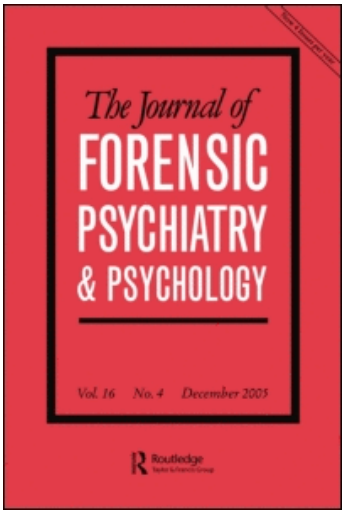

Journal of Forensic Psychiatry & Psychology
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t714592861

The identification and management of suicide risk in local prisons

Jane Senior [a]; Adrian J. Hayes [a]; Daniel Pratt [a]; Stuart D. Thomas [b]; Tom Fahy [b]; Morven Leese [b]; Andy Bowen [a]; Greg Taylor [a]; Gillian Lever-Green [a]; Tanya Graham [b]; Anna Pearson [a]; Mukhtar Ahmed [c];Jenny J. Shaw [a]
[a] North West Forensic Academic Network, University of Manchester, Liverpool, UK [b] Institute of Psychiatry, London, UK [c] Guild Lodge, Preston, UK

To cite this Article Senior, Jane , Hayes, Adrian J. , Pratt, Daniel , Thomas, Stuart D. , Fahy, Tom , Leese, Morven , Bowen, Andy , Taylor, Greg , Lever-Green, Gillian , Graham, Tanya , Pearson, Anna , Ahmed, Mukhtar andShaw, Jenny J.(2007) 'The identification and management of suicide risk in local prisons', Journal of Forensic Psychiatry & Psychology, 18: 3, 368 — 380
To link to this Article: DOI: 10.1080/14789940701470218
URL: http://dx.doi.org/10.1080/14789940701470218

The Journal of Forensic Psychiatry & Psychology,
September 2007; 18(3): 368 – 380

Routledge
Taylor & Francis Group

The identification and management of suicide risk in local prisons

JANE SENIOR[1], ADRIAN J. HAYES[1], DANIEL PRATT[1], STUART D. THOMAS[2], TOM FAHY[2], MORVEN LEESE[2], ANDY BOWEN[1], GREG TAYLOR[1], GILLIAN LEVER-GREEN[1], TANYA GRAHAM[2], ANNA PEARSON[1], MUKHTAR AHMED[3], & JENNY J. SHAW[1]

[1]*North West Forensic Academic Network, University of Manchester, Liverpool, UK,* [2]*Institute of Psychiatry, London SE5 8AF, UK, and* [3]*Guild Lodge, Preston, UK*

Abstract
This study aimed to examine rates of mental illness and suicidal ideation in a random sample of prisoners in four UK prisons, and to examine the characteristics and quality of care received by prisoners identified as at current risk of suicide/self harm. Methods used were: cross-sectional study of mental illness and suicidal ideation in a random sample of prisoners, and in all prisoners specifically managed as a suicide risk; examination of suicide risk care plans; and comparative study of information sharing across suicide risk and healthcare documentation. Results showed that prisoners identified as at risk of suicide/self harm had significantly higher rates of clinically significant symptoms of mental illness, as measured by a standardized instrument, than the general prison population. There was a high level of suicide risk that had not been identified. Problems with the delivery of planned care interventions were revealed and little congruence was found between systems of documentation. The suicide care planning system was correctly targeting a proportion of those at risk but high levels of unmet need remained. The care planning and information sharing processes within prisons and between prisons and other agencies should be improved.

