HM Prison & Probation Service

ACCT

Assessment, Care in Custody and Teamwork

User guidance

Contents

The ACCT process

Documents in the ACCT must appear in this order.

A resident has self-harmed, or is at risk of self-harm or suicide.

SECTION 2: CONCERN FORM

- Immediate observation levels set and handed to wing/unit supervisor or custodial manager.
- Any immediate factors added to 1.1 RISKS, TRIGGERS AND PROTECTIVE FACTORS.

SECTION 3: IMMEDIATE ACTION PLAN

- Completed by wing/unit supervisor or custodial manager within 1 hour of 2.1 CONCERN FORM being raised. Observation levels reviewed, and conversation levels set.

SECTION 4: ACCT ASSESSMENT

- Carried out by trained assessor within 24 hours of Concern Form being raised, to highlight key risk information for the case review.
- Complete 1.1 RISKS, TRIGGERS AND PROTECTIVE FACTORS.
- Provide and discuss Wellbeing Plan.

SECTION 5: CASE REVIEWS

- Multidisciplinary, facilitated by Case Co-ordinator within 25 hours of 2.1 CONCERN FORM being raised.
- Complete Care Plan. This includes updating RISKS, TRIGGERS AND PROTECTIVE FACTORS and completing 1.2 RESIDENT CONTRIBUTION, 1.3 SOURCES OF SUPPORT PLAN and 1.4 SUPPORT ACTIONS.

SECTION 6: ONGOING RECORD

- Maintained daily and, if required, further case reviews. Continuation forms can be found in Annex B and additional case review forms can be printed. These must be inserted into section 5.

ACCT closed by case review team

- Do not close the ACCT until all actions in 1.4 SUPPORT ACTIONS are complete.

SECTION 7: POST-CLOSURE

- Complete 7.2 POST-CLOSURE MONITORING for a minimum of 7 days after the closure of the ACCT, followed by 7.1 POST-CLOSURE REVIEW.
- The individual is encouraged to fill out 7.3 ACCT QUESTIONNAIRE.
- Further reviews conducted according to need. Additional post-closure review forms can be printed and must be inserted into section 7.

- An ACCT can be reopened at any point up to 6 weeks after closure if risk increases again. A new Immediate Action Plan must be completed.
- The Case Co-ordinator must determine whether a new ACCT assessment is needed.

Introduction

Assessment, Care in Custody and Teamwork (ACCT) is the case management approach used in prisons and the youth secure estate. ACCT is used to support individuals in prison or children and young people in our care who are considered to be at risk of self-harm or suicide.

This guidance is for use by any member of staff, including:

- anyone working in a prison or the youth secure estate who may identify that someone is struggling and at risk of harming themselves (this includes staff from a range of disciplines such as chaplaincy, healthcare, education, workplace staff, gym staff and family service providers)
- staff undertaking specific ACCT roles (such as Case Co-ordinators or ACCT Assessors)
- staff from the establishment or any external organisations involved in ACCT case reviews
- anyone engaging or having contact with individuals being supported through ACCT

The mandatory actions that must be carried out when an ACCT is open are detailed in policy. This guidance provides more detail about how ACCT should be implemented in practice.

The sections in this guidance reflect the structure of the ACCT. Where a section is numbered in the guide, this matches with the numbered section in the ACCT.

The guidance is not structured to be read from beginning to end – you can move to relevant sections using the contents page or index.

Each section starts with information about the purpose of that stage of the ACCT, who should carry it out and when.

Understanding risk

For ACCT to work effectively, it is essential to understand risk.

Understanding suicide risk is critical in helping us prevent suicide. It helps us give **the right support to the right people at the right time**. It helps us make **defensible decisions**, and to have **confidence** in the decisions we have made. A detailed **guide on understanding risk** can be found in the Safety Support pages on the HMPPS intranet.

Understanding self-harm risk is critical in helping us provide the right support through ACCT. We know self-harm is also a risk indicator for suicide, and it is important that it is taken seriously.

Hopelessness is a key risk indicator for suicide, and expressions of hopelessness or expecting the worst must be taken seriously.

The following warning signs may suggest someone is at risk of suicide or self harm:

Feeling internally or externally trapped (I have no control over my life)

e.g. internally: trapped by painful thoughts or feelings; externally: being in custody, being subject to immigration powers, being subject to behaviour management sanctions, removal from association.

Low fear of pain or death (I'm not afraid to die)

e.g. victims of abuse (physical, emotional, domestic), substance abuse, history of self harm, escalating self harm.

Loneliness (I'm afraid and alone)

e.g. breakdown of family relationships, bereavement, feeling of not belonging.

Feeling defeated (I'm defeated, I've lost everything, I've been brought down)

e.g. loss of family and friends, loss of social standing in community, loss of job, business.

Hopelessness (I have nothing to live for

e.g. expecting the worst, nothing to look forward to, feeling unable to change anything.

Feeling burdensome (I am a burden to others)

e.g. unable to provide for family, financial burden to them for canteen, taking up staff time.

1. Care Plan

1.1 Risks, triggers and protective factors

What?: What is this section for?

For an ACCT to be effective in supporting someone, it needs to be tailored and specific to them and their circumstances. To do this, we need to evaluate the individual's risks, triggers and the protective factors that help them cope. This helps us understand and better support them during times of crisis.

The Care Plan (including the risks, triggers and protective factors page) is at the start of the ACCT, as it is an important resource that must be referred to throughout the ACCT process by all people in the persons care.

Who?: Who must fill out this section of the ACCT?

The person completing the Concern Form should first note any initial risks, triggers and protective factors they have identified. This form then must be completed by the ACCT Assessor, then updated by Case Co-ordinators during case reviews, and any other members of staff involved with the individual. For example, if during routine observations and conversations, a new risk, trigger, or protective factor becomes apparent, the member of staff carrying out that observation or conversation must update this in the ACCT.

When?: When must this section be completed and updated?

During the ACCT assessment, case reviews and on an ad-hoc basis by any member of staff in contact with the individual as and when they become apparent.

What are risks, triggers and protective factors?

Risk factors: Pre-existing, internal characteristics about a person that may increase their risk of self-harm or suicide (e.g. mental health diagnosis, adverse childhood experiences, having been close to people who have died by suicide, previous psychological trauma). Risk factors can be mitigated through focus on helping a person to live with their difficult experiences.

Remember: Someone's risk of harm can fluctuate depending on the mix between their risk factors, triggers, protective factors and current circumstances.

Remember: Some people who deliberately harm themselves are not always able to identify a specific trigger.

Triggers: Situations or events that temporarily raise someone's risk of self-harm or suicide. They are external and temporary. Triggers can be addressed and often resolved (e.g. through additional emotional support over the anniversary of a death).

Protective factors: Conditions or attributes (skills, strengths, resources, supports or coping strategies) that help people deal more effectively with stressful events, and lower their risk of self-harm or suicide. These could include counselling, family support, activities that someone enjoys, meaningful employment or education, distraction materials (such as crosswords or meditation).

Examples of triggers and risk factors

There are many examples of events that could lead to someone self-harming or considering taking their own life. Some of these are more commonly seen in custody, such as:

Triggers

- Guilty verdict – particularly if unexpected
- Long or unexpected sentence
- First time in custody
- First night in custody
- Separation from family
- Bullying and intimidation
- Debt
- Adjudication award, segregation, change in incentive level, loss of Release on Temporary License (ROTL)
- Events relating to past trauma (e.g. for victims of domestic abuse, involvement in a violent incident)
- Parole – particularly if negative outcome
- Recall – particularly if long sentence or Imprisonment for Public Protection (IPP)
- Transfer (both to another establishment and to another location)

Risks

- Drug use – including psychoactive substances
- Guilt over offence – especially if family members are victims
- Past traumatic event
- Being socially isolated

Single-cell occupancy is also a risk factor for suicide, and the cell-sharing risk assessment (CSRA) must be considered when determining the safest place for an individual thought to be at risk of suicide. However, in some circumstances, making an individual share could increase risk, and due consideration should be given to distress changes could cause to the individual, and any undue burden the cell or room-mate may feel they would be put under.

There are many other established specific risk factors for suicide in secure estate populations. The **Risk Identification Toolkit** can be found on the safety pages on the HMPPS intranet and provides details on some of these.

Mental illness is a significant risk factor for self-harm and suicide. It is very important to stay alert for signs that someone is mentally unwell. This can include persistent low mood, but also a broad range of symptoms such as disordered eating (such as avoiding food or stimulating vomiting), hearing voices, or rapid mood changes. If you are concerned about someone's mental health, you must refer them for a mental health assessment – this can be done by filling out the mental health referral form (Annex G).

Transgender individuals may be more at risk of self-harm if one of their triggers is being treated as male when they identify as female, and vice versa. When supporting transgender individuals through ACCT, PSI 2016/17 on the care and management of transgender individuals in prison must be considered alongside the ACCT process.

For **individuals who are married, have partners or who are parents**, imprisonment will bring a number of challenges and can lead to breakdowns of relationships. Family service providers can often be important in supporting family relationships through imprisonment, but it is important to also be alert to individuals who are experiencing relationship breakdowns, as this can both remove a significant protective factor, and be a particularly risky time.

In some **cultural or religious groups**, there may be a significant stigma against self-harm. In this case, the individual may have peer support as a protective factor but may specifically request that this is or is not someone from their cultural or religious community within the establishment. When assessing risk, consider whether the individual may be more likely to hide self-harm as a result of stigma or shame.

Foreign national individuals may have significant anxieties around deportation, and finding out new information about their case may be a significant trigger for thoughts about self-harm or suicide. It is therefore important that breaking any news related to immigration proceedings is handled sensitively, and the opening of an ACCT is considered in the event of an individual receiving bad news. When breaking bad news, check that there is a clear understanding, as confusion can cause unnecessary distress, and use translation services if needed.

