)
Rare/irregular	14	(23)	11	(14)
Every month	15	(24)	25	(32)
Every week	8	(13)	17	(22)
Other	2	(3)	3	(4)
TOTAL	62	(100)	79	(101)

Chi-square=4.31 df=4 n.sig.

1 missing

Table 4.70 Problems with visits

	subject group		comparison group	
	No.	%	No.	%
No	12	(22)	20	(27)
Yes	43	(78)	54	(73)
TOTAL	55	(100)	74	(100)

Chi-square=0.46 df=1 n.sig.

13 missing

Table 4.71 How many letters do you receive per week?

	subject group		comparison group	
	No.	%	No.	%
None	8	(13)	12	(15)
One	27	(44)	18	(23)
Between 2 and 5	21	(34)	29	(37)
6 or more	4	(7)	19	(24)
Other	1	(2)	1	(1)
TOTAL	61	(100)	79	(100)

Chi-square=11.54 df=4 p<0.05

2 missing

Table 4.72 Would you like to receive more letters?

	subject group		comparison group	
	No.	%	No.	%
No	15	(25)	31	(40)
Yes	37	(63)	29	(37)
Other	7	(12)	18	(23)
TOTAL	61	(100)	79	(100)

Chi-square=10.71 d.f.=2 p<0.01

2 missing

Table 4.73 Would you like to get more visits?

	subject group		comparison group	
	No.	%	No.	%
No	5	(8)	23	(29)
Yes	55	(90)	54	(68)
Other	1	(2)	2	(3)
TOTAL	61	(100)	79	(100)

Chi-square=9.76 df=2 p<0.01

2 missing

Table 4.74 Do letters and visits help you cope?

	subject group		comparison group	
	No.	%	No.	%
No	6	(10)	9	(11)
Yes	48	(80)	61	(77)
Worse	1	(2)	1	(1)
Other	5	(8)	8	(10)
TOTAL	60	(100)	79	(99)

Chi-square=0.25 df=3 n.sig.

3 missing

Table 4.75 When was your last visit?

	subject group		comparison group	
	No.	%	No.	%
No visits received	14	(23)	14	(18)
One - seven days	17	(28)	30	(38)
Eight - thirty days	21	(34)	26	(33)
Over 30 days	9	(15)	10	(13)
TOTAL	61	(100)	80	(101)

Chi-square=1.65 df=3 n.sig.

1 missing

Table 4.76 Experience of visits

		subject group		comparison group	
		No.	%	No.	%
How did you feel just before your visit?	Anxious	11	(26)	14	(22)
	Excited	19	(44)	29	(45)
	Depressed	4	(9)	3	(5)
	Hostile	2	(5)	1	(2)
	Normal	5	(12)	14	(22)
	Other	2	(5)	6	(6)
	TOTAL	43	(101)	65	(101)
		Chi-square=3.51 df=5 n.sig.			
How did you feel just after the visit?	Anxious	1	(2)	5	(8)
	Excited	9	(21)	22	(34)
	Depressed	29	(66)	25	(38)
	Normal	3	(7)	3	(5)
	Relieved	0	-	3	(5)
	Other	2	(5)	7	(11)
	TOTAL	44	(101)	65	(101)
		Chi-square=10.54 df=5 p<0.10			
How long does that feeling last?	Hours	15	(38)	30	(48)
	To next day	6	(15)	12	(19)
	Days	14	(35)	17	(27)
	Other	5	(13)	4	(6)
	TOTAL	40	(101)	63	(100)
		Chi-square=2.38 df=3 n.sig.			
Is that feeling typical of most visits?	No	3	(7)	5	(8)
	Yes	35	(83)	52	(81)
	Other	4	(10)	7	(11)
	TOTAL	42	(100)	64	(100)
		Chi-square=0.07 df=2 n.sig.			

Table 4.77 Thinking about people outside

		subject group		comparison group	
		No.	%	No.	%
How often do you think about people on the outside you miss?	All the time	39	(64)	38	(48)
	Sometimes	15	(25)	32	(40)
	Rarely	2	(4)	6	(8)
	Other	5	(8)	4	(5)
	TOTAL	61	(101)	80	(101)
		Chi-square=5.81 df=3 n.sig.			
Does thinking about people on the outside make being in here easier or harder?	Easier	5	(9)	9	(12)
	Harder	50	(85)	45	(58)
	Depends	2	(3)	13	(17)
	Other	2	(3)	11	(14)
	TOTAL	59	(100)	78	(101)
		Chi-square=13.32 df=3 p<0.004			

5 missing

Table 4.78 Is it easier to keep in touch or forget the world outside?

	subject group		comparison group	
	No.	%	No.	%
Keep in touch	27	(47)	36	(46)
Forget	17	(29)	19	(24)
Forget, but can't	9	(16)	7	(9)
Both	2	(3)	11	(14)
Other	3	(5)	5	(6)
TOTAL	58	(100)	78	(99)
	Chi-square=5.56 df=4 n.sig.			

6 missing

Table 4.79 Do you keep in touch with current events?

	subject group		comparison group	
	No.	%	No.	%
No	26	(43)	18	(23)
Yes	23	(38)	45	(56)
Some, limited	12	(20)	17	(21)
TOTAL	61	(101)	80	(100)

Chi-square=7.00 df=2 p<0.05

1 missing

Table 4.80 Do you read newspapers, watch news, etc.?

	subject group		comparison group	
	No.	%	No.	%
No	18	(30)	9	(11)
Limited interest	5	(8)	8	(10)
Local papers	2	(3)	5	(6)
Own radio	5	(8)	5	(6)
Try but restricted	12	(20)	11	(14)
Newspaper regularly	6	(10)	16	(20)
Mixture	10	(16)	26	(33)
Other	3	(5)	0	-
TOTAL	61	(100)	80	(100)

Chi-square=17.43 df=7 p<0.02

1 missing

Table 4.81 Contact with probation officers

		subject group		comparison group	
		No.	%	No.	%
Have you had any contact with your outside Probation Officer?	No	24	(39)	32	(40)
	Letters	9	(15)	9	(11)
	Visits	12	(19)	22	(28)
	Both	10	(16)	12	(15)
	Other	7	(11)	5	(6)
	TOTAL	62	(100)	80	(100)
		Chi-square=2.36 df=4 n.sig.			
Has any of that contact been useful?	No	19	(48)	19	(37)
	Some	6	(15)	3	(6)
	Yes	14	(35)	28	(54)
	Other	1	(3)	2	(4)
	TOTAL	40	(101)	52	(101)
		Chi-square=4.51 df=3 n.sig.			
In what way useful?	Welfare	12	(57)	14	(44)
	Parole	0	-	4	(13)
	Contact	5	(24)	6	(19)
	Mixture	4	(19)	5	(16)
	Other	0	-	3	(9)
	TOTAL	21	(100)	32	(101)
		Chi-square=5.30 df=4 n.sig.			