Keywords: *Prison, suicide, self harm, mental health, risk, care planning*

Introduction

The rate of suicide among prisoners in England and Wales has been rising over recent years (Royal College of Psychiatrists, 2002), although it fell in

Correspondence: Jane Senior, North West Forensic Academic Network, University of Manchester, Hostel 1, Ashworth Hospital, Maghull, Liverpool, L31 1HW, UK. E-mail: jane.senior@merseycare.nhs.uk

ISSN 1478-9949 print/ISSN 1478-9957 online © 2007 Taylor & Francis
DOI: 10.1080/14789940701470218

2005 (figures obtained directly from the Home Office). Conversely, the rate of suicide in the UK general population has been falling in recent years (National Institute for Mental Health in England, 2003) to a rate of 8.5 per 100,000 for the 3 years 2003–6 (National Institute for Mental Health in England, 2007), 12 times lower than the prison rate of 102.6 per 100,000 (Safer Custody Group, 2005). There is evidence to suggest that prisoners with mental health problems are at greater risk of suicide (Towl & Crighton, 2000), and women are over-represented in those who complete suicide or carry out acts of self harm (Snow, Paton, Oram, & Teers, 2002).

In England and Wales, suicides are most prevalent in 'local prisons', where those awaiting trial, those serving short sentences, and those serving the early part of longer sentences are located (Shaw, Baker, Hunt, Moloney, & Appleby, 2004; Towl & Crighton, 1998). By virtue of these functions, local prisons invariably have a high turnover of prisoners, with many people staying for only short periods before they are either released back into the community or transferred to longer-term establishments.

In 1991, HM Prison Service introduced an operational policy for the identification and management of prisoners at risk of suicide. Known colloquially as the F2052SH system (from the reference number of the document opened when a prisoner is considered to be at risk), its emphasis was on multidisciplinary care. Hence, staff from all professional disciplines were responsible for the management of suicide risk, in contrast to the previous heavy emphasis on intervention from health care staff.

Any member of prison staff could initiate the F2052SH procedure for any prisoner identified as at risk of suicide. Once an F2052SH document was opened, the prisoner was assessed – first by the initiating member of staff, then by the officer in charge of the prison wing, a nurse, and a medical officer. The document included a multidisciplinary care plan detailing required interventions; this care plan had to be updated at multidisciplinary reviews, held at least fortnightly. Any staff member that has contact with a prisoner with an open F2052SH recorded this contact in a supervision record, with policy dictating that three observations per day should be made. The system could be discontinued at any review meeting, when staff and prisoner agreed that risk has reduced sufficiently. F2052SH documents were kept at the same location as the prisoner and were available for all staff to consult, thus differing from confidential clinical records available only to health care staff.

The adequacy and effectiveness of the F2052SH policy was called into question as the UK prison suicide rate continued to rise following its inception. Specifically, the system was described as a 'paper exercise' focussing on the recording of bland, ineffective care plans (Her Majesty's Chief Inspector of Prisons, 1999; Royal College of Psychiatrists, 2002).

The current study is the first clinical evaluation of this suicide risk management system. The first aim of this study was to assess the ability of the F2052SH system to identify effectively those at high risk of suicide by comparing rates of suicidal ideation and mental illness between those identified as a suicide risk and a random sample of the prison population. The second aim was to examine the quality and efficacy of F2052SH care planning.

Method

This study was conducted in four local prisons in England: one adult male prison, two male young offender institutions (housing prisoners aged 18–21), and one female establishment (housing both adults and young offenders). There were two components to the study.

1. Comparison of prisoners specifically identified as a suicide risk with the general prison population

On specific census dates, we identified at each site those prisoners with open F2052SH documents and a stratified random sample of prisoners. The sample ensured representation from all areas of the prison, including health care centres (medical wings), remand and sentenced wings, vulnerable prisoner units (where prisoners are located who may be at risk from other prisoners, for example due to the type of crime with which they are charged), and detoxification centres.