Some **disabled individuals** may not readily have access to activities that could be significant protective factors, so consideration must be given to what reasonable adjustments can be made to facilitate this. If the individual requires communication support, such as Easy Read, concepts explained in plain English, or a British Sign Language interpreter, then this must be provided.

Older and disabled individuals frequently report loneliness as a key risk factor, as they may not have as many sources of support outside of prison who they can turn to. This can also apply to those serving long sentences, or who are care experienced. Some older individuals in prison have said that a particularly important protective factor is that they have peer support networks in prison, and time to chat and get to know staff.

This is not an exhaustive list of examples but highlights how an individual's identity and background will often strongly influence their risks, triggers and protective factors, and the support they will need. This is why it is important to get to know the individual and work to understand their circumstances from their perspective.

How can information on risks, triggers and protective factors be used?

The information contained in the risks, triggers and protective factors page (1.1) can be used when supporting an individual at risk of harm to themselves. This must be considered:

- when completing the Support Actions
- when setting observation and conversation levels
- when developing Emergency Access Plans for individuals on constant supervision
- by all staff undertaking observations and conversations with the individual

Where an individual's behaviour is particularly challenging for staff it is important to consider why. All behaviour has a purpose and it is important to consider the underlying causes to address it. Risks and triggers are important considerations, and protective factors may help in supporting an individual to move away from challenging behaviour. This aligns with Challenge, Support and Intervention Plans (CSIPs), and risks, triggers and protective factors must be considered across both case management systems.

How we manage challenging behaviour (e.g. through adjudications, location in segregation, moving down an incentive level) can also influence risk. Understanding existing risks, triggers and protective factors can be valuable in navigating this. This understanding allows effective identification of Support Actions that can reduce the impact of any outcome or decision that may increase risk.

More information on the risks for suicide can be found on the intranet pages on **risk identification** and **suicide and self-harm prevention**, as well as on the **safety group pages**.

1.2 Resident Contribution

What?: This section allows the contribution of the individual to be clearly documented in the ACCT. This is an important part of ensuring ACCT takes a person-centred approach, promoting active involvement of the individual and ensuring this is clearly documented.

Who?: The individual should have the opportunity to contribute to their ACCT in a range of ways, including during case reviews. The Resident Contribution form is one way that a written contribution can be recorded in the ACCT itself, and referred back to. There are a variety of ways the form can be completed, and this must be explained to the individual.

The Resident Contribution form can be completed by the individual themselves, with support from appropriate peers, staff or other sources of support where required. People for whom English is not a fluent language must be offered assistance to complete the form either with a member of staff using translation services, or in their native language using translation services. If the individual has low literacy, they can nominate a trusted person to assist their filling out the form. This must then be signed by the Case Co-ordinator.

When?: Before or during case reviews.

The ACCT process can only be effective if it is appropriately tailored to the individual. This means there must be good communication between staff and the individual at all stages so support is provided that best fits their needs.

Attending an ACCT review during a time of crisis can be daunting. The Case Co-ordinator is encouraged to check before the meeting that the individual is comfortable with where it will take place, if there are specific members of staff they would like to attend and then confirm all attendees.

The individual must:

- have the opportunity to be involved in all case reviews
- be introduced to the people involved
- have each part of the process – including what to expect – explained to them
- have regular opportunities to provide input and feedback

The Resident Contribution form can provide insights that can be used by the multi-disciplinary team to inform discussion, and to input directly into the rest of the Care Plan, including the Support Actions. It also gives the individual some control of their care, which is an important part of a person-centred approach. It is important that this feedback is documented, as it ensures that the individual can make a meaningful contribution to their ACCT, and that their input can be referred to at later stages. If the individual takes the form away to complete, the Case Co-ordinator is responsible for checking that it is brought back to the next case review.

The Care Plan, including the Resident Contribution form, is an important resource that must be referred to by all people involved in the ACCT process. The Care Plan is at the start of the ACCT process for this reason.

The Resident Contribution form is only one way of ensuring that the individual is included in decisions about their support. Evidence shows that meaningful conversations, keeping the ACCT up to date with information relevant to risk, promoting involvement in case reviews, providing translation services and reasonable adjustments, and making the ACCT process transparent and easy to understand, will all help provide better outcomes.

Wellbeing Plans

What?: The Wellbeing Plan is a useful self-help tool that includes a number of activities that can support wellbeing. Any individual can request a Wellbeing Plan – they do not need to be supported through ACCT to access this. It is good practice, however, for the Wellbeing Plan to be offered to the individual during the ACCT assessment, as another route through which they can consider their own needs and shape their care.

Who?: This is completed by the individual, with support from staff, appropriate peers or other trusted sources of support if required. The ACCT Assessor may start a conversation about the usefulness of the plan with the individual during the ACCT assessment and encourage completion. The Case Co-ordinator may also wish to subsequently raise this with the individual.

When?: At any time. This should be a resource also available to those not on an ACCT. For individuals receiving support through ACCT, however, the ACCT assessment may provide an ideal time to highlight this resource.

Completing a Wellbeing Plan can play a vital role in keeping an individual safe during periods of distress or crisis.

While the plan is not mandatory, staff can ask the individual if they would like to complete one and explain the benefits of doing so. Individuals in prison or the youth secure estate can ask for or be offered a Wellbeing Plan at any time. If the offer of completing a Wellbeing Plan is accepted, this should be recorded in the ACCT (where will depend on when this was offered i.e. during ACCT assessment or case review). It is also worth bearing in mind that a time of crisis may not be the best time to fill out the plan, and it may take time for the individual to complete.

What are the benefits of a Wellbeing Plan?

- It provides the individual with a go-to list of things they can do to reduce and manage their distress. For example, it can include a list of coping mechanisms the individual can work through when feeling distressed, or it may remind them of positive things in their life and sources of hope.
- It facilitates honest communication between an individual and the team caring for them (if they are happy to share content).
- It gives the individual a sense of control over their care and support by focusing on what they can do to cope during a period of distress or crisis.
- It can help them to better engage in the ACCT process.

The Wellbeing Plan is for the individual to use. It is therefore essential that they have access to it at all times. You should discuss with the individual where they want to keep it – either in their cell/room or somewhere that a member of staff can easily retrieve it for them. Bear in mind that the Wellbeing Plan may contain personal and sensitive information which can only be viewed, used or shared with the individual's permission.

Remember: A Wellbeing Plan is not a substitute for support provided via staff, and must not replace Support Actions or the ACCT process.

1.3 Involving sources of support

What?: The Sources of Support plan is used to document the support networks a resident has which help to keep them safe. This may include staff members (such as chaplaincy or key workers), peer support or support outside prison or youth secure estate (such as family and friends). This page also includes a permission box for the individual to agree to other external sources of support to be involved in the ACCT process, and what information can be shared.

Who?: Can be initiated by the ACCT Assessor, but is explored in detail and co-ordinated by the Case Co-ordinator. This form can subsequently be updated by any staff, but remains the responsibility of the Case Co-ordinator and should be discussed at case reviews.

When?: Sources of Support Plan first explored with the individual during the first case review. Then involvement can occur at any stage after that.

Where consent to share information is given, and the relevant checks have been made to ensure that contact is appropriate, efforts made to engage external sources of support will need to be documented in the Record of Case Review and/or the Ongoing Record as appropriate.

Once engaged, sources of support may be involved in supporting and progressing Support Actions, case reviews, Care Plans, Wellbeing Plans, or any other action deemed appropriate.

Why is it helpful to engage external sources of support with the ACCT process?

It is important to invest the time to ask an individual who is being supported using ACCT whether they would like a family member, friend or other source of support to be involved in their care to boost the support available to them. *Note: in the youth secure estate, notifying family or carers that the young person is being supported through ACCT is standard practice and they can only be excluded from this process in exceptional circumstances, e.g. where there are safeguarding proceedings in place that prevent contact with family.*

An individual's family or significant other may well be in a better position to know when something is wrong, and to spot signs of improvement. They can also offer insight into past behaviour, what is 'normal' for that individual and what support has helped in the past. In this way, they may be a valuable addition to the multi-disciplinary team supporting the individual to reduce their risk of harm. We must act on the information received from sources of support such as families, as they often know the person best.

If you have the permission of the individual you can share relevant information about their ACCT support with the designated family members or significant others.

Not all individuals will give consent for information relating to the ACCT to be shared with their family or friends, and it is important to respect this decision. It is also important to keep in mind that involving family or significant others may feel right at certain times and not others, so this needs to be reviewed and discussed regularly – consent must not be assumed indefinitely.

It is important that we respect people's wishes when it comes to involving loved ones with case management, and this is also true the other way round. Some individuals being supported through ACCT may wish to have their family or friends engaged and updated on the support they are receiving, but these people may not want to be involved. These situations need to be handled sensitively. Just as we respect the wishes of the individual, we also need to respect the wishes of family and friends if they do not wish to be involved in the process. It may be that the family requires support to be able to participate. Liaising with your third sector family support provider may enable you to provide this if needed.

Relationships with families and significant others are often very complex and care must be taken to ensure the selected contacts are appropriate in supporting the individual. For example, there may be risk of further harm where an individual has been a victim of domestic abuse, where family members may be victims of crime, or where there are safeguarding issues with children.

Obtaining consent to share information

It is important that you obtain consent from the individual before involving a member of their family or a significant other in their ACCT Care Plan. You need to establish what level of involvement they would like there to be and what information they are happy to be shared. The Sources of Support Plan can be used to record this information.

When asking an individual being supported through ACCT for their consent, it is important that you are satisfied they have the capacity to make an informed decision. More information about capacity can be found **here**. If you are uncertain, your local mental health team should be involved, as they will also be able to provide input and advice on this matter. Translation services and reasonable adjustments must be used when required.

The individual must be made aware that they can withdraw their consent at any time.

How can you involve families and significant others?

Note: In youth secure estate it must be the norm to involve families and establishments may already have a process in place.