Table 4.82 Have you had contact with anyone else?

	subject group		comparison group	
	No.	%	No.	%
No	42	(68)	67	(84)
AA	2	(3)	1	(1)
Prison Visitors	7	(11)	3	(4)
Samaritans	4	(7)	0	-
Drug Counsellors	2	(3)	1	(1)
Other	5	(8)	8	(10)
TOTAL	62	(100)	80	(100)
	Chi-square=10.58 df=5 <0.10			

Table 4.83 Release plans

	subject group		comparison group	
	No.	%	No.	%
None	24	(40)	14	(18)
Yes, specific	8	(13)	28	(36)
Yes, general	28	(47)	31	(40)
Other	0	-	5	(6)
TOTAL	60	(100)	78	(100)
4 missing	Chi-square=16.83 df=3 p<0.001			

Table 4.84 Relationships with other prisoners

		subject group		comparison group	
		No.	%	No.	%
Do you have any close friends in here?	No	28	(45)	37	(46)
	Some	20	(32)	22	(28)
	Yes	13	(21)	20	(25)
	Other	1	(2)	1	(1)
	TOTAL	62	(100)	80	(100)
		Chi-square=0.55 df=3 n.sig.			
Where did you meet them?	Here	17	(45)	25	(51)
	In prison	5	(13)	4	(8)
	Outside	9	(24)	15	(31)
	Both	6	(16)	5	(10)
	Other	1	(3)	0	-
	TOTAL	38	(101)	49	(100)
		Chi-square=2.88 df=4 n.sig.			
How do you mix in here?	On own	28	(45)	19	(24)
	One mate	6	(10)	6	(8)
	Few close friends	6	(10)	11	(14)
	Small group	7	(11)	11	(14)
	Lots of mates	1	(2)	7	(9)
	Float around	11	(18)	24	(30)
	Other	3	(5)	1	(1)
	TOTAL	62	(101)	79	(100)
1 missing		Chi-square=12.54 df=6 p<0.05			

Table 4.84 (Cont.)

Do you have difficulties with other prisoners?	No	21 (34)	37 (47)
	Yes	40 (65)	34 (43)
	Other	1 (2)	8 (10)
	TOTAL	62 (101)	79 (100)
		Chi-square=8.42 df=2 p<0.02	
1 missing			

Table 4.85 Relationships with staff

		subject group		comparison group	
		No.	%	No.	%
What sort of relationship do you have with staff?	Good	6	(10)	19	(24)
	Some good	6	(10)	7	(9)
	OK	28	(45)	28	(35)
	Avoid contact	10	(16)	21	(27)
	Difficulties	12	(20)	4	(5)
	TOTAL	62	(101)	79	(100)
		Chi-square=12.88 df=4 p<0.02			
1 missing					
Is it easy to get on with staff in here?	No	15	(25)	11	(14)
	Yes	19	(32)	35	(44)
	Some	23	(38)	28	(35)
	Other	3	(5)	6	(8)
	TOTAL	60	(100)	80	(101)
		Chi-square=4.07 df=3 n.sig.			
2 missing					
Are staff in here helpful?	Not helpful	19	(31)	17	(21)
	Quite helpful	32	(52)	48	(60)
	Very helpful	11	(18)	14	(18)
	Don't know	0	-	1	(1)
	TOTAL	62	(101)	80	(100)
		Chi-square=2.43 df=3 n.sig.			

Table 4.85 (Cont.)

How are staff helpful?	Practical	12 (32)	35 (58)
	Personal	18 (49)	7 (12)
	Both	6 (17)	13 (21)
	Other	1 (3)	5 (8)
	TOTAL	37 (101)	60 (99)
		Chi-square=16.83 df=3 p<0.001	
How could staff be more helpful?	Couldn't/DK	7 (12)	17 (22)
	Practical	5 (8)	11 (14)
	Personal	31 (51)	20 (26)
	Both	12 (20)	11 (14)
	Other	6 (10)	19 (24)
	TOTAL	61 (101)	78 (100)
		Chi-square=13.72 df=4 p<0.01	
3 missing			
Do staff try to get close to you or keep their distance	Distant	36 (58)	37 (46)
	Close	14 (23)	18 (23)
	Varies	6 (10)	9 (11)
	Other	6 (10)	16 (20)
	TOTAL	62 (101)	80 (100)
		Chi-square=3.43 df=3 n.sig.	
Have you had any problems with staff?	None	31 (50)	50 (63)
	Some	19 (31)	24 (30)
	Yes	12 (19)	6 (8)
	TOTAL	62 (100)	80 (101)
		Chi-square=4.83 df=2 p<0.10	

Table 4.86 Discipline in prison

		subject group		comparison group	
		No.	%	No.	%
What would you do if you had a grievance or a complaint?	Nothing	16	(27)	18	(23)
	See Officer	12	(20)	22	(29)
	See Governor	17	(28)	9	(12)
	See BOV	3	(5)	4	(5)
	All official channels	6	(10)	12	(16)
	Fight	3	(5)	3	(4)
	Other	3	(5)	9	(12)
	TOTAL	60	(100)	77	(101)
		Chi-square=8.69 df=6 n.sig.			
5 missing					
Number of disciplinary offences on your record?	None	37	(61)	51	(64)
	1-3	16	(26)	19	(24)
	4 or more	8	(13)	10	(13)
	TOTAL	61	(100)	80	(101)
		Chi-square=1.00 df=3 n.sig.			
1 missing					
What is the main type of offence?	Mixture	6	(17)	14	(30)
	Assaults	2	(6)	1	(2)
	Drugs	1	(3)	0	–
	Disobedience	6	(17)	8	(17)
	Damage	3	(9)	0	–
	Unauthorised poss	3	(9)	4	(9)
	Disrespect	0	–	2	(4)
	Many petty	2	(6)	1	(2)
	Other	12	(34)	17	(36)
	TOTAL	35	(101)	47	(100)
		Chi-square=9.61 df=8 n.sig.			
How do you feel about discipline?	Don't mind	8	(33)	8	(27)
	Dislike	3	(13)	8	(27)
	Unfair	5	(21)	7	(23)
	Strongly negative	7	(29)	7	(23)
	Other	1	(4)	0	–
	TOTAL	24	(100)	30	(100)
		Chi-square=2.98 df=4 n.sig.			

Table 4.86 (Cont.)

Do you think the disciplinary system is fair?	No	19 (42)	32 (52)
	Yes	7 (16)	6 (10)
	Some	7 (16)	7 (11)
	Other	0 -	4 (6)
	Don't know	12 (27)	13 (21)
	TOTAL	45 (101)	62 (100)
		Chi-square=4.85 df=4 n.sig.	
How much remission have you lost?	None	46 (77)	59 (77)
	1-20 days	5 (8)	6 (8)
	21+ days	9 (15)	12 (16)
	TOTAL	60 (100)	77 (101)
		Chi-square=0.02 df=2 n.sig.	

5 missing

Table 4.87 Experience of isolation

		subject group		comparison group	
		No.	%	No.	%
Loss of privileges	No	53	(87)	70	(88)
	Yes	8	(13)	10	(13)
	TOTAL	61	(100)	80	(101)
		Chi-square=0.00 df=1 n.sig.			
1 missing					
Unfurnished room/protective custody	No	22	(36)	71	(89)
	Yes	39	(64)	9	(11)
	TOTAL	61	(100)	80	(100)
		Chi-square=42.78 df=1 p<0.001			
1 missing					
Segregation block: punishment	No	50	(82)	64	(81)
	Yes	11	(18)	15	(19)
	TOTAL	61	(100)	79	(100)
		Chi-square=0.02 df=1 n.sig.			

2 missing

Table 4.87 (Cont.)