Prisoners provided informed consent, and were interviewed using a number of measures:

- a demographic and criminological proforma designed for the study
- the Brief Psychiatric Rating Scale (BPRS; Overall & Gorman, 1962), which examines the severity of 24 psychiatric symptoms, each rated on a scale of 1–7: a score of 4 or above indicates a clinical level of severity
- the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, & Trexler, 1974), on which 20 yes/no questions are scored to give a measure of hopelessness: a score of 9 or above indicates increased risk of suicide (Beck, Steer, Kovacs, & Garrison, 1985)
- the Beck Scale for Suicidal Ideation (BSS; Beck, Steer, & Ranieri, 1988), which investigates previous suicide attempts and current suicidal ideation: a positive answer to either of two screening questions leads to further questions on current suicide intent, and this threshold was used as a cut-off in this study
- the Camberwell Assessment of Need Forensic Short Version (CANFOR-S; Thomas et al., 2003), which examines 25 domains of health and social need and determines whether needs are met or unmet

according to whether any support had been provided and whether this support was perceived as adequate: an unmet need is defined as inadequate support for a current problem area

2. Audit of care planning

We examined a sample of F2052SH documents that had been closed in the three months prior to the census dates. We investigated the reasons for the initiation of the F2052SH procedures, subsequent care planning and reviews, and the process of closure.

For a smaller sample of documentation, we also compared F2052SH records with clinical records in order to examine the sharing of risk-pertinent information between staff groups. We identified entries in clinical records relating to suicide and self injury and cross-referenced these with F2052SH documentation to assess whether information on risk was shared among all staff (i.e., was included in the F2052SH) or known only to health care staff (i.e., recorded only in the clinical records).

Statistics

Chi-square and Mann-Whitney U tests were used to compare groups. Analyses were carried out using SPSS (v. 10.1) and STATA.

Results

1. Comparison of prisoners identified as a suicide risk with the general prison population

Results from the interviews are presented in Table I. We approached 271 prisoners for inclusion in the random sample and 264 (97%) agreed to be interviewed. The random sample comprised 12% of the total prison population across the study sites, and was representative of their respective populations with regard to socio-demographic and offence data. Six prisoners selected in the random sample had open F2052SH documents. These people were excluded from the sample as they were represented in the group identified as a current risk. Overall, therefore, the random prison population sample consisted of 258 prisoners.

Random sample. The mean age of this group was 26 years ($SD = 9$) and over half were single (145; 56%). There were 82 women (32%) and 176 men (68%). The majority of prisoners described their ethnic origin as white (225; 87%), and most were unemployed prior to imprisonment (174; 67%). Also, 77 prisoners (30%) were on remand awaiting trial and the remaining 181 (70%) had been convicted and sentenced.

Table I. Interview data from cross-sectional sample and open F2052SH sample with comparisons.

	Cross-sectional sample of prisoners (excluding those with open F2052SH) *n* (258)		Current suicide risk (open F2052SH) *n* (73)		Comparison of non-F2052SH cross-sectional and open F2052SH samples	
	n	%	*n*	%	χ^2 (*df*)	*p*
Offence history						
Violent/sex offences	136	53	27	37	5.63 (1)	<.05
Mental health history						
Previous contact with services	64	25	47	64	39.99 (1)	<.001
BPRS						
Clinical anxiety*	32	12	36	49	47.49 (1)	<.001
Clinical depression*	25	10	40	55	73.35 (1)	<.001
Clinical suicidality*	8	3	29	40	76.87 (1)	<.001
Clinical hallucinations*	14	5	23	32	38.98 (1)	<.001
CANFOR-S unmet needs						
Food	99	38	29	40	0.04 (1)	ns
Daytime activities	96	37	44	60	12.40 (1)	<.001
Safety to self	14	5	40	55	101.58 (1)	<.001
Psychological distress	47	18	36	49	29.29 (1)	<.001
BHS						
Above cut-off (≥9)	43	17	45	62	58.97 (1)	<.001
BSS						
Above cut-off (level of suicidal ideation requiring further clinical assessment)	31	12	39	53	63.77 (1)	<.001

(*continued*)

Table I. (*Continued*).