Where the individual has consented to their family or others being involved with their care, the Case Co-ordinator must make reasonable efforts to engage them in the ACCT process.

The family may have been in contact with other departments such as chaplaincy, healthcare, probation or the Youth Offending Team (YOT). It may be possible to obtain background information from these departments. To ensure that vulnerable people (including the individual) are protected, it is important to check with offender management or the person's case worker that there are no issues or restrictions around contact with family members.

You should discuss family involvement with the ACCT multi-disciplinary team and the individual as part of a case review. Approach a nominated person sensitively, explaining your role in supporting the individual. Tell them what ACCT is and reassure them about the actions that are being taken to keep the individual safe. Refer to the ACCT information leaflet for external sources of support and ensure copies are available for those being engaged in the process. Allow them to discuss their involvement with the individual if they need to.

Consider inviting family members or significant others to attend ACCT case review meetings, either in person or via teleconference. If this is not possible arrange to keep in touch with them regularly, either by phone or email, so that their views are included and they are told of any developments. Involve them when developing Support Actions, as they may have valuable insight in understanding what has helped the individual in the past.

Many prisons will work with third-sector organisations that help individuals in prison and the youth secure estate and their families stay in contact. These may be able to help you when making family contact, as this is their area of expertise.

Supporting people on ACCT without family involvement

For some individuals, contact with family or significant others may not be appropriate and/or could increase their risk of self-harm and suicide. Some individuals have no family to support them. In these cases, consider whether other sources of support may be available. For example, support could also be provided by:

- a close friend
- a guardian
- Listeners, other peer support workers and Samaritans (via telephone or letter)
- Childline or Barnardo's (in the youth secure estate)
- prison visitors and Prisoners' Penfriends
- chaplains
- any professionals the individual has an ongoing and trusted relationship with
- keyworker (or CuSP worker in the youth secure estate)
- local authority (e.g. for care leavers)
- advocacy services (particularly for individuals of minority or protected characteristic groups)

1.4 Creating effective Support Actions

What?: Support Actions are one of the most important parts of the Care Plan. They set out to address risk factors and encourage protective factors through meaningful action.

Who?: Support Actions are established by the case review team (including the individual), overseen by the Case Co-ordinator, and should be responsive to the individual's identified needs.

When?: Support Actions are agreed and documented during the first case review, then updated as actions are completed and added in subsequent case reviews.

Support Actions must:

- be populated, reviewed and revised (if necessary) at each case review
- be the focal point of support for the individual, personalised to them and their needs
- contain meaningful actions with clear outcomes and owners

Support Actions will need to identify all immediate and long-term risks, and actions taken to mitigate them. This includes any actions taken to mitigate an identified risk before the first case review.

The Support Actions form is:

- a record of needs, actions and responsibilities
- a tool for managing risk
- a plan that can be used and understood by the individual, staff, families and significant others, and other agencies (where relevant)
- something which focuses on the needs of the individual and which they can be involved in developing and actioning
- based on a thorough assessment of need and risk by the multi-disciplinary team
- co-ordinated by the Case Co-ordinator
- shared and agreed with those involved in its development and with a responsibility for action (including the individual)

The Support Actions form is not:

- a tick-box exercise – it is an essential element in engaging individuals requiring support and communicating what will be done to help the individual
- a wish list – it is a plan of agreed, achievable elements of care that are specific, measurable, achievable, relevant and time-bound (SMART)

Support Actions must consider:

Practical actions e.g. removing access to means of suicide. This must be a measured response to perceived risk.

Actions that staff can undertake e.g. helping the individual make family contact, helping the individual identify and secure purposeful activity.

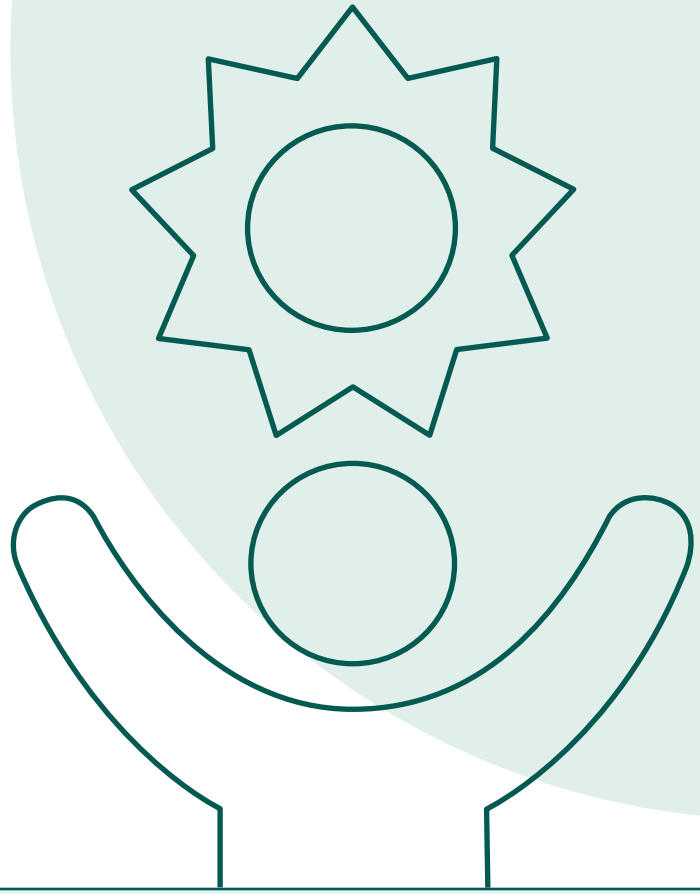
Actions the individual can do e.g. speaking to a member of staff they trust when they feel they need to self-harm, engaging with a programme or activity they enjoy, completing a Wellbeing Plan.

Referrals the individual would benefit from e.g. mental health teams, substance misuse teams, family service providers. Referral outcomes must also be noted in the Support Actions form.

Support Actions must also:

- focus on building on the individual's strengths and resilience
- reflect specific needs where necessary, such as cultural and ethnic background, gender or sexuality, disabilities and reasonable adjustments
- be appropriate to age and maturity level
- include crisis and contingency arrangements if necessary
- identify any unmet needs and how to address them
- be specific, with time-bound actions clearly allocated to individuals
- be shared and communicated effectively, ensuring understanding

Examples of considerations and actions required are detailed overleaf. These examples are illustrative only, and do not constitute a comprehensive list. Each individual's Support Actions will be different, tailored to their circumstances.



Considerations	Actions
 Withdrawing from drugs or alcohol	→ Referral to substance misuse recovery support – and follow-up → Appointment with GP – and follow-up → Distraction activities provided
 In debt	→ Key Worker to fill out a Debt Support Plan with person requiring support → Support in budgeting canteen allowance → Undertaking a finance course
 Feeling alone	→ Link to peer support through the Listener scheme → Weekly visit arranged with the chaplain → Engage with family service provider to facilitate regular family contact
 Feeling hopelessness	→ Person to complete Safety Support plan, and helped to build on their positive attributes and coping mechanisms, and to consider aspects of their care and support they can influence
 Has a suicide plan	→ Remove means from possession, document in Case Review along with when and how they can be returned → Move to shared cell (if assessed to be appropriate)
 Engaged in no meaningful activity	→ Enrol in a gym class → Enrol in an education programme → Apply for employment

Engaging the individual with the Care Plan

Planning individual support is about understanding the effect self-harm or suicidal ideation has on someone's whole life and the underlying reasons that are contributing to this. You need to understand all the issues that are increasing their risk, and put bespoke measures into place to address them. It is important to help the individual to identify ways they feel their issues could be addressed. It can sometimes be difficult to engage individuals in the ACCT process; the following may help:

- Use familiar and comfortable language, mirroring the individual's own words and phrases. Avoid jargon and abbreviations.
- Encourage them fill out the Resident Contribution form. Translation services are available in all prisons, and must always be used when required. ACCT information leaflets and Wellbeing Plans are available in multiple languages on the intranet.
- Encourage the individual to establish goals that are specific, measurable, achievable, relevant and time-bound (SMART).
- Remember that Support Actions exist for the benefit of the individual and are based around their needs and their perspectives.
- Involve the individual in agreeing and writing the plan, including them in the process and giving them a sense of control over the direction of care. This includes writing it in a format they are comfortable with. Discuss how they want it to be set out, and always offer them a copy when done.
- Be flexible – if they are uncomfortable talking at a formal review, consider speaking to them outside a formal setting. Allow them to submit their thoughts in writing if that would help. Make sure everyone in a meeting introduces themselves and explains their role to the individual.
- Try to involve sources of support (e.g. family, significant others, friends, external agencies) if appropriate. They often hold vital information about an individual's background and potential triggers. For more information **see the sources of support chapter**.