Segregation block: adjudication	No	49 (80)	65 (83)
	Yes	12 (20)	13 (17)
	TOTAL	61 (100)	78 (100)
		Chi-square=0.06 df=1 n.sig.	
3 missing			
R43 GOAD	No	54 (89)	74 (93)
	Yes	7 (12)	6 (8)
	TOTAL	61 (101)	80 (101)
		Chi-square=0.65 df=1 n.sig.	
1 missing			
R43 Own Protection	No	31 (53)	58 (73)
	Yes	28 (48)	22 (28)
	TOTAL	59 (101)	80 (101)
		Chi-square=5.87 df=1 p<0.02	
3 missing			
CI10/74 or 37/90	No	58 (97)	76 (95)
	Yes	2 (3)	4 (5)
	TOTAL	60 (100)	80 (100)
		Chi-square=0.23 df=1 n.sig.	
2 missing			
Why placed in solitary?	Risk	29 (57)	7 (21)
	Adjudication	3 (6)	3 (9)
	Punishment	3 (6)	10 (29)
	Mixture	13 (26)	6 (18)
	Other	3 (6)	8 (24)
	TOTAL	51 (101)	34 (101)
		Chi-square=19.44 df=4 p<0.001	
Length of time in solitary	None	12 (19)	50 (63)
	1 day	15 (24)	4 (5)
	2-6 days	16 (26)	6 (8)
	7+ days	19 (31)	20 (25)
	TOTAL	62 (100)	80 (101)
		Chi-square=32.47 df=3 p<0.001	

Table 4.87 (Cont.)

How did you feel about that?	Shocked/angry	11	(22)	8	(27)
	Uncomfortable	26	(53)	6	(20)
	Indifferent	11	(22)	14	(47)
	Other	1	(2)	2	(7)
	TOTAL	49	(99)	30	(101)
		Chi-square=9.66 df=3 p<0.05			

Table 4.88 Have you ever tried to escape?

	subject group		comparison group	
	No.	%	No.	%
No	53	(85)	69	(86)
Yes, escaped	4	(6)	5	(6)
Yes, attempted	1	(2)	0	-
Other	4	(6)	6	(8)
TOTAL	62	(99)	80	(100)
	Chi-square=1.35 df=3 n.sig.			

Table 4.89 Special interest variable: is the inmate a disciplinary problem?

	subject group		comparison group	
	No.	%	No.	%
No	44	(71)	64	(80)
Some	12	(19)	10	(13)
Yes	6	(10)	6	(8)
TOTAL	62	(100)	80	(101)
	Chi-square=1.63 df=2 n.sig.			

Table 4.90 Experience at prison reception

		subject group		comparison group	
		No.	%	No.	%
Did you see a HO or the (S)MO on reception?	Neither	4	(7)	5	(6)
	Doctor	19	(31)	22	(28)
	Hospital Officer	6	(10)	7	(9)
	Both	31	(51)	42	(53)
	Other	1	(2)	4	(5)
	TOTAL	61	(101)	80	(101)
		Chi-square=1.33 df=4 n.sig.			
1 missing					
What were you asked on reception	Suicide questions not mentioned	4	(6)	5	(6)
	Suicide mentioned spontaneously	19	(31)	22	(28)
	Suicide mentioned prompted	6	(10)	7	(9)
	Can't remember suicide questions	31	(51)	42	(53)
	Other	1	(2)	4	(5)
	TOTAL	61	(100)	80	(101)
		Chi-square=1.33 df=4 n.sig.			
1 missing					

Table 4.91 The hospital

		subject group		comparison group	
		No.	%	No.	%
Have you had any contact with the hospital since?	No	2	(3)	24	(30)
	Occasional	5	(8)	20	(25)
	Yes	5	(40)	32	(40)
	Currently in hospital	30	(48)	4	(5)
	TOTAL	62	(99)	80	(100)
Opinion of the hospital	No opinion	0	–	17	(23)
	Positive	13	(21)	10	(14)
	Negative	36	(59)	28	(38)
	Indifferent	11	(18)	17	(23)
	Other	1	(2)	2	(3)
	TOTAL	61	(100)	74	(101)
7 missing					
Were you referred by the wing to the hospital	No	36	(58)	71	(89)
	No, but on file	1	(2)	1	(1)
	Yes	19	(31)	7	(9)
	Don't know	2	(3)	0	–
	Other	4	(7)	1	(1)
	TOTAL	62	(101)	80	(100)
Current/ recent medical treatment	None	30	(49)	58	(73)
	Anti-depressants	2	(3)	2	(3)
	Sleeping tablets	4	(7)	2	(3)
	Tranquillizers	3	(5)	0	–
	Mixture	2	(3)	1	(1)
	Other	21	(34)	17	(21)
	TOTAL	62	(101)	80	(101)
Have you been referred to a psychiatrist?	No	27	(44)	56	(70)
	Yes	14	(23)	14	(18)
	Current	15	(25)	4	(5)
	Other	5	(8)	6	(8)
	TOTAL	61	(100)	80	(101)

1 missing

Table 4.91 (Cont.)

Reason for referral?	Don't know	2	(6)	0	–
	Assessment	11	(32)	10	(44)
	Suicide risk	11	(32)	2	(9)
	Depression	6	(18)	2	(9)
	Counselling	1	(3)	1	(4)
	Problem	3	(9)	7	(30)
	Other	0	1	1	(4)
	TOTAL	34	(101)	23	(100)

Table 4.92 Have you ever injured yourself deliberately on this sentence/in here?

	subject group		comparison group	
	No.	%	No.	%
No	10	(16)	69	(86)
Yes	43	(71)	2	(3)
Thought about it	5	(8)	4	(5)
Other	3	(5)	5	(6)
TOTAL	61	(100)	80	(100)

1 missing

Table 4.93 Aspects of imprisonment

		subject group		comparison group	
		No.	%	No.	%
Worst thing about prison?	Losing Freedom	16	(26)	28	(35)
	Away from family	12	(19)	13	(16)
	Boredom	5	(8)	3	(4)
	Conditions	5	(8)	6	(8)
	Isolation	4	(7)	1	(1)
	Other Inmates	2	(3)	2	(3)
	Told what to do	2	(3)	2	(3)
	Mixture	7	(11)	13	(17)
	Other	9	(15)	11	(14)
	TOTAL	62	(100)	79	(100)
		Chi-square=5.74 df=8 n.sig.			

1 missing

Table 4.94 Using time or doing time?

		subject group		comparison group	
		No.	%	No.	%
Plan time, or live day by day?	Plan	4	(7)	10	(13)
	Day by day	55	(90)	60	(76)
	Other	2	(3)	6	(11)
	TOTAL	61	(100)	79	(100)
		Chi-square=5.01 df=2 p<0.10			
2 missing Using sentence to achieve achieve?	Achieve	2	(3)	17	(21)
	Getting through	43	(72)	54	(68)
	Can't use it	10	(17)	5	(6)
	Other	5	(8)	4	(5)
	TOTAL	60	(100)	80	(100)
		Chi-square=12.26 df=3 p<0.01			
2 missing Anything want to change about self?	No	13	(22)	19	(38)
	Yes-educational	12	(20)	14	(28)
	Yes-work	6	(10)	7	(9)
	Yes-personal	22	(37)	21	(26)
	Mixture	3	(5)	3	(4)
	Other	4	(7)	6	(8)
	TOTAL	60	(100)	80	(100)
		Chi-square=3.97 df=5 n.sig.			
2 missing Most important/ interesting do?	Nothing	23	(38)	30	(38)
	Education	9	(15)	9	(11)
	Work	6	(10)	4	(5)
	Gym/PE	2	(3)	13	(17)
	Reading/Writing	5	(8)	7	(9)
	Painting/Drawing	7	(12)	3	(4)
	Association	2	(3)	3	(4)
	Visits	1	(2)	2	(3)
	Other	6	(10)	8	(10)
	TOTAL	61	(100)	79	(100)
		Chi-square=9.99 df=8 n.sig.			
2 missing					