	Cross-sectional sample of prisoners (excluding those with open F2052SH) *n* (258)		Current suicide risk (open F2052SH) *n* (73)		Comparison of non-F2052SH cross-sectional and open F2052SH samples	
	n	%	*n*	%	χ^2 (*df*)	*p*
Specific plan for suicide	7	3	15	21	29.17 (1)	<.001
Access to method and/or opportunity	12	5	19	26	30.63 (1)	<.001
Courage and ability to commit suicide	10	4	23	32	48.40 (1)	<.001
Suicide note completed	1	0.4	7	10	20.43 (1)	<.001
Ever attempted suicide (lifetime)	65	25	59	81	75.16 (1)	<.001
F2052SH currently open	0	0	73	100		
	Mean	*SD*	Mean	*SD*	Mann-Whitney U	*p*
Demographics						
Age	26.45	9.40	30.32	7.98	6272.50	<.001
Total scores						
BPRS	29.82	6.38	41.47	11.18	3301.50	<.001
CANFOR-S unmet needs	2.83	2.46	6.15	3.52	4137.50	<.001

*Score of 4 or greater on AN individual item of the BPRS.
Mann Whitney U test reported for continuous data, chi square test of association for categorical data.

A quarter disclosed previous contact with mental health services (64; 25%). The same proportion had attempted suicide at some time in their lives (65; 25%). According to the BPRS, 32 prisoners (12%) were rated as clinically anxious, 25 (10%) as clinically depressed, and 14 (5%) as having a clinical level of hallucinations, indicating possible psychosis. According to ratings on the BSS, 31 prisoners (12%) had a level of suicidal ideation requiring further clinical assessment while 43 (17%) scored above the cut-off for hopelessness on the BHS. The BSS revealed that seven prisoners (3%) had made a specific suicide plan and 12 (5%) considered they had access to the method and opportunity to complete suicide. The three most common unmet needs according to the CANFOR-S were for suitable food, daytime activities, and support for psychological distress.

Current suicide risk. On the census dates, 90 prisoners had an open F2052SH document, representing 4% of the overall population of the four prisons. Of these, 73 (81%) agreed to be interviewed.

In this group, there were 28 women (38%) and 45 men (62%). The mean age of this group was 30 years ($SD = 8$) and again over half were single (40; 55%). The majority of prisoners described their ethnic origin as white (64; 88%), and most were unemployed prior to imprisonment (57; 78%). In all, 24 prisoners (33%) were on remand awaiting trial and the remaining 49 (67%) had been convicted. Almost two-thirds had had prior contact with mental health services (47; 64%), and most had previously attempted suicide (59; 81%).

According to the BPRS, 36 (49%) were rated as clinically anxious, 40 (55%) as clinically depressed, and 23 (32%) as having a clinical level of hallucinations. The BSS showed that 39 prisoners (53%) were rated as having a level of suicidal ideation requiring further clinical assessment, and 45 (62%) rated above the cut-off for hopelessness on the BHS. Findings showed that 15 (21%) had made a specific plan for suicide, and 19 (26%) considered they had access to the method and opportunity to complete suicide. In this group, the three most common CANFOR-S unmet needs were for daytime activities, support for safety to self, and support for psychological distress.

Comparison. When the two groups were compared, we found that those identified as at risk of suicide were significantly older and significantly less likely to have a main offence of a violent or sexual nature. This group had significantly higher rates of anxiety, depression, and hallucinations, and scored significantly higher on all three measures of suicidal ideation. Finally, they had significantly more unmet needs on all CANFOR-S domains except suitable food, which appeared to be a common unmet need for all prisoners. In the random sample, we found 31 (12%)

prisoners with a BSS level of suicidal ideation requiring further clinical investigation but with no F2052SH document open.

2. Audit of care planning

F2052SH audit. Audit data are presented in Table II. In the three months prior to the census dates, 518 F2052SH documents were closed in the four sites, of which we examined a random sample of 251 (48%).

Table II. Data from audit of closed F2052SH documents ($n = 251$).