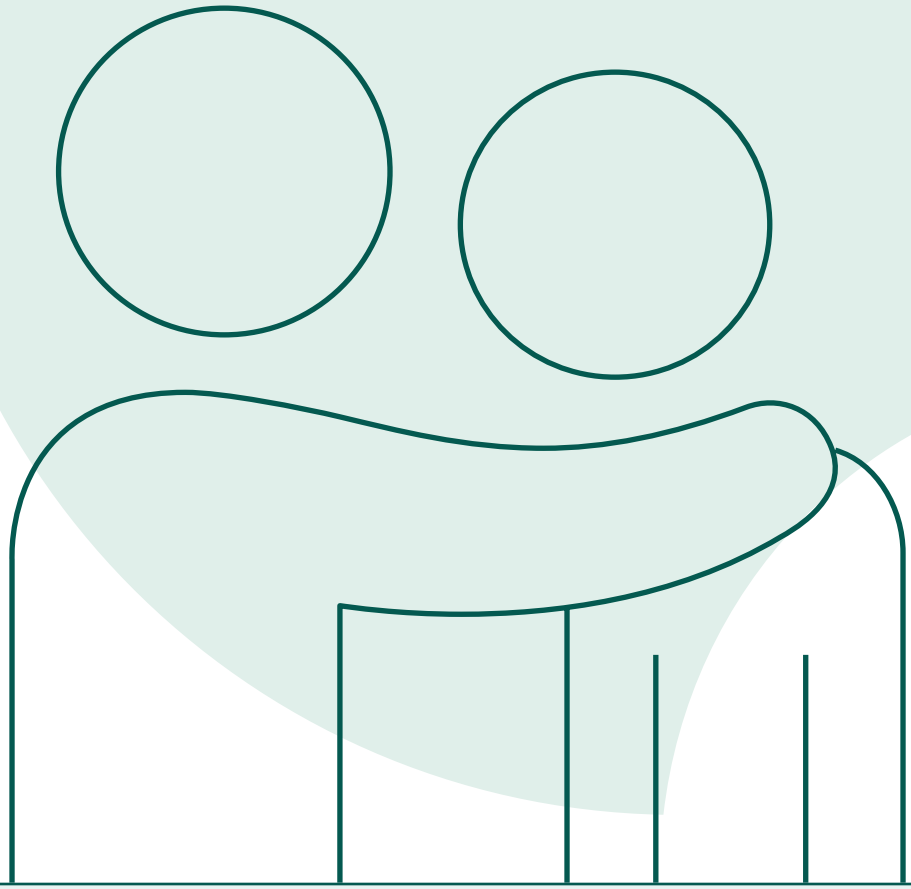
Developing Support Actions

Support Actions must be reviewed and updated at all ACCT case reviews. They must take account of any circumstances that may have caused a change to risk or affected any other part of the Care Plan. This could include:

- any change in location
- changes to the individual's incentive level (e.g. an enhanced incentive level may offer greater opportunities for distraction or additional family contact, whereas basic may result in a reduction)
- breakdown of relationships (inside or outside prison)
- any adjudications that the individual has been subject to, and their outcome (adjudications must be conducted with consideration given to all risk-related information contained in the ACCT)

- having items or clothing removed from personal possession – this decision needs to be documented in the case review, along with arrangements for returning any possessions, and any alternatives provided i.e. supervised shaving rather than a razor in possession. (any decision to remove clothing must consider decency, and any potential negative impacts of removing items on wellbeing; decisions to remove medication must be made in consultation with healthcare)
- whether the individual has been subject to use of force – this may have significant repercussions on wellbeing for people with past trauma, particularly related to any kind of violence

People will all be affected by situations in different ways. Some people are severely affected by circumstances that others find manageable. It is therefore important to consider the individual and what is known about their risks, triggers and protective factors when considering risk and how it can be mitigated. For example, where an individual has survived domestic violence, they may find any use of force highly distressing or triggering; or where an individual's family is considered a protective factor, they may find moving down an incentive level particularly difficult if additional visits are removed.



2. Completing the Concern Form

What?: An ACCT must be opened whenever the information available about an individual leads a member of staff to believe that they are at risk of self-harm or suicide. To open an ACCT, the Concern Form must be completed, clearly setting out the information that indicates current risk and has led to concerns. This must include any relevant background information gained from knowledge of, or engagement with, the individual.

Who?: Any member of staff can complete a Concern Form; you do not have to be a particular grade or belong to a particular staffing group. The member of staff concerned about the individual **must** be the person to complete the Concern Form; this responsibility cannot be passed to another member of staff. The Concern Form must then be passed to a wing/unit supervisor or orderly officer so that they can complete an Immediate Action Plan.

When?: Complete a Concern Form **immediately** if you think an individual is at risk of self-harm or suicide. If you consider the risk of suicide to be imminent, or if they are acutely distressed, take action immediately. **Do not leave the individual alone**. Continue filling out the form as soon as possible after the immediate risk has been mitigated.

As soon as possible, the member of staff completing the concern form should consult with the wing/unit supervisor or orderly officer who will be completing the Immediate Action Plan to discuss and set initial levels of conversations and observations. They should record these on the first page of the ACCT document.

If the person completing the Concern Form is not directly employed by HMPPS (e.g. education provider), once completed they should immediately hand the Concern Form over to HMPPS staff who will set initial levels of observations and conversations.

*In all cases, the Concern Form must be passed to a wing/unit supervisor or orderly officer **as soon as possible** within one hour, so that they can complete an Immediate Action Plan.*

The Concern Form highlights the information that has led to the staff member feeling concerned. This could include:

- any recent suicide attempt or statement of intent to take own life

It is important to ask direct questions about suicidal thoughts and plans. Asking direct questions is not likely to increase a person's risk of suicide, and as much background as possible allows support to be best tailored to the individual.

- any recent self-harm or statement of intent to self-harm

Sensitive but direct questions are important in order to understand this information.

- known triggers

Triggers are known to increase risk of self-harm or suicide. It is therefore important that they are documented, so appropriate immediate steps can be taken.

- known risk factors e.g. history of self-harm, social isolation, history of trauma or abuse, mental illness, alcohol or drug dependency
- other signs of concern e.g. deterioration in self-care, withdrawal from usual routine, expressing feelings of self-blame, loss of control or hopelessness

To make an effective decision on levels of risk, it is important to consider all available information, not just individual pieces of information received in isolation.

Risks, triggers and protective factors will be different for everyone and an individual's circumstances should always be considered when assessing and addressing risk. This includes engaging with the individual and not just making a paper-based judgement.

Understanding individual circumstances will come in large part from simply getting to know people, but there are other sources of information that you can consider to make an informed and balanced assessment. These could include:

- Offender supervisor – can provide information about an individual's history and may be able to provide insight on past experiences and behaviour
- Keyworker – likely to have good knowledge of the individual and have developed a consistent and trusting relationship with them
- ACCT history – accessible on P-NOMIS or the SDT
- CSIP history – accessible on P-NOMIS or the SDT
- Healthcare staff – may have important clinical information relevant to the level of risk an individual may pose to themselves
- NOMIS case notes, safer custody team – may be able to provide any relevant information relating to the individual, both in respect of self-harm and violence

3. Completing the Immediate Action Plan

What?: The Immediate Action Plan puts in place immediate support or action that will keep the individual safe until a full assessment and case review can take place.

It must be completed as soon as possible after the Concern Form is raised (and no later than one hour afterwards) in discussion with the member of staff completing the Concern Form. Initial observation levels must be set and recorded on the first page of the ACCT on completion of the Concern Form, and reviewed when completing the Immediate Action Plan in case any circumstances have changed or new risk information has come to light.

The Immediate Action Plan must take account of information on the Concern Form. The member of staff completing the Concern Form, the individual themselves and other appropriate staff must be consulted to make informed decisions to keep the individual safe. The Immediate Action Plan contains a number of prompts to be considered.

The individual should also be provided information about the ACCT at this stage (e.g. through the Resident Information Sheet) to address any initial questions or concerns.

The Immediate Action Plan prompts for a number of key stakeholders who should also be informed of the open ACCT at this stage.

Who?: Wing/unit supervisor or orderly officer (if the individual moves location during the first hour, the wing/unit supervisor of the receiving unit should complete the Immediate Action Plan). Healthcare should also be notified on the opening of an Immediate Action Plan and relevant information should be requested from them to inform it, as per local arrangements. The healthcare point of contact can then ensure that the most relevant healthcare team are notified of the opening of the ACCT.

When?: An Immediate Action Plan must be completed **within one hour** of the Concern Form being raised.

Below are a list of actions to consider – further examples are available **here**.

	Actions to consider NB: These are suggestions only and will vary by individual
Location	Is the current location of the individual likely to increase their risk? If so, what can be done to reduce the risk (e.g. shared cells, locating cells closer to wing staff, use of specialised cells)? While cell-sharing often lowers risk of suicide, moving to a shared cell/room or closer to wing staff on an ACCT can be difficult for the individual, particularly if they are not with someone they trust or are uncomfortable with them knowing that they're on an ACCT. It is important that the individual and anyone with whom they may be sharing has input into this decision as appropriate.
Frequency of staff support	What level of observation and conversation is appropriate to manage risk to this individual? Are different levels of observation and conversation required at different times of the day? What other staff support can be offered alongside meaningful conversations (e.g. keyworker, chaplain)?
Medical intervention	Is a mental or physical health referral required? Is the mental health team already seeing them and, if so, what is their view? Are there any urgent clinical needs? Does the individual need to be referred to mental health or the drug and alcohol team? Does IP medication need to be restricted or removed? More guidance on IP medication can be found **here**.
Avenues of communication	Does the individual have access to a phone and PIN credit, especially if in early days? Do they know how to access the Samaritans or Childline? Do they have writing material? If the site has other technology, can they have access to it? Do they have any communication needs that are not being met (e.g. foreign language interpreting, British Sign Language interpreting, learning disabilities, or other communication difficulties)?
Support access	Is the individual aware of the prison's support systems? This could include Listeners, safer custody representatives, emotional wellbeing mentors. In the youth secure estate consider Advocates, social workers, Case Workers, CuSP officers.
Other immediate actions	Do any items need removing (e.g. razors, materials that could be used as ligatures)? Are distraction materials required? If the risk of suicide is considered very high, discuss with your duty governor the possibility of providing alternative accommodation or clothing, or whether the individual should be supported through constant supervision.

4. ACCT assessment

4.1, 4.2, 4.3 Completing the ACCT assessment

What?: The purpose of an ACCT assessment is to gather and review all available risk-pertinent information from necessary resources, including interviewing the individual.

Who?: All stages must be completed by a trained Assessor. It is good practice to consider which trained Assessor is best placed to conduct the interview. The individual may feel more comfortable discussing their circumstances with a member of staff of a specific gender, or one who they know and have a good relationship with.

When?: The ACCT assessment must be completed **within 24 hours** of the Concern Form being raised.