Table 4.95 Coping with problems

		subject group		comparison group	
		No.	%	No.	%
What do you do if feeling down?	Keep to self/Nothing	22	(36)	27	(34)
	Talk to staff	10	(16)	8	(10)
	Talk to prisoner	4	(7)	9	(11)
	Varies	4	(7)	3	(4)
	Occupy self	3	(5)	16	(20)
	Other	18	(30)	16	(20)
	TOTAL	61	(100)	79	(100)
		Chi-square=9.66 df=5 p<0.10			
2 missing					
Who do you turn to for help?	No-one	30	(49)	37	(47)
	Staff	11	(18)	8	(10)
	Probation	3	(5)	4	(5)
	Chaplain	2	(3)	1	(3)
	Other inmate	6	(10)	14	(18)
	Letter	1	(2)	2	(3)
	Several	5	(8)	8	(10)
	Other	3	(5)	5	(6)
	TOTAL	61	(100)	79	(100)
		Chi-square=4.16 df=7 n.sig.			
2 missing					

Table 4.96 Thoughts of past and future

		subject group		comparison group	
		No.	%	No.	%
Day dream?	No	19	(31)	23	(29)
	Yes	38	(61)	45	(56)
	All the time	5	(8)	12	(15)
	TOTAL	62	(100)	80	(100)
		Chi-square=1.60 df=2 n.sig.			
How often do you think about the past?	All Time	19	(31)	11	(14)
	A lot	23	(37)	23	(29)
	Some	14	(23)	35	(44)
	Never	6	(10)	11	(14)
	TOTAL	62	(100)	80	(100)
		Chi-square=10.50 df=3 p<.02			
How often do you think about the future?	A lot	17	(28)	35	(44)
	Some	25	(41)	28	(35)
	Never	19	(31)	17	(21)
	TOTAL	61	(100)	80	(100)
		Chi-square=4.02 df=2 n.sig.			
1 missing					
Do you feel hopeful and optimistic about your release?	A lot	17	(28)	45	(57)
	Some	17	(30)	19	(24)
	Never	24	(39)	12	(15)
	Other	3	(5)	3	(4)
	TOTAL	61	(100)	79	(100)
		Chi-square=14.68 df=3 p<0.005			
3 missing					

Table 4.97 Sleeping problems

	subject group		comparison group	
	No.	%	No.	%
A lot	28	(45)	23	(29)
Sometimes	19	(31)	14	(18)
Never	14	(23)	42	(53)
Other	1	(2)	1	(1)
TOTAL	62	(100)	80	(100)

Chi-square=13.18 df=3 p<.005

Table 4.98 The prison experience - in general

	subject group		comparison group	
	No.	%	No.	%
Difficult	34	(59)	36	(46)
Endurable	5	(9)	13	(17)
Indifferent	11	(19)	20	(25)
Positive	2	(3)	1	(1)
Other	6	(10)	9	(12)
TOTAL	58	(100)	79	(100)

Chi-square=4.03 df=4 n.sig.

5 missing

Table 4.99 Why is the prison experience difficult (or not)?

	subject group		comparison group	
	No.	%	No.	%
Boredom/Inactivity	7	(14)	6	(8)
Conditions	5	(10)	10	(13)
Other Inmates	7	(14)	2	(3)
Pressure	5	(10)	8	(11)
Rules/Regulations	5	(10)	6	(7)
Uncertainty	2	(4)	4	(5)
Other	10	(19)	20	(27)
Familiarity	6	(12)	11	(15)
Not Applicable	4	(8)	9	(12)
TOTAL	51	(102)	76	(101)

Chi-square=8.09 df=8 n.sig.

Table 4.100 The prison experience - for you

	subject group		comparison group	
	No.	%	No.	%
Difficult	44	(72)	34	(43)
Endurable	6	(10)	22	(28)
Indifferent	8	(13)	18	(23)
Positive	-		2	(3)
Other/Mixture	3	(5)	4	(5)
TOTAL	61	(100)	80	(100)

Chi-square=14.11 df=4 p<0.01

1 missing

Table 4.101 Why is the prison experience difficult for you (or not)?

	subject group		comparison group	
	No.	%	No.	%
Conditions	1	(2)	4	(6)
Other Inmates	5	(10)	1	(1)
Pressure	3	(6)	4	(6)
Rules/Regulations	3	(6)	4	(6)
Uncertainty	3	(6)	4	(6)
Lack of Contact	5	(10)	8	(12)
Particular Problems	16	(31)	8	(12)
Other	8	(16)	22	(32)
Familiarity	3	(6)	11	(16)
TOTAL	51	(101)	69	(101)

Chi-square=17.19 df=9 p<0.05

Table 4.102 Main problems which have to be faced

	subject group		comparison group	
	No.	%	No.	%
None	2	(3)	7	(9)
Being Bullied	9	(15)	3	(4)
Away from Home	9	(15)	16	(21)
Loneliness	1	(2)	-	
Regimes/Frustration	6	(10)	22	(28)
The Staff	3	(5)	1	(3)
Boredom	11	(18)	4	(5)
Other	12	(20)	23	(30)
TOTAL	53	(100)	76	(100)

Chi-square=22.21 df=7 p<0.01

Table 4.103 'Hopelessness' score

	subject group		comparison group	
	No.	%	No.	%
0 - 3	6	(11)	34	(44)
4 - 8	18	(32)	28	(36)
9+	33	(58)	16	(21)
TOTAL	57	(100)	78	(100)

Chi-square=25.01 df=2 p<.0001

7 missing

Table 4.104 What could the prison service do to make prison more tolerable?

	subject group		comparison group	
	No.	%	No.	%
More family contact	4	(7)	4	(5)
Communication with staff	6	(10)	4	(5)
Conditions	4	(7)	6	(8)
Pay and work	1	(2)	0	-
Better training/regime provision	10	(16)	22	(28)
Several	19	(31)	28	(35)
Other	10	(16)	8	(10)
Don't know	7	(11)	8	(10)
TOTAL	61	(100)	80	(101)

Chi-square2=5.86 df=7 n.sig.

1 missing

Table 4.105 Advice to new inmates

	subject group		comparison group	
	No.	%	No.	%
None	10	(18)	9	(12)
Keep head down	29	(54)	41	(53)
Don't tell offence	1	(2)	2	(3)
Talk to staff	2	(4)	1	(1)
Keep in touch with family	0	-	1	(1)
Keep busy	2	(4)	5	(6)
Mixture	3	(6)	6	(8)
Other	7	(13)	13	(17)
TOTAL	54	(101)	78	(101)
10 missing	Chi-square=3.62 df=7 n.sig.			