	n	%	95%CI
Rates of completion			
Front sheet information recorded	198	79	74–84
Case review signed	233	93	90–96
Residential manager signature on closure	230	92	88–95
Rates of completion – healthcare section			
Healthcare worker's assessment legibly recorded	218	87	83–91
Doctor's review section legibly recorded	114	45	39–52
Summary of initial case review			
Initial review held within 72 hours	135	54	48–60
Support plan identified	177	71	65–76
Specific actions delegated to individuals	48	19	14–24
Specific actions delegated to departments	121	48	42–54
Date set for next meeting	40	16	11–20
Elements within initial support plan			
Support the prisoner	152	61	55–67
Closer supervision	103	41	35–47
Shared cell	67	27	21–32
Cell or unit change	17	7	4–10
Involve in association/activities	8	3	1–5
Allocate personal officer or key worker	6	2	1–4
Involve family	5	2	0–4
Change of employment	5	2	0–4
Reward positive coping by prisoner	2	1	0–2
In-cell hobbies	3	1	0–3
Involve in group work	1	0	0–1
Help prisoner with future planning	1	0	0–1
Arrange special befriending	0	0	0–0
Other	44	18	13–22
Summary of case closures			
Closure decided at case review	217	87	82–91
Evidence of presence of appropriate personnel	119	47	41–54
Evidence of positive improvement/reduced risk at closure	160	64	58–70
Evidence of ongoing actions to support prisoner after closure	79	32	26–37

Percentages and 95% CIs reported to nearest whole numbers.

Most sections where staff were directed to complete factual information were completed legibly and comprehensively. However, doctors' contributions were considered to be illegible in 137 documents (55%).

When examining elements of the care plans in detail, we found that vague statements such as 'support the prisoner' and 'closer supervision' were used very frequently (152; 61%, and 103; 41% respectively). More specific interventions were rare, such as 'involve in group work' (one document) and 'reward positive coping' (two documents).

Actions arising from care plan elements were infrequently delegated to specific individuals or departments and, at the female establishment, were significantly less likely to have been completed if not delegated in this way ($\chi^2 = 5.55$, $p = .05$).

At the time of case closure, there was evidence of a reduction in suicide risk in most reviews (160 documents; 64%). However, fewer than half of the case closures examined (119; 47%) were attended by personnel who had previous documented contact with the prisoner. Following closure of the F2052SH, ongoing support was formally planned in less than a third of cases (79; 31%).

Communication. We compared clinical records and F2052SH entries for 26 people. In total, there were 71 entries in clinical records relating to suicide and self harm, and a corresponding entry was made in the F2052SH in only 41 cases (58%). In 40 (56%) of the entries in clinical records, health care staff made no specific note that the prisoner had an open F2052SH, which would have indicated that the staff were aware that the prisoner was at elevated risk of suicide.

Discussion

Main findings

This study is the first clinical evaluation of the system used in England and Wales to identify and manage prisoners at risk of suicide. The data showed that the F2052SH system did identify those with a high level of suicidal ideation, a group with higher levels of mental illness than the general prison population. These prisoners had comparable BPRS scores (Marder & Meibach, 1994) and higher levels of CANFOR-S unmet need than UK psychiatric inpatients (Wright, Shanks, Alexopoulou, & Thorn, 2001). However, there was also a large group of prisoners with clinically significant mental health needs and risk of self harm/suicide that had not been identified by the F2052SH system.

We found that the F2052SH process concentrated on the physical surveillance of vulnerable prisoners rather than on encouraging meaningful interactions. Care plans were vague and there appeared to be little

accountability to ensure that planned interventions were delivered. Important information relevant to suicide risk was often recorded only in clinical records and was not shared with non-health care staff that held day-to-day responsibility for the care and supervision of high-risk prisoners. More open sharing of vital information about risk is, in our view, an essential component in the effective assessment and management of prisoners vulnerable to suicide and self harm. Education and culture change is needed to permit health care staff, who have traditionally operated within an ethos of over-arching confidentiality, to be comfortable in the disclosure of relevant, risk-pertinent information to increase the safety of at-risk prisoners.

In addition, there was a lack of any structure to provide support for ongoing needs following closure of an F2052SH. It is known that risk of suicide is increased in the period following discharge from in-patient mental health care (Department of Health, 2001). Recent research also shows an elevated risk of suicide following release from prison (Pratt, Piper, Appleby, Webb, & Shaw, 2006). It is possible that risk may be similarly high following the termination of F2052SH monitoring while in custody: this is an area requiring further investigation.

The proportion of prisoners from ethnic minorities was similar in both the random sample and the sample of those identified as at risk of suicide or self harm. This proportion, while representative of the establishments under study, was higher than that in the national population of prisoners (Home Office, 2002). Data show that ethnic minorities are under-represented in completed suicides (Shaw et al., 2004).