Before the assessment interview:

Before the interview, the Assessor must gather and review all available risk-pertinent information, then document on the ACCT Assessment Key Information page. This will enable information on specific risks and triggers to be gathered if the individual does not volunteer it during the interview. This page prompts for relevant resources, but the list is not exhaustive. Information relating to risks, triggers and protective factors should also be recorded in section 1.1 of the Care Plan.

During the assessment interview:

- Every effort **must** be made to engage with the individual.
- The Assessor must explain the purpose of the ACCT, what will happen next and the purpose of the first case review.
- If the individual refuses to take part in the interview, the ACCT Assessor must try to establish why they are unwilling to participate. They might be more likely to take part later once they have collected their thoughts (though it still has to be within 24 hours of the Concern Form being completed), or they may be more comfortable with a different Assessor (for example, if the individual is female they might feel more comfortable with a female Assessor and vice versa). If this is unsuccessful, the Assessor must undertake the assessment based on all available information (e.g. pre-sentence reports, OASys, CSIPs, Asset Plus, healthcare information, SDT, C-NOMIS case notes and previous ACCTs if possible). Further information on what to do if a an individual refuses to engage can be found on the **intranet**.
- Where the individual does not speak English, ACCT assessments must be undertaken with the assistance or involvement of a staff interpreter, or an appropriate translation service. Translation services or interpreters may also be required where English is not an individual's first language, as they may find more complex discussions around self-harm and suicide hard to understand.

- Where the individual has a learning disorder or difficulties, use plain English and make sure you leave enough time to determine whether they understand, explaining in different ways if required. Sometimes mental health or education teams have staff who specialise in supporting people with learning disabilities – ask them for advice on undertaking the assessment. The ACCT information leaflet and Wellbeing Plan are available in Easy Read for those with low literacy.
- During the interview, the Assessor must use general interviewing skills to gather information relating to risk. The questions are only a reminder of the areas to be covered.
- The Assessor must explain that the information discussed will be made available to the case review team to help plan the person's care.
- The Assessor must ask the individual to sign the 'Agreement to sharing of information' on the Key Information page, and (if there is agreement) complete that form. If the individual does not wish to sign this form or is unable to, this must be documented on the Agreement to Sharing Information. In this case, staff who are involved in the individual's ACCT must only share information that relates to the risk and how to reduce it, and must share it only with other staff. This may include: relevant parts of the Support Actions page for staff involved in actions; known risks, triggers and protective factors for those interacting with the individual; and observation and conversation levels. You must explain to the individual that some information relating to risk will still be shared.
- The Assessor must record the outcome of the interview in the ACCT assessment interview (4.1). They must ensure the discussion is recorded clearly and thoroughly document any information that will help the case review team make an informed assessment of the individual's level of risk.
- The Assessor must record any possible avenues of support discussed during the assessment interview for the case review team to consider when establishing actions to support the individual.
- The Assessor can also highlight the Wellbeing Plan, and offer support to help the individual to complete it. More information on the Wellbeing Plan can be found in the **resident contribution** section.

After the assessment interview:

- The Assessor must complete the ACCT Assessor's Assessment (4.3), summarising their assessment of all the information gathered, including the interview.
- The Assessor must attend the first case review unless there are exceptional circumstances – if they cannot, the reason must be recorded on the initial case review paperwork.
- In all instances, the Case Co-ordinator must be provided with full documentation from the ACCT assessment prior to this taking place. This must highlight any areas of risk discussed as part of the assessment, and any protective or mitigating factors that would be helpful to mitigate the risk. The Case Co-ordinator must always take the time to familiarise themselves with the ACCT assessment documentation prior to the first case review.

- If the ACCT Assessor is unable to attend the first case review, the Case Co-ordinator should confirm whether they have any questions about the content of the assessment prior to the first case review taking place and the ACCT Assessor should make the Case Co-ordinator aware of any further views they would like to contribute to the review.
- The Assessor is the advocate for the individual at the first case review. They ensure the issues discussed during the assessment are acknowledged by the first case review team, and can be recorded on the form where relevant.

5. Completing case reviews

What?: Case reviews are multi-disciplinary meetings used to decide the individual's care and track progress. The initial case review is critical and is an opportunity for a multi-disciplinary team to review the assessment, discuss the risks identified, put in place and, if the individual is content to share, refer to the Wellbeing Plan.

The discussions that take place during case reviews must be documented in a Record of Case Review (5.1), and subsequent forms or continuation sheets can be printed from the ACCT annexes that are available on the intranet. A case review in alternative location form (Annex C) must be used for case reviews which take place while the individual is in a non-residential location (e.g. healthcare or segregation unit/care and separation unit). The Case Co-ordinator should assure themselves that other members of the case review team agree the content of the case review notes, for example via a wet signature on the Record of Case Review form or via circulating the notes for confirmation if reviews are typed. The case review form must always be placed in the ACCT document without delay as it contains key information that other staff need to be aware of.

The Care Plan (including Support Actions and the Sources of Support Plan) must be updated following case reviews. The Resident Contribution, Defensible Decisions Log and risks, triggers and protective factors form must also be updated where necessary.

Who?: Multi-disciplinary team led by a consistent Case Co-ordinator, involving the individual and their sources of support where appropriate.

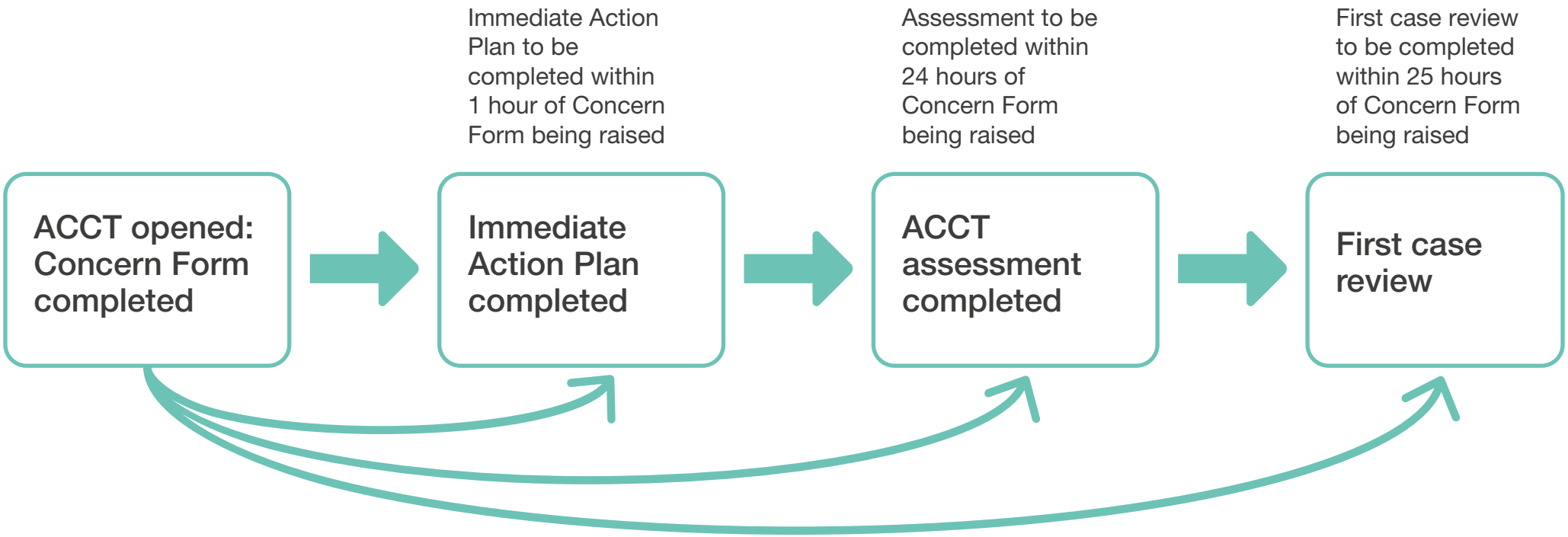
It is good practice to consider which Case Co-ordinator is best placed to oversee the ACCT, as the individual may feel more comfortable engaging with the process if a member of staff they know and trust is co-ordinating it. If the individual does not want to engage with the case review in person, the Case Co-ordinator should explore why and whether they can make a contribution another way (e.g. written, or verbally beforehand). If the individual wants to provide a written contribution but has low English literacy, reasonable adjustments must be provided through language services, or by allowing the person to complete a written contribution with a trusted source. It is important that consent for sharing information is revisited with the individual so that they understand how and where their information is being used, and any concerns noted and (where necessary) addressed in the Record of Case Review.

The ACCT Assessor and the person undertaking the first case review must not be the same person, unless exceptional circumstances require it. Any exceptional circumstances must be recorded in the ACCT. The Case Co-ordinator is also responsible for writing up the content of the case review.

Where an individual is already supported by CSIP, their CSIP Case Manager must also be their ACCT Case Co-ordinator. Having a different Case Manager and Case Co-ordinator is acceptable only in exceptional circumstances, for example where the existing CSIP Case Manager is on leave or absent from the prison during the timescales required for the first Case Review to take place; where there would be an unacceptable delay in developing the individual's CSIP; or where the original Case Manager or Case Co-ordinator is unavailable due to leave or being away from the prison and the interim Case Manager or Case Co-ordinator is unable to manage both. Where overlaps in risk factors have been identified, the same multi-disciplinary team should be involved in the development and review of both ACCT Care Plans and CSIPs.

The multi-disciplinary case review team must include all parties involved in the care of the individual. At the first case review certain people must be invited (as outlined below), but at subsequent reviews attendance will depend on the specific needs and support required for the individual (e.g. those involved in Support Actions, those that know the individual well).

When?: The first case review **must** be completed **within 25 hours** of the Concern Form being raised (in practice, this equates to 24 hours after the Immediate Action Plan is completed), following the ACCT assessment. It is good practice for the first case review to take place immediately after the ACCT assessment.