Table 4.106 Suicidal thought and action

		subject group		comparison group	
		No.	%	No.	%
Thought of Suicide?	None	13	(21)	63	(79)
	Yes	40	(65)	11	(14)
	Recent	4	(6)	1	(1)
	Some	1	(2)	3	(4)
	Past	4	(6)	2	(2)
	TOTAL	62	(100)	80	(100)
Attempted Suicide on this sentence?	No	26	(42)	75	(94)
	Could	5	(8)	1	(1)
	Yes	26	(42)	1	(1)
	Other	5	(8)	3	(4)
	TOTAL	62	(100)	80	(100)
Why Attempted (or Considered)?	Outside Problems	15	(29)	2	(11)
	Inside Problems	7	(14)	4	(21)
	Both	21	(40)	8	(42)
	Don't Know	2	(4)	2	(11)
	Other	7	(14)	3	(16)
	TOTAL	52	(101)	19	(101)

Table 4.107 Other inmate suicides and attempted suicides

		subject group		comparison group	
		No.	%	No.	%
Know anyone attempted or committed suicide in prison?	No	25	(40)	21	(26)
	Yes-Attempt	24	(38)	31	(39)
	Yes-Suicide	12	(19)	28	(35)
	Other	1	(2)	-	
	TOTAL	62	(100)	80	(101)
		Chi-square=6.46 df=3 p<0.10			
Why do you think inmates do this?	Can't handle sentence	9	(15)	17	(21)
	Depression	9	(15)	10	(13)
	Problems	19	(31)	16	(20)
	Attention	3	(5)	9	(11)
	Several	9	(15)	15	(19)
	Don't Know	8	(13)	5	(6)
	Other (eg boredom)	4	(7)	8	(10)
	TOTAL	61	(100)	80	(100)
1 missing		Chi-square=6.86 df=6 n.sig.			
Are Most Attempts serious?	No	16	(26)	33	(41)
	Yes	41	(66)	40	(50)
	Can't Tell	2	(3)	6	(8)
	TOTAL	59	(100)	79	(100)
4 missing		Chi-square=5.12 df=2 p<0.01			
Can you tell which are serious?	No	9	(15)	26	(33)
	Yes	27	(44)	35	(46)
	Sometimes	15	(28)	15	(20)
	Other	2	(3)	1	(1)
	TOTAL	53	(100)	77	(101)
		Chi-square=5.38 df=3 n.sig.			
How?	Method	22	(51)	31	(60)
	Knowing person	13	(30)	4	(8)
	Don't Know	3	(7)	6	(12)
	Other (eg. intuition)	5	(12)	11	(21)
	TOTAL	43	(100)	52	(101)
		Chi-square=8.77 df=3 p<.05			

TABLES FOR CHAPTER 5

Table 5.1 Timing of interviews

		No. %
Days Between Incident and Interview:	Up to 3 Days	18 (29)
	4 - 7 Days	6 (10)
	8 - 28 Days	8 (13)
	29+ Days	17 (27)
	Other/NA	13 (21)
	TOTAL	62 (100)

Table 5.2 Age and status of interviewees

		No. %
Age Group:	YP's (under 21)	21 (34)
	Adults (21+)	41 (66)
	TOTAL	62 (100)
Status	Remanded	30 (48)
	Convicted	2 (3)
	Sentenced	30 (48)
	TOTAL	62 (100)

Table 5.3 Major offences charged with

		No.	%
Current offence:	Murder	5	(8)
	Manslaughter	1	(2)
	Violence	14	(23)
	Sexual	18	(29)
	Robbery	5	(8)
	Burglary	12	(19)
	Theft	3	(5)
	Arson	4	(7)
	TOTAL	62	(100)
Previous offence:	Violence	21	(34)
	Sexual	9	(15)
	Robbery	3	(5)
	Burglary	14	(23)
	Theft	3	(5)
	Not Applicable	12	(19)
	TOTAL	62	(100)

Table 5.4 Method and location of injury

		No.	%
Method:	Cut Arms	18	(29)
	Cut Wrists (across)	18	(29)
	Cut Wrists (length)	4	(7)
	Hanging	4	(7)
	Cut Neck	1	(2)
	Set Fire	1	(2)
	Overdose	1	(2)
	Swallow (blade, battery)	5	(9)
	Other1	14	(22)
	TOTALS	66*	(100)
Location:	Single Cell	9	(17)
	Shared Cell	16	(31)
	Cell for 3	6	(12)
	Landing	1	(2)
	Hospital Single Room	5	(10)
	Hospital Ward	1	(2)
	Hospital Seclusion	4	(8)
	Segregation	5	(10)
	Other2	5	(10)
	TOTAL	52	(100)

1. Includes food refusal (3 days+); cuts to chest + thigh, punched and smashed window, and threat only.
2. Includes outside prison; work or education areas; other medical observation; police cells.

* Some prisoners injured themselves in more than one way.

Table 5.5 Any indication of Rule 43?

	No.	%
Yes	27	(44)
No	22	(36)
Other	3	(5)
NA/Missing	10	(16)
TOTAL	62	(100)

Table 5.6 Timing of incidents

		No.	%
Day of Week:	Mon	5	(8)
	Tue	9	(15)
	Wed	8	(13)
	Thurs	5	(8)
	Fri	4	(7)
	Sat	4	(7)
	Sun	5	(9)
	DK/Other	22	(35)
	TOTAL	62	(100)
Time into Sentence:	First day	3	(6)
	2 - 7 days	5	(10)
	8 - 21 days	6	(12)
	22-98 days	33	(66)
	Other	3	(6)
	TOTAL	50	(100)
Time after arrival:	First day	5	(10)
	2 - 7 days	7	(14)
	8 - 21 days	8	(16)
	22-98 days	26	(52)
	Other	4	(8)
	TOTAL	50	(100)
Time in Day:	00.00-06.00	1	(2)
	06.00-12	7	(11)
	12.00-18.00	11	(18)
	18.00-24.00	16	(26)
	Other/NA	27	(43)
	TOTAL	62	(100)

Table 5.7 Treatment required

		No.	%
Treatment:	No or Little Treatment	19	(31)
	Plaster	2	(3)
	Steri-strip	5	(8)
	Sutures (only)	13	(21)
	Transfer Prison Hospital	6	(10)
	Transfer Outside Hospital	12	(19)
	Information not available/applicable	5	(8)
	TOTAL	62	(100)
No. Sutures:	0	37	(60)
	3-10	7	(11)
	11+	18	(29)
	TOTAL	62	(100)

Table 5.8 Severity of intent (self-report)

	No.	%
Definitely Wanted to Die	16	(26)
Partly Wanted to Die	16	(26)
Not Sure	7	(11)
Definitely Didn't Want to Die	11	(18)
Other	12	(20)
TOTAL	62	(100)

Table 5.9 Planning of injury

	No.	%
Impulsive (Less than 1 hour)	27	(44)
Premeditated (Over 1 hour)	19	(31)
Other/NA	16	(25)
TOTAL	62	(100)

Table 5.10 Evidence of planning/precautions taken

	No.	%	N
Planning (time)	16	(26)	62
Suicide Note	5	(8)	62
Warnings Given	5	(8)	62
Precautions Taken	13	(21)	62

Table 5.11 Immediate and long-term outcome (Who seen by?)*

	Immediate		Long-Term (Post 24 hours)	
	No.	%	No.	%
Doctor	44	(71)	29	(47)
Psychiatrist	12	(19)	10	(16)
Hospital Officer	22	(36)	18	(29)
Chaplain	9	(15)	4	(7)
Probation	7	(11)	8	(13)
Psychology	–		1	(2)
Landing Officer	5	(8)	6	(10)
Governor grade	3	(5)	1	(2)
Board of Visitors	–		2	(3)
Samaritans	1	(2)	2	(3)
Other	1	(2)	1	(2)
Visited From Outside	7	(12)	9	(16)