Limitations

The cross-sectional data we report were representative of the prison populations from which they were taken, but it is not known if they can be generalized to other sites, given the wide variation in prison service provision across the country. Only one local adult male prison was included in our study, although this type of prison generally has higher suicide rates and greater numbers of open F2052SH documents than long-term male establishments. It is likely that levels of mental health problems and suicide risk in more stable sentenced prison populations may be lower. Our study was cross-sectional, representing a snapshot of the four prisons; several such studies would provide a more representative picture.

Related studies

Previous studies have shown high rates of previous self harm (Singleton, et al., 1998), high levels of unmet need, and poor detection of mental illness

in prison populations (Birmingham, Mason, & Grubin, 1996). This study is the first to examine specifically the clinical, social, and demographic characteristics of those monitored as at high risk of self harm in prisons.

A recent study of completed suicide in custody (Shaw et al., 2004) found that only about a quarter of these prisoners were cared for under the F2052SH system at the time of their death; a further 28% had been previously monitored on an F2052SH closed by the time of their death.

Of the prisoners who complete suicide, a third do so within their first seven days of custody (Crighton & Towl, 1997; Shaw et al., 2004). This finding emphasizes the importance of systematic screening and monitoring of prisoners in the early period of custody, as well as increased vigilance at sensitive times during a prisoner's confinement. Such interventions, as well as the provision of safer environments (e.g., free of ligature points/CCTV monitoring) and adequate detoxification services, are being introduced across the national prison estate as part of Her Majesty's Prison Service's Safer Custody Group's (2001) initiatives to reduce prison suicides. However, we would argue that, in addition, a more effective care planning and monitoring system of those at risk is also required.

Implications

We found that the F2052SH system did not identify all those who, according to the results of standardized screening tools, were at high risk of suicide. There is therefore a need for accurate initial screening to ensure rapid identification of those at risk (Mitcheson, Rix, Renvoizee, & Schweiger, 1994), followed by comprehensive assessment and subsequent monitoring and treatment in the prison environment (Birmingham et al., 1996). We recommend the introduction of systems comparable to the Care Programme Approach (CPA; Department of Health, 1990) into prisons, with care coordinators accountable for ensuring the delivery of individualized, specific, appropriate care plans, including ongoing support plans following closure. At-risk prisoners should be active participants in the process throughout, encouraging them to proactive partners, rather than passive recipients, in the process of care, support, and risk reduction. Wherever possible, information relevant to risk should be shared among all staff working with the vulnerable prisoner, while maintaining a prisoner's right to confidentiality and complying with data protection laws. However, because the risk factors for suicide are present in a majority of prisoners, there is also a need for prevention and health promotion measures targeting the whole prison population, including more availability of meaningful activities, strategies to promote and maintain family contacts, and comprehensive detoxification services. With the introduction of these initiatives those at risk of suicide, and the prison population as a whole, should receive a higher standard of care.

Since this research, a new system of care and management has been established for prisoners at risk of suicide and self harm. ACCT (Assessment, Care in Custody, and Teamwork) builds on the multi-disciplinary approach to suicide prevention engendered by the F2052SH, and includes more robust initial assessments of risks and needs. New roles have been introduced (assessor and case manager), promoting accountability in ensuring the delivery of care plan elements. Furthermore, there is an emphasis on personalized care, on fully engaging with prisoners in their own care, on the consistent involvement of appropriate staff, and on quality interactions between staff and prisoners. The majority of prisons have now begun using ACCT and time will tell what effect the changes will have on the level of suicide and self harm in prison.

References

Beck, A. T., Steer, R. A., Kovacs, M., & Garrison, B. (1985). Hopelessness and eventual suicide: A 10-year perspective study of patients hospitalised with suicidal ideation. *American Journal of Psychiatry*, *142*, 559–563.

Beck, A. T., Steer, R. A., & Ranieri, W. F. (1988). Scale for Suicidal Ideation: Psychometric properties of a self-report version. *Journal of Clinical Psychology*, *44*, 499–505.