Subsequent case reviews must be completed periodically, at a frequency agreed by the case review team. The date and time of the next review should be agreed, where possible, at the current review to ensure all can attend, providing continuity of care and support. The frequency of reviews must be dictated by the level of risk – there is no recommended set frequency as it must be personalised to the individual. Reviews may need to be weekly (or sometimes more frequent). Or if the issues being addressed are long-term and the individual is relatively stable, it may be appropriate to meet less often, such as every other week or monthly. When planning when case reviews should take place, consideration must be given to any upcoming trigger dates or known events which may influence risk.

For some individuals self-harm may be a long-term coping mechanism, so ACCT support may be required for longer. It is important to consider individual factors such as this when taking decisions related to the timing of case reviews, location of the individual, and status of in-possession items, and to use ACCT flexibly.

If any of the following occurs, an urgent case review needs to take place (this is in addition to planned case reviews):

- new identified trigger
- change in behaviour that causes concern (such as a change in the method, frequency or lethality of self-harm, isolating behaviour or warning signs such as giving away possessions)
- significant traumatic event (such as a death in the prison), a change in circumstance (such as a transfer between establishments)
- any other information received to suggest increased risk (including from family or external sources of support)

What if someone can't attend a case review?

All those in the **'must' and 'should' columns** must be invited to the first case review, with enough notice. Where anyone is not able to attend they must be given the opportunity to share any information and raise any issues that they think need to be discussed on a written contribution form (Annex H).

Where the individual themselves does not wish to attend a case review they must be given the opportunity to contribute as well as being updated on the outcome, including any agreed actions, as soon as possible. It is useful to explore with the individual why they do not wish to attend, to establish whether any adjustments could be made.

What if that ACCT is closed at the first case review?

If the ACCT is closed at the first case review, the following steps **must** still take place:

- completion of a Care Plan (including Support Actions, Sources of Support Form, and Risks and Triggers Form)
- post-closure process (including post-closure monitoring and post-closure review)

These steps are important as it is important to document what factors have meant that risk has reduced for the individual, as these may be useful support measures in the future. It also is important to monitor their progress to ensure no additional support is required.

Assessing risk

Identifying someone's risk level is difficult; every individual will have a different background and will be facing a unique set of circumstances. Despite this, you can use the information available about an individual's risks, triggers and protective factors, alongside assessing their presentation and situation, to make defensible decisions around level of risk.

Generally, **the more risk factors an individual has, the greater their risk of suicide and self-harm will be** (cumulative risk). Decisions about risk must be made on an individual basis by a multi-disciplinary team depending on known risks, triggers, protective factors, presentation and situation – relying on presentation solely can be misleading.

Case reviews in a non-residential location

A case review must also be held before discharge from healthcare where the individual is located there. A representative from the receiving wing must attend this review, alongside the multi-disciplinary team supporting the individual. The case review in alternative location (Annex C) must be completed.

Where an individual supported via ACCT is subject to segregation or separation, a case review must take place within 24 hours. The case review in alternative location (Annex C) must be completed to document this. The case review team will need to consider the impact of segregation on the risk of the individual, and how this can be mitigated. Healthcare staff should also be invited to this review, with consideration given as to whether an urgent mental health referral is required – if so the mental health referral form (Annex G) can be used.

Where segregation or separation is ended for an individual being supported through ACCT, a case review will need to take place on the same day as this decision. As with healthcare, a case review in alternative location (Annex C) will need to be completed. If timing means that a full multi-disciplinary review cannot take place on the same day (for example if the decision to end segregation is made outside of the core day when some members of the case review team are not available), then an additional, full multi-disciplinary case review will need to take place as soon as possible the next day.

Timescales	Who must attend	Who else should attend	Support Actions	Other actions required
First case review				
Must be completed within 25 hours of Concern Form being raised, and after completion of ACCT assessment	Case Co-ordinator (minimum of HMPPS Band 4) Healthcare representative must always be invited – a mental health professional is advisable if available ACCT Assessor (In exceptional circumstances, if Healthcare or ACCT Assessors are unable to attend, written input can be provided instead) Individual (unless unwilling or unable)	A member of staff who knows the individual well (e.g. keyworker, CuSP officer, residential member of staff) The person who raised the initial concern Any staff who can contribute to support and care; this may be someone who is already supporting the individual or whom they feel comfortable with	Draw up and agree Support Actions People responsible for actions to be agreed and responsibly communicated Chair and individual to sign and date Support Actions Copy of Support Actions to be given to the individual Wellbeing Plan to be offered Sources of Support Plan to be completed	Record who attended the review and in what capacity (name, role, contribution); make introductions if unfamiliar to the individual The healthcare representative must refer to healthcare records such as SystmOne before attending Discuss the ACCT assessment and all headings in the Support Actions section in detail to ensure all risks and mitigating and protective factors disclosed are considered Discuss whether the group considers the individual to be at immediate risk of suicide or serious self-harm Ask the individual what support they would like to be put in place, and record their views Discuss sources of support and how these will be involved (if appropriate) Record reasons for decisions Set observation and conversation levels Agree action to safeguard the individual if crisis reached – including location and removal of items (if required) Discuss location and whether any possessions need to be removed (if high risk) Consider whether a referral to the mental health team is required (if so, Annex G may be used) Date for next review and people required to attend NOMIS updated with case notes, and local process undertaken (e.g. informing safer custody team)

Timescales	Who must attend	Who else should attend	Support Actions	Other actions required
Ongoing case reviews				
Reviews must be set in line with the known risk and level of support required Urgent ad-hoc reviews are mandatory following increases in frequency and / or severity of self-harm or change in method used; where a significant traumatic event takes place or change in circumstance occurs; or in other circumstances which suggest increased risk (Reviews need to be meaningful and generate outcomes)	Case Co-ordinator (minimum of HMPPS Band 4) Individual (unless unwilling or unable) Any staff who can contribute to support and care (including those with assigned Support Actions)	A member of staff who knows the individual well (e.g. keyworker, CuSP officer) Family / friends (if beneficial and agreed by the resident)	Support Actions to be reviewed to identify issues that have been resolved, any outstanding actions or new actions required for continuing issues and any new emerging issues Copy of Support Actions to be given to individual	Update observation and conversation levels if required Discuss location and whether any possessions need to be removed or if any possessions can be returned (if required) Record who attended the review and in what capacity (name, role, contribution) NOMIS updated with case notes

Timescales	Who must attend	Who else should attend	Support Actions	Other actions required
Final case review				
	Case Co-ordinator (minimum of HMPPS Band 4 or healthcare equivalent) Individual (unless unwilling or unable) Any staff who can contribute to support and care (including those with assigned Support Actions)	A member of staff who knows the individual well (e.g. keyworker, CuSP officer) Any other member of staff who can provide an update on Support Actions or the individual's current risk (a unit officer is recommended) Family / friends (if beneficial and agreed by the resident)	All Support Actions must be reviewed to ensure they are complete – an ACCT cannot be closed unless all actions are complete For a final case review before release, equivalent support in the community must be discussed	Explain the post-closure process and ensure the individual knows what support continues to be available to them once the ACCT is closed Record to be made of who attended the review and in what capacity (name, role, contribution) Agree and set the date for the post-closure interview, ensuring the Case Co-ordinator will be able to complete it. Discuss if it would be beneficial for any other members of the case review team to attend For a final case review before release, key information in the ACCT should be shared with Probation and the receiving Approved Premises (AP) / Bail, Accommodation and Support Service (BASS) staff NOMIS updated with case notes; closing date added to 'ACCT Open' NOMIS alert; 'ACCT post-closure' NOMIS alert raised

Remember: Continuity of care is important – ongoing reviews should be booked when the Case Co-ordinator is on duty, and reasons provided if the Case Co-ordinator cannot attend.

Multi-disciplinary working

It is essential that case reviews are individualised and multi-disciplinary, involving from all departments with knowledge of the individual, and consideration of all interventions that may help to address their needs. If case reviews are not multi-disciplinary, issues and risks may not be identified, nor addressed appropriately. Staff such as the individual's keyworker and offender supervisor/manager may know the person and their backgrounds particularly well. It is also worth thinking about inviting people from across the prison who may interact with the individual in different environments and have different relationships with them e.g. education, psychology, chaplaincy, residential staff, and workplace staff. They will have their own specialisms and will have different insights into support measures that could be put in place.

Consistency

Although who is invited to attend case reviews may evolve based on identified risks (although the Case Co-ordinator must be consistent), it is important to maintain consistency as far as possible, to be able to effectively monitor risks and progress. This could be achieved by having an agreed single point of contact within different departments for each individual. For example, in all case reviews where a substance misuse worker is required to attend, every effort must be made to ensure that this is the same substance misuse worker that has attended any previous case reviews for the individual. If they cannot attend the next case review in person, they will have to give a written contribution. It will likely be more valuable to have a written contribution from someone who is actively working with the individual than to have physical attendance from a professional attending on a rota who may not know them.

Planning

A key part of ensuring consistent multi-disciplinary attendance at case reviews is effectively planning when the next review will take place. While urgent reviews may be required at times of heightened risk, it is generally helpful for the date and time of the next case review to be settled at the end of the current one, considering the availability of the multi-disciplinary team as well as well as the risk presented by the individual. This will give all attendees enough notice to plan their work, allocate time to contribute to the review, progress actions and prepare by refamiliarising themselves with the ACCT to ensure they have a good understanding of the person's situation (this could include information from past case reviews, the ACCT assessment, and any existing Support Actions). It will also be reassuring for the individual, who may want to be clear about the arrangements for their ongoing support and be involved.

Who to include

Membership of the multi-disciplinary ACCT team will depend on individual circumstances. For example, for a individual with strong faith beliefs it may be useful to invite their chaplain; or for transgender individuals it may be useful to invite the equalities lead, the person chairing their transgender Case Review Board, advocacy services, or specific healthcare professionals (if they are going through a medical transition).