* N=62, in each case

Table 5.12 Post-Incident location

		No.	%
Short-Term (First 24 hours):	Seclusion in Protected Conditions	32	(51)
	Seclusion Semi-Protected Conditions	3	(5)
	Hospital Room	12	(19)
	Hospital Shared Room	2	(3)
	Hospital Ward	11	(18)
	Other	2	(3)
	TOTAL	62	(100)
Long-Term (Post 24 hours):	Hospital In-patient	30	(48)
	Returned to Wing	12	(20)
	Ordinary Location (different)	1	(2)
	Rule 43	3	(5)
	Segregation	2	(3)
	Transfer Out	1	(2)
	Other/NA	13	(21)
	TOTAL	62	(100)

Table 5.13 Resolution of problems

Alleviation of Problems:	Yes	7	(11)
	Some	11	(18)
	No	30	(48)
	Other	3	(5)
	N/A	11	(18)
	TOTAL	62	(100)
What form did this help take	None	22	(36)
	Practical	3	(5)
	Contact/Communication	6	(10)
	Emotional Relief	6	(10)
	Other	2	(3)
	N/A	23	(37)
	TOTAL	62	(100)

Table 5.14 Likely to repeat?

	No.	%
Yes	16	(26)
Maybe	13	(21)
Don't Know	5	(8)
No	14	(23)
Other	14	(23)
TOTAL	62	(100)

Table 5.15 Outcome of injury

		No.	%
None		17	(34)
Transfer		7	(14)
Change Location		16	(32)
Resolved Problem		1	(2)
Received Visit		2	(4)
Other		7	(14)
TOTAL		50	(100)
Alleviation of Problems:	Yes	4	(8)
	Some	11	(22)
	No	30	(60)
	Worse	5	(10)
TOTAL		50	(100)

Table 5.16 Location of the causes of self-injury

	No.	%
Outside Problems	5	(10)
Inside Problems	14	(28)
Both	28	(56)
Other	3	(6)
TOTAL	50	(100)

Table 5.17 Motivating factors

	No.	%
Prison Pressures	37	(77)
Depression	32	(67)
Boredom	21	(44)
Lack of Communication From Outside	17	(35)
Temper or Anger	17	(35)
Close Relationship Threatened	12	(25)
Any Others? (state)	10	(21)
Bad News, or Dear John Letter	8	(17)
Guilt For the Offence	6	(13)
Mental Illness, Psychiatric Problem	4	(8)

TABLES FOR CHAPTER SIX

Table 6.1 The most valuable aspect of a prison officer's job

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Welfare/Relationships	66	(51)	38	(54)	9	(41)	15	(44)
All Valuable	13	(10)	8	(11)	3	(14)	2	(6)
Security	2	(2)	1	(1)	-	(-)	1	(3)
Dealing with Staff	9	(7)	3	(4)	2	(9)	4	(12)
Several	11	(9)	6	(9)	-	(-)	5	(15)
None	11	(9)	10	(14)	1	(1)	-	(-)
Other	18	(14)	4	(6)	7	(31)	7	(21)
TOTAL	130	(100)	70	(100)	22	(100)	34	(100)

Chi-square=22.98 df=12 p<.05

Table 6.2 The importance of welfare, as part of a prison officer's job

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
V.Imp	93	(72)	50	(71)	15	(68)	28	(74)
Q.Imp	24	(19)	12	(17)	4	(18)	8	(21)
Not V.Imp	7	(5)	5	(7)	1	(5)	1	(3)
Other	6	(5)	3	(4)	2	(9)	1	(3)
TOTAL	130	(100)	70	(100)	22	(100)	38	(100)

Chi-square=2.52 df=6 n.sig.

Table 6.3 The most important part of a prison officer's job

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Security	50	(39)	32	(46)	9	(41)	9	(24)
All Aspects	25	(19)	14	(20)	2	(9)	9	(24)
Welfare	42	(32)	18	(26)	8	(36)	16	(42)
Other	13	(10)	6	(9)	3	(14)	4	(11)
TOTAL	130	(100)	70	(100)	22	(100)	38	(100)

Chi-square=7.37 df=6 n.sig.

Table 6.4 Conflict between the welfare and security aspects of a prison officer's job

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Yes	18	(14)	6	(9)	3	(14)	9	(24)
Some Conflict	40	(31)	22	(31)	6	(27)	12	(32)
None	64	(49)	39	(56)	12	(55)	13	(34)
Other	8	(6)	3	(4)	1	(5)	4	(11)
TOTAL			70	(100)	22	(100)	38	(100)
			Chi-square=8.30 df=6 n.sig.					

Table 6.5 Are suicide and self-injury problems that prison officers should have to deal with?

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Yes	89	(69)	47	(67)	17	(77)	25	(68)
Yes - Reservations	26	(20)	16	(23)	3	(14)	7	(19)
No	6	(5)	4	(6)	1	(5)	1	(3)
Other	8	(6)	3	(4)	1	(5)	4	(11)
TOTAL	129	(100)	70	(100)	22	(100)	37	(100)
			Chi-square=3.26 df=6 n.sig.					

Table 6.6 Do prison staff feel able to deal with suicide and self-injury?

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Yes	27	(21)	16	(23)	7	(32)	4	(11)
Yes - Reservations	39	(30)	25	(36)	4	(18)	10	(27)
Some/Most	24	(19)	9	(13)	7	(32)	8	(22)
No	35	(27)	17	(24)	4	(18)	14	(38)
Other	4	(3)	3	(4)	-		1	(3)
TOTAL	129	(100)	70	(100)	22	(100)	37	(100)
			Chi-square=11.99 df=8 n.sig.					

Table 6.7 Do prison staff feel able to deal with suicide and self-injury, by establishment?

	Prison 1		Prison 2		Prison 3		Prison 4	
	No.	%	No.	%	No.	%	No.	%
Yes	6	(21)	11	(33)	2	(7)	8	(21)
Yes - Reservations	12	(43)	10	(33)	11	(37)	6	(16)
Some/Most	8	(29)	3	(9)	3	(10)	10	(26)
No	1	(4)	8	(24)	12	(40)	14	(37)
Other	1	(4)	1	(3)	2	(7)	-	(-)
TOTAL	28	(100)	33	(100)	30	(100)	38	(100)

Chi-square=26.77 df=12 p<.01

Table 6.8 What is the role of prison officers in the management and prevention of suicide and self-injury?

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Contact, Communication/ Observation	56	(43)	30	(43)	10	(46)	16	(44)
Referral/Information	22	(17)	13	(19)	4	(18)	5	(14)
Several	27	(21)	13	(19)	2	(9)	12	(33)
Impossible/No Role	14	(11)	12	(17)	2	(9)	-	
To Play								
Other	8	(6)	2	(3)	4	(18)	2	(7)
TOTAL	128		70	(100)	22	(100)	36	(100)

Chi-square=17.45 df=8 p<.05

Table 6.9 Whose responsibility are the problems of suicide and self-injury?