Beck, A. T., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The Hopelessness Scale. *Journal of Consulting and Clinical Psychology*, *42*, 861–865.

Birmingham, L., Mason, D., & Grubin, D. (1996). Prevalence of mental disorder in remand prisoners: Consecutive case study. *British Medical Journal*, *313*, 1521–1524.

Crighton, D., & Towl, G. (1997). Self-inflicted deaths in prison in England and Wales: An analysis of the data for 1988–1990 and 1994–1995. *Issues in Criminological and Legal Psychology*, *28*, 12–20.

Department of Health. (1990). *Caring for People. The Care Programme Approach for People with a Mental Illness Referred to Specialist Mental Health Services*. Joint Health/Social Services Circular. C(90)23/LASSL(90)11. London: Department of Health.

Department of Health. (2001). *Safety first: Five-year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: Department of Health.

Her Majesty's Chief Inspector of Prisons. (1999). *Suicide is everyone's concern: A thematic review*. London: Home Office.

Home Office. (2002). *Prison statistics England and Wales 2002*. London: Her Majesty's Stationery Office.

Marder, S. R., & Meibach, R. C. (1994). Risperidone in the treatment of schizophrenia. *American Journal of Psychiatry*, *151*, 825–834.

Mitcheson, S., Rix, K. J. B., Renvoizee, E. B., & Schweiger, M. (1994). Recorded psychiatric morbidity in a large prison for male sentenced and remanded prisoners. *Medicine, Science and the Law*, *34*, 324–330.

National Institute for Mental Health in England. (2003). *National Suicide Prevention Strategy for England: Annual report on progress 2003*. London: Department of Health.

National Institute for Mental Health in England. (2007). *National Suicide Prevention Strategy for England Annual report on progress 2006*. Leeds: NIMHE.

Overall, J. E., & Gorman, D. R. (1962). The Brief Psychiatric Rating Scale. *Psychological Reports*, *10*, 799–812.

Pratt, D., Piper, M., Appleby, L., Webb, R., & Shaw, J. (2006). Suicide in recently released prisoners: A population-based cohort study. *The Lancet*, *368*, 119–123.

Royal College of Psychiatrists. (2002). *Suicide in prisons* (CR99). London: Royal College of Psychiatrists.

Safer Custody Group. (2001). *Preventing suicides and making prisons safer for all those who live and work there.* London: Her Majesty's Prison Service.

Safer Custody Group. (2005). *Safer Custody Group Self Inflicted Deaths Trends Report 2005*. London: NOMS.

Shaw, J., Baker, D., Hunt, I. M., Moloney, A., & Appleby, L. (2004). Suicide by prisoners: National clinical survey. *British Journal of Psychiatry*, *184*, 263–267.

Singleton, N., Meltzer, H., Gatward, R., Coid, J., & Deasy, D. (1998). *Psychiatric morbidity among prisoners in England and Wales: A survey carried out in 1997 by the Social Survey Division of ONS on behalf of the Department of Health.* London: Her Majesty's Stationery Office.

Snow, L., Paton, J., Oram, C., & Teers, R. (2002). Self-inflicted deaths during 2001: An analysis of trends. *The British Journal of Forensic Practice*, *4*(4), 3–17.

Thomas, S., Harty, M. A., Parrott, J., McCrone, P., Slade, M., & Thornicroft, G. (2003). *The Forensic CAN (CANFOR): A needs assessment for forensic mental health service users.* London: Gaskell.

Towl, G., & Crighton, D. (1998). Suicide in prisons in England and Wales from 1988 to 1995. *Criminal Behaviour and Mental Health*, *8*, 184–192.

Towl, G., & Crighton, D. (2000). Risk assessment and management. In G. Towl, L. Snow, & M. McHugh (Eds.), *Suicide in prisons* (pp. 66–92). Leicester: British Psychological Society.

Wright, S., Shanks, J., Alexopoulou, E., & Thornicroft, G. (2001). *Third Croydon psychiatric bed study* (Occasional paper of the Health Services Research Department). London: Institute of Psychiatry.