However, in all cases the individual should be an active member of the team. It is important that the Case Co-ordinator takes the time to explain the ACCT process to the individual, and that they are encouraged to contribute to case reviews and feed into decisions relating to their care. As mentioned previously, family, friends or other external sources of support may also be a valuable addition to case review discussions.

The following example outlines a possible scenario in which the needs of an individual change. This is reflected by changes in the core membership of the review team.

Case review	Risks identified	Attendees
1	Family argument resulting in lack of access to children Medication issues – different medication from that prescribed in community Detoxing	Case Co-ordinator ACCT Assessor Wing officer PACT or family support worker Healthcare representative Substance misuse worker
2	No change	No change
3	Family argument resulting in lack of access to children (ongoing) Medication issues – correct medication prescribed (resolved) Detoxing – complete (substance misuse work ongoing) Struggling to engage with regime due to lack of literacy skills (new issue)	Case Co-ordinator Wing officer Representative from family service provider Substance misuse worker Education representative Keyworker Healthcare representative
4	No change	No change
5	Family argument resulting in lack of access to children (resolved) Substance misuse work – completed (resolved) Engaging with Toe by Toe – working to improve literacy (resolved)	Case Co-ordinator Wing officer Representative from family service provider Substance misuse worker

Setting appropriate levels of observations and conversations

The frequency of ACCT observations and conversations must be set independently and at a level that reflects the assessed risk and needs of the individual, and written clearly on the first page of the ACCT. Individuals with a high risk of suicide or serious self-harm are likely to require a high frequency of conversation and observation. Understanding the level of risk an individual presents is essential to ensuring conversation and observation levels are set appropriately. This must be balanced against the impact that frequent observations can have on wellbeing, particularly at night. Observations must always be carried out at irregular and unpredictable intervals but in line with levels set by the case review team.

At each case review the individual's identified risks **must** be discussed. More information on setting observation and conversation levels can be found **here and here**.

Levels of observations

The purpose of observations is to check on the welfare and immediate safety of an individual. There is no minimum level of observations. It is therefore possible that an individual can be receiving support through ACCT without any observations being used. In contrast, other individuals may need four an hour, or constant supervision. Decisions about the level of observations must be defensible, agreed by the multi-disciplinary team, and the justification for the decision recorded in the ACCT.

Observations must be conducted in the least obtrusive manner possible, particularly at night, while ensuring the individual's welfare.

Conversations

Meaningful conversations are more supportive and helpful to a resident than observations. They provide staff with information and engagement opportunities that help effectively assess levels of risk. They also provide the individual with an avenue of support. Meaningful conversations are about building mutual trust through active listening, and asking open questions.

The number of conversations required will vary depending on the individual and their preference. They should always be set at a minimum of once per day. Some people may prefer having the opportunity to sit down and have a meaningful talk with someone once a day, while others will need more frequent support. Use open questions to encourage a conversation with the individual.

Decisions about agreed frequency of conversations must be defensible, and justification for the decision recorded in the ACCT.

Constant supervision

Constant supervision in the prison setting is defined as a period of one-to-one observation of an individual, who has been identified to be at serious risk of carrying out acts of self-harm or other behaviours which could lead to that individual accidentally or intentionally killing themselves, and which has been implemented in order to reduce this risk and intervene in the case of an emergency.

Both the individual at risk and prison member of staff conducting constant supervision must be supported by a multi-disciplinary team as part of the ACCT process. The prison member of staff conducting the constant supervision will need to possess good interpersonal skills to enable them to engage with the individual in a supportive manner in order to attempt to reduce the risk of them engaging in life-threatening behaviours.

Overview

Constant supervision must be in place for the shortest amount of time possible and used as a last resort. This is important because we know that constant supervision can feel oppressive and may be distressing for the individual. Authorisation for constant supervision can be given only by the duty governor, or night orderly officer in consultation with the duty governor. Decisions must be taken in consultation with the senior clinical manager wherever possible (or senior nurse where the senior clinical manager is unavailable).

An individual subject to constant supervision is observed and supported by a designated prison member of staff who remains within eyesight at all times, and within a suitable distance to enable them to physically intervene in an emergency (an Emergency Access Plan, will set out how to intervene in an emergency. This is Annex J within the ACCT. It should be completed and reviewed by the case review team). It must be used as an opportunity to engage with the individual and support them to address their difficulties constructively (e.g. through sitting, chatting, encouraging/supporting people to participate in activities, to relax, to talk about any concerns). Constant supervision is not simply watching an individual requiring support and, for this reason, the term ‘constant watch’ must be avoided.

The person at risk will also be supported through the ACCT process by a multi-disciplinary ACCT case review team.

Anyone placed on constant supervision must also be referred to the Safety Intervention Meeting (SIM).

It is imperative that the use of constant supervision is regularly reviewed and carefully considered, as we know that risk is dynamic and can change over time. Reviews will need to balance the potentially negative effect of constant supervision against the risk of self-harm.

Purposeful activity, engaging with the regime and contact with external sources of support such as family are particularly important during times of crisis, and must be discussed and facilitated wherever possible and appropriate. Thought must also be given as to how constant supervision can be used flexibly alongside these activities.

When should constant supervision be used?

Constant supervision is a response to acts of self-harm or other behaviours which could lead to that individual accidentally or intentionally ending their life. It must only be in place for the shortest time possible. This includes, but is not limited to:

- where the individual engages in self-harm behaviours which are likely to result in a high degree of harm or death and/or are very frequent
- where there are credible and persistent plans to inflict acts of self-harm that are considered to be life-threatening

Constant supervision is an acute intervention designed for use in exceptional circumstances, and must form part of a wider ACCT Care Plan designed to provide the individual with ongoing intervention and encouragement to reduce their level of risk.

Constant supervision can be used flexibly and may only be in place for part of the day. For example, an individual could be placed on constant supervision during the night, but under less frequent observation during the day, while involved in activities where the risk of suicide or severe self-harm is not as high.

Risk is dynamic and can change quickly, and the need for constant supervision must be kept under regular review. For this reason, a member of the ACCT multi-disciplinary team must visit and speak with the individual daily to monitor their wellbeing, review their location and consider any other interventions that could reduce their risk and promote recovery as part of their ACCT Care Plan. This includes considering whether it is safe for the individual to be removed from constant supervision and/or whether it is necessary to refer the individual to the mental health team for assessment.

Who decides that constant supervision will be used?

The use of constant supervision must be considered by multi-disciplinary partners wherever possible – usually members of the ACCT case review team, who will have a good knowledge of the individual and their risk.

Authorisation for constant supervision can be given only by the duty governor, or night orderly officer in consultation with the duty governor. Decisions must be taken in consultation with the senior clinical manager wherever possible (or senior nurse where the senior clinical manager is unavailable). If there is no healthcare cover when constant supervision is authorised, the senior clinical manager/senior nurse must be informed of the decision to authorise constant supervision as soon as they become available. The mental health team must also be informed of the authorisation at the earliest opportunity. The decision and the reasons for it must be documented in the case review form.

If healthcare staff feel that constant supervision should be put in place but prison staff disagree with this, constant supervision will need to be put in place temporarily while the decision is escalated to the governor (or duty governor if they are away from the establishment) for review at the earliest opportunity.

Following the authorisation of constant supervision, each case must then be considered at an urgent case review as soon as possible (see **'When must constant supervision be reviewed?'** for more detail).

When authorising constant supervision, the duty governor or night orderly officer will also need to consider the most appropriate location for the individual to be supported. Gated cells must be used wherever available. If this is not an option then consider other locations which may be suitable (e.g. Is the individual's own cell suitable? Is there a quieter unit where the environment may be more calming?). This will depend on the circumstances of both the individual, with consideration given to known risks, triggers and protective factors, and the resources available in the establishment. Locating an individual being supported through constant supervision in a care and separation unit should be avoided wherever possible, as the segregation environment can have an adverse impact on mental health and risk of suicide. However, if the decision is made that an individual needs to be located in this environment, then reasons for this must be defensible and recorded in a defensible decision log (Annex E). Consider also how these risks can be mitigated against, such as through access to protective factors and engagement with the regime where appropriate.

Be mindful that just because someone is on constant supervision, this does not mean that they have to remain in their cell for this to be conducted. As noted in the **'How should staff conducting constant supervision engage with the person at risk?'** section, people being supported through constant supervision should always be encouraged to engage with activities that may reduce their risk of harm, and this includes activities outside of the cell.

Who should undertake constant supervision?

Constant supervision must be conducted by the most appropriate prison member of staff who is a minimum HMPPS operational Band 3. Where the case review team feel that complementary support from healthcare staff or clinicians would be beneficial this would need to be agreed and put in place accordingly.

Skills relevant to carrying out constant supervision include interpersonal and empathic communication skills. These skills will enable staff to engage with the individual, providing them with an opportunity to talk about their thoughts and feelings if they want to, and for the individual to feel heard and acknowledged. Where the individual does not speak English, every effort must be made to provide supervising staff who can speak their language or access to a translation service. Consideration should also be given as to whether providing access to Easy Read or plain English materials would be beneficial.

The staff member responsible for undertaking constant supervision will need to take account of the individual's characteristics and circumstances (including factors such as ethnicity, sexual identity, age and gender), considering any previously reported trauma and ability to engage with the person at risk, as well as any known security information which may represent a risk to particular staff.

Note that during time in cell, anyone undertaking constant supervision must be able to access the cell immediately in a life-threatening situation – either through using cell keys carried on-person or, if they do not carry keys (e.g. during the night state), through accessing sealed pouch keys. Details of how to respond in an emergency will be set out in the person's Emergency Access Plan.

It is important to have frequent changes of staff undertaking constant supervision so that staff do not become burnt out or desensitised. The frequency of staff changes should be considered by the orderly officer, on the advice of the multi-disciplinary case review team and will depend on individual circumstances. For example, if the individual has highly complex and challenging needs then more frequent changes may be beneficial. However, if the individual has a particularly constructive relationship with a certain member of staff then they may not require rotating as frequently providing they can positively engage with that individual for longer periods of time without the resident or staff member experiencing any adverse effects. However, a full handover between supervising staff members will be necessary (see Annex I: Constant supervision handover and daily visits recording).