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Everybody's	63	(49)	27	(39)	16	(76)	20	(57)
Several	14	(11)	11	(16)	-	(-)	3	(9)
Hospital	9	(7)	7	(10)	1	(5)	1	(3)
Prison Officers	13	(10)	9	(13)	2	(10)	2	(6)
Management	13	(10)	6	(9)	-	(-)	7	(20)
The Inmate	5	(4)	3	(4)	2	(10)	-	(-)
Other	8	(6)	6	(9)	-	(-)	2	(6)
TOTAL	125	(100)	69	(100)	21	(100)	35	(100)

Chi-square=22.36 df=12 p<.05

Table 6.10 Officers receiving suicide prevention training

		Trained L1	Trained N2	Limited3 L	Limited3 N	No Training L	No Training N	TOTALS L	TOTALS N
Uniformed Staff	No.	12	12	11	10	47	48	70	70
	%	(17)	(17)	(16)	(14)	(67)	(69)	(100)	(100)
Hospital Staff	No.	4	8	8	4	9	9	21	21
	%	(19)	(38)	(38)	(19)	(43)	(43)	(100)	(100)
Governor/ Specialist Grades	No.	9	4	2	5	26	29	32	38
	%	(24)	(10)	(5)	(14)	(68)	(76)	(100)	(100)

for local training Chi-square=11.21 df=4 p<.05
for national training Chi-square=8.39 df=4 p<.06

1. Local training
2. National training
3. The category 'limited' was introduced in the previous research project because so many of the staff expressed reservations about the extent and quality of the training they had received. This was borne out in the current research also.

Table 6.11 Officers receiving suicide prevention training, by establishment

		Trained L1	Trained N2	Limited3 L	Limited3 N	No Training L	No Training N	TOTALS L	TOTALS N
Prison 1	No.	5	7	2	7	22	15	29	29
	%	(17)	(24)	(7)	(24)	(76)	(52)	(100)	(100)
Prison 2	No.	8	5	4	4	20	23	32	32
	%	(25)	(16)	(12)	(12)	(63)	(72)	(100)	(100)
Prison 3	No.	–	4	3	4	27	22	30	30
	%	(–)	(13)	(10)	(13)	(90)	(73)	(100)	(100)
Prison 4	No.	12	8	13	4	13	26	38	38
	%	(32)	(21)	(34)	(11)	(34)	(68)	(100)	(100)

for local training Chi-square28.04 df=6 p<.001.
for national training Chi-square=4.87 df=6 n.sig.

Table 6.12 Staff awareness of procedures

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Aware	88	(68)	46	(66)	20	(95)	22	(58)
Patchy	36	(27)	22	(31)	1	(5)	12	(32)
No Knowledge	6	(5)	2	(3)	–	(–)	4	(10)
TOTAL	130	(100)	70	(100)	21	(100)	38	(100)

Chi-square=11.81 df=4 p<.02

Table 6.13 Staff awareness of procedures, by establishment

	Prison 1		Prison 2		Prison 3		Prison 4	
	No.	%	No.	%	No.	%	No.	%
Aware	14	(48)	19	(59)	26	(87)	29	(76)
Patchy	14	(48)	11	(34)	2	(7)	8	(21)
No Knowledge	1	(3)	2	(6)	2	(7)	1	(3)
TOTAL	29	(100)	32	(100)	30	(100)	38	(100)

Chi-square=15.33 df=6 p<.02

Table 6.14 How well do suicide prevention procedures work by type of staff

	All Staff	Officers	Hospital Staff	Others	
	No. %	No. %	No. %	No. %	
Very Well	15 (12)	12 (17)	1 (5)	2 (6)	
Quite Well	55 (44)	26 (37)	14 (67)	15 (43)	
Problems	39 (31)	23 (33)	5 (24)	11 (31)	
Other/Don't Know	17 (13)	9 (13)	1 (5)	7 (20)	
TOTAL	126 (100)	70 (100)	21 (100)	3 (100)	
		Chi-square=9.61 df=4 p<.05			

Table 6.15 How well do suicide prevention procedures work by establishment

	Prison 1	Prison 2	Prison 3	Prison 4
	No. %	No. %	No. %	No. %
Very Well	5 (17)	4 (13)	3 (10)	3 (8)
Quite Well	12 (41)	14 (47)	12 (40)	17 (46)
Problems	5 (17)	8 (27)	13 (43)	13 (35)
Other/Don't Know	7 (24)	4 (13)	2 (6)	4 (11)
TOTAL	29 (100)	30 (100)	30 (100)	37 (100)
			Chi-square=8.82 df=9 n.sig.	

Table 6.16 Co-operation and communication between hospital and discipline staff

	All Staff	Officers	Hospital Staff	Others	
	No. %	No. %	No. %	No. %	
Good	39 (31)	23 (33)	6 (29)	10 (29)	
Some Problems	48 (37)	24 (34)	9 (43)	15 (40)	
Clear Problems	40 (32)	23 (33)	6 (29)	11 (31)	
TOTAL	130 (100)	70 (100)	21 (100)	36 (100)	
		Chi-square=0.86 df=4 n.sig.			

Table 6.17 Co-operation and communication between hospital and discipline staff by establishment

	Prison 1		Prison 2		Prison 3		Prison 4	
	No.	%	No.	%	No.	%	No.	%
Good	6	(21)	11	(36)	2	(7)	20	(53)
Some Problems	8	(27)	12	(39)	10	(36)	17	(45)
Clear Problems	15	(52)	8	(26)	16	(57)	1	(3)
TOTAL	29	(100)	31	(100)	28	(100)	38	(100)

Chi-square=33.25 df=6 p<.001

Table 6.18 Suicide and self-injury: separate or related problems?

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Separate Problems	57	(45)	30	(44)	10	(48)	17	(47)
Related	32	(25)	23	(33)	3	(14)	6	(17)
Some Overlap	36	(29)	16	(23)	8	(38)	12	(33)
TOTAL	125	(100)	69	(100)	21	(100)	35	(100)

Chi-square=3.82 df=4 n.sig.

Table 6.19 Staff perceptions of main factors in prison suicide

	Staff Indicating V.Imp.		Q.Imp.		Not V.Imp.		Other		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No	%
Depression	107	(82)	13	(10)	1	(1)	9	(7)	130	(100)
Bad News or Dear John Letter	87	(67)	28	(22)	2	(2)	13	(10)	130	(100)
Guilt (at the offence)	60	(46)	46	(35)	14	(11)	9	(7)	130	(100)
Lack of Communication	56	(43)	57	(44)	5	(4)	12	(9)	130	(100)
Prison Pressures	38	(29)	59	(45)	24	(19)	9	(7)	130	(100)
Mental Illness/ Breakdown	17	(13)	53	(41)	49	(38)	11	(9)	130	(100)
Temper/Anger	13	(10)	48	(37)	58	(45)	11	(9)	130	(100)
Boredom	17	(13)	47	(36)	56	(43)	10	(8)	130	(100)

Table 6.20 Location of the causes of suicide in prison

	All Staff	Officers	Hospital Staff	Others
	No. %	No. %	No. %	No. %
Personal	56 (43)	34 (49)	5 (24)	7 (45)
Situational	5 (4)	3 (4)	2 (10)	- (-)
Both	68 (52)	33 (47)	14 (67)	21 (55)
TOTAL	129 (100)	70 (100)	21 (100)	38 (100)