What is involved in undertaking constant supervision?

Prior to conducting constant supervision

The case review team will support the prison member of staff conducting constant supervision by ensuring that all relevant information is recorded in the ACCT – this includes ensuring that case reviews are fully documented and that identified risks, triggers and protective factors are kept up to date. The prison member of staff conducting constant supervision must also be provided with an Emergency Access Plan (Annex J) developed by the case review team and be made aware of how they can draw on immediate support from other staff if needed (e.g. use of radio, alarm, verbal alert).

Handovers between staff undertaking constant supervision need to be comprehensive, and at each handover of staff the checklist must be completed in Annex I. Handovers are required when staff are taking over a constant supervision for a sustained period of time. Staff must consult the full ACCT Care Plan in advance of taking over.

To note: If staff are taking over a constant supervision for a short period of time (for example to allow for the supervising staff member to take a comfort break), it is not necessary to complete a full written handover. In these situations a verbal handover of key information will suffice.

What is an Emergency Access Plan?

The Emergency Access Plan (Annex J) sets out what must happen if an individual on constant supervision engages in serious acts of self-harm or other behaviours which could lead to that individual accidentally or intentionally killing themselves. The case review team must use Annex J to create the plan as soon as they have made the decision to place the individual on Constant Supervision. The plan must be reviewed at each subsequent case review while constant supervision remains in place. The plan must set out precisely what the supervising prison member of staff must do in these circumstances, including how to raise the alarm (including Code Red and Code Blue), when to enter the cell (which may differ during the day and night, or on the basis of whether the staff member is carrying keys), when use of force is permitted to prevent self-harm and what Personal Protective Equipment (PPE) must be used. The Emergency Access Plan must be individualised, taking account of the person's known risks, triggers and protective factors.

How should staff undertaking constant supervision engage with the individual?

The supervising prison member of staff must be located where they are able to see and talk with the individual, to respond to them immediately in the event of an incident or emergency. Staff must familiarise themselves with the contents of the ACCT and receive a full handover from the previous staff member if they are taking over for a sustained period of time, ensuring they understand the situation so that they can provide individualised support to the individual. If anything in the ACCT is unclear, this should be raised with the wing/unit manager or ACCT Case Co-ordinator for clarification at the earliest possible opportunity. The supervising member of staff is responsible for interacting and engaging with the individual and encouraging them to do things that will support a reduction in risk, in a way that is sensitive to their individual needs (as identified in their ACCT Care Plan), while remaining prepared to raise the alarm and/or to intervene in line with the Emergency Access Plan (Annex J).

Although constant supervision will be necessarily intrusive, it is important that the least intrusive level of supervision appropriate to the situation is adopted so that due sensitivity is given to an individual's wellbeing and dignity while maintaining safety for the individual and those around them.

Staff must make every effort to engage with the individual. This includes taking the time to introduce themselves, and explain that the purpose of their observations is to help keep the individual safe and to monitor their wellbeing.

It is important to be aware of the power of everyday interactions. Making small talk during a crisis can help, and starting a conversation can be invaluable in interrupting suicidal thoughts and letting someone know that they matter. If the individual does not wish to initially engage in conversation, be patient. Let them know that you are there if they would like to talk, and consider trying again if it feels right. Even if they do not want to talk, it is important that they feel able to do so should they want to. You do not have to be a specialist to do this.

For further information on how to engage with someone in a suicidal crisis, the **Samaritans' Small Talk Saves Lives Campaign** is a good starting place. The **Self-Harm Guide** provides prompts on how to have a conversation with someone engaging in self-harm. The Samaritans **SHUSH active listening tips** may also be useful in having difficult conversations.

Staff must also encourage the individual to engage in activities that may help to reduce their risk, including participation in the normal regime or even going for a walk. It may be useful for establishments to keep a record of local activities, resources and support services that could be used for individuals on constant supervision. The kinds of activities that are felt to be helpful and safe will need to be considered during case reviews.

Some **in-cell resources** have been produced at a national level. Establishments are encouraged to consider the development of similar resources at a local level according to the needs of their population.

Consideration must be given to how supervision can be carried out in a way that respects the individual's privacy as far as practicable and minimises any distress. In particular, how an individual's dignity can be maximised without compromising safety when individuals are in a state of undress, such as when using the toilet, bathing, showering, or dressing.

How should constant supervision be documented?

Staff conducting constant supervision must maintain accurate records of events during the period of supervision to accurately record progress and inform care planning. This means ensuring the following pages in the ACCT are completed:

- Ongoing Record (6.1)
- Constant supervision handover and daily visits recording form (Annex I)
- Emergency Access Plan (Annex J)
- Risks, triggers and protective factors form (this should be updated if any new ones are identified (1.1)

Continuation form (Annex B) if further space is required for any of these forms

The wing manager should also add a daily summary to the constant supervision handover and daily visits form, as well as making an entry on the individuals NOMIS case notes, outlining any key information from the Ongoing Record.

It should also be noted that if healthcare staff were to interact with the individual at risk in any capacity during the period of constant supervision, this would need to be recorded by healthcare on SystmOne as per healthcare policies and procedures.

Ongoing Record

The Ongoing Record documents how staff have attempted to engage with the individual, and what activities have been undertaken or considered.

A good Ongoing Record entry is one that is person-focused, individualised and provides a good level of detail as to what activities have been explored or undertaken. Ongoing record entries include both summaries, and documenting conversations. This could include:

- clearly explaining how the individual was presenting throughout the course of the constant supervision, providing details of any activities or conversations that took place (including suggested activities or conversation that may have been turned down)
- explaining how activities or engagement impacted presentation
- any topics of conversation that were particularly helpful or unhelpful
- details of any actions that may have been promised to the individual and that will need to be followed up

Example of a good conversation entry

Paul was very quiet this morning and did not wish to attend his usual workshop. I suggested going for a walk in the yard as he has previously found this to be helpful in improving his mood. Paul was more talkative while walking in the yard and we talked about football and how he is looking forward to taking his son to a game when he is released. Paul talked about his previous ambitions to work in the fitness industry and I suggested talking to gym staff for their advice on how Paul could get back into this. Paul agreed that this was a good idea and I have asked gym staff to come and talk to him. When he was back in his cell, Paul became quiet again but did accept the suggestion of a distraction pack and he has been doing sudoku puzzles since.

Example of a good summary entry

Lauren was asleep when I took over constant supervision from Officer Higgs. Lauren slept for most of the morning, waking up at 10am. Lauren noted that this was the first time she has had a decent night's sleep in a week and said that she was feeling better for it. Lauren and I spoke about the reasons she had been struggling to sleep (mainly noise related), and the negative impact this can have on her mood. I promised that I would enquire as to whether it would be possible for Lauren to get some earplugs and have raised this with SO Butler. Lauren was happy to attend her usual education class and worked well throughout. She appeared to get on particularly well with Miss Williams (teacher) and when we were walking back to Lauren's cell she told me that she felt Miss Williams 'gets' her and has always believed in her. When back in her cell Lauren started to do some in-cell exercises and ate her lunch. Previous entries suggest that Lauren has not had much of an appetite over the last few days, but today she ate all of her food.

These details will inform the staff member who takes over what activities the individual may find helpful, possible topics of conversation to prompt engagement and any actions that need to be followed up on. It will also help them to understand what 'normal' might look like for that individual, as well as helping the case review team make an informed judgement on the individual's progress.

On the other hand, a poor entry will provide limited detail on what occurred during that particular period of constant supervision. A poor entry will make general statements and provide the bare facts about what has happened, without providing any meaningful explanation. This will make it harder for the prison member of staff taking over the constant supervision to understand what the individual might find helpful, and it will also limit the ability of the case review team to effectively monitor changes in mood and progress.

Examples of poor Ongoing Record entries:

> Paul was very quiet this morning and did not wish to attend his usual workshop. We walked in the yard then returned to the cell where Paul was given a distraction pack.

> Lauren slept until 10am then attended education.
> She appeared fine throughout. On returning to her cell Lauren started doing in-cell exercises and ate her lunch.

Constant supervision handover and daily visits recording

Annex I must be completed by any member of staff supervising the individial for a sustained period of time. One form must be completed for each 24 hour period, and placed in the folder alongside the ongoing record for that day. At each handover, the checklist must be completed in Annex I, and any visitors to the individual should complete the visitors log. The Case Co-ordinator (or wing/unit manager if the Case Co-ordinator is unavailable) must complete the daily review summary section of Annex I each day.

What is the contribution of the multi-disciplinary ACCT case review team?

The case review team must consider whether the individual on constant supervision should be referred to the mental health team for assessment. Depending on whether an assessment is required, the mental health team will then determine what their involvement and/or that of the primary care team(s) needs to be. This may change over time but any clinical Care Plan and/or risk management plan agreed must be included in the ACCT Care Plan. As with all ACCT case reviews, any other multi-disciplinary partners relevant to supporting the individual should attend case reviews and contribute to the person's Care Plan.

Every individual on constant supervision must be seen every 24 hours by the ACCT Case Co-ordinator (or wing/unit manager if Case Co-ordinator is unavailable). In addition to the Case Co-ordinator, the individual may also be visited by any other member of the case review team that is supporting them to provide complimentary support. It is for the case review team to decide if this would be beneficial and who this may be if so. For example, it may be a member of education staff, a member of the healthcare team, a member of chaplaincy or any other professional who knows the individual well and will be able to make a judgement as to their progress. Where possible, continuity of care should be maintained to build positive trusting relationships between the individual and the case review team. Therefore careful consideration must be given as to who will be available to undertake these visits in the coming days.

These visits will ensure that the individual's