For 'personal' vs 'both' and 'situational' together
Chi-square=5.54 df=4 p<0.1

Table 6.21 Staff perceptions of main factors in prison self-injury

	Staff Indicating				TOTAL
	V.Imp.	Q.Imp.	Not V.Imp.	Other	
	No. %	No. %	No. %	No. %	No. %
Depression	84 (65)	30 (23)	7 (5)	9 (7)	130 (100)
Bad News or Dear John Letter	77 (59)	29 (22)	5 (4)	19 (15)	130 (100)
Guilt (at the offence)	35 (27)	52 (40)	32 (25)	11 (8)	130 (100)
Lack of Communication	57 (44)	53 (41)	11 (9)	9 (7)	130 (100)
Prison Pressures	49 (38)	53 (41)	19 (15)	9 (7)	130 (100)
Mental Illness/ Breakdown	27 (21)	44 (34)	48 (37)	11 (9)	130 (100)
Temper/Anger	52 (40)	41 (32)	28 (22)	9 (7)	130 (100)
Boredom	59 (45)	43 (33)	18 (14)	9 (7)	130 (100)

Table 6.22 Staff perceptions of main factors in prison suicide and self-injury (open question)

Main factors	SUICIDE		SELF-INJURY	
	Staff indicating			
	No.	%	No.	%
INDIV+SITUATIONAL				
Outside Pressure/Family	68	(53)	21	(16)
Several (Internal+External)	41	(32)	27	(21)
INDIVIDUAL				
Guilt, Shame, Remorse	32	(25)	4	(3)
Helplessness/Frustration	19	(15)	18	(14)
No Future/Hopelessness	17	(13)	3	(2)
Inadequacy/Unable to Cope	16	(12)	30	(23)
Depression	12	(9)	10	(8)
Lack of Self Respect	10	(8)	7	(5)
Psychiatric Illness	8	(6)	7	(5)
Anxiety	5	(4)	3	(2)
Anger	3	(2)	5	(4)
SITUATIONAL				
Pressure from Other Inmates	40	(31)	45	(35)
The Sentence (etc.)	29	(22)	7	(5)
Fear/Uncertainty	22	(17)	7	(5)
Conditions/Prison Environment	21	(16)	13	(10)
Isolation/No one to Talk to	15	(12)	9	(7)
First time Offender	16	(12)	2	(2)
Stress	10	(8)	5	(4)
Bang Up/Boredom	3	(2)	13	(10)
Don't Know	7	(5)	4	(3)
Other	22	(17)	13	(10)
Attention-seeking/Cry for help	–	–	55	(43)
Manipulation (specific)	–	–	43	(34)
Manipulation (general)	–	–	18	(14)

Table 6.23 Similarity of reasons given for suicide and self-injury

	No.	%
No Overlap	66	(51)
Some Overlap	30	(23)
Similar Reasons	27	(21)
Missing/Not Known	7	(5)
TOTAL	130	(100)

Table 6.24 Personal experience of inmate suicide or serious suicide attempts in custody

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Suicide	72	(56)	34	(49)	14	(67)	24	(63)
Serious Attempt(s)	38	(29)	27	(39)	6	(29)	5	(13)
None	11	(8)	6	(9)	-		5	(13)
Other	8	(6)	3	(4)	1	(5)	4	(11)
TOTAL	129	(100)	70	(100)	21	(100)	38	(100)

Table 6.25 Staff support after suicide and self-injury

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Not Enough	82	(71)	47	(75)	15	(75)	20	(61)
Some/Improving	20	(17)	6	(10)	5	(25)	9	(27)
Yes	7	(6)	4	(6)	-		3	(9)
Not Necessary/Other	7	(6)	6	(9)	-		1	(3)
TOTAL	116	(100)	63	(100)	20	(100)	33	(100)
			Chi-square=10.16 df=6 n.sig.					

Table 6.26 Do staff experience depression, anxiety or unreasonable levels of stress?

	All Staff	Officers	Hospital Staff	Others
	No. %	No. %	No. %	No. %
Yes	120 (95)	67 (96)	18 (86)	35 (97)
No	3 (3)	1 (1)	2 (9)	- (-)
Other	4 (3)	2 (3)	1 (5)	1 (3)
TOTAL	127 (101)	70 (100)	21 (100)	36 (100)
		Chi-square=6.09 df=4 n.sig.		

Table 6.27 Reasons for staff depression/anxiety and stress

	All Staff	Officers	Hospital Staff	Others
	No. %	No. %	No. %	No. %
Nature of Job	76 (61)	43 (62)	12 (57)	21 (60)
No Support	14 (11)	5 (7)	5 (24)	4 (11)
Normal Reasons	6 (5)	3 (4)	1 (5)	2 (6)
Mixture	22 (18)	13 (19)	2 (10)	7 (20)
Other/Don't Know	7 (5)	5 (7)	1 (5)	1 (3)
TOTAL	125 (100)	69 (100)	21 (100)	35 (100)
		Chi-square=5.90 df=8 n.sig.		

Table 6.28 Do you know any prison officers who have committed suicide?

	All Staff	Officers	Hospital Staff	Others
	No. %	No. %	No. %	No. %
No	42 (33)	18 (26)	2 (10)	22 (58)
Yes - Suicide	61 (48)	38 (54)	14 (67)	9 (18)
Yes - Attempt	13 (10)	7 (10)	4 (19)	2 (5)
Yes - Contemplated	7 (5)	5 (7)	-	2 (5)
Other	6 (4)	2 (3)	1 (5)	3 (8)
TOTAL	129(100)	70(100)	21 (100)	38(100)
		Chi-square=24.21 df=8 p<.01		

Table 6.29 Prison staff morale

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Very High	10	(8)	7	(10)	-		3	(8)
Good	31	(24)	19	(27)	2	(10)	10	(26)
Moderate	42	(33)	26	(37)	6	(29)	10	(26)
Poor	23	(18)	9	(13)	5	(24)	9	(24)
Very Poor	19	(15)	9	(13)	7	(33)	3	(8)
Other	4	(3)	-		1	(5)	3	(8)
TOTAL	129	(100)	70	(100)	21	(100)	38	(100)

Chi-square=18.90 df=10 p<.05

Table 6.30 Staff descriptions of staff-inmate relationships

	All Staff		Officers		Hospital Staff		Others	
	No.	%	No.	%	No.	%	No.	%
Good	100	(78)	57	(82)	17	(81)	26	(68)
Reasonable	25	(19)	12	(17)	4	(19)	9	(23)
Difficult	4	(3)	1	(1)	-		3	(8)
TOTALS	129	(100)	70	(100)	21	(100)	38	(100)

Chi-square=5.22 df=4 n.sig.

Table 6.31 Staff descriptions of staff-inmate relationships, by establishment

	Prison 1		Prison 2		Prison 3		Prison 4	
	No.	%	No.	%	No.	%	No.	%
Good	26	(90)	29	(91)	23	(77)	22	(58)
Reasonable	3	(10)	3	(9)	7	(23)	12	(32)
Difficult	-		-		-		4	(11)
TOTAL	29	(100)	32	(100)	30	(100)	38	(101)

Chi-square=18.76 df=6 p<0.01

1 missing

Table 6.32 Do inmates ever have to worry about their own physical safety, from other inmates?

	All Staff	Officers	Hospital Staff	Others
	No. %	No. %	No. %	No. %
Yes	91 (72)	52 (74)	16 (73)	23 (64)
Some	33 (26)	17 (24)	6 (27)	12 (33)
No	2 (2)	1 (1)	-	1 (3)
TOTAL	126 (100)	70 (100)	22 (100)	36 (100)

For differences between staff groups on 'yes' and 'some', Chi-square=1.78 df=4 n.sig.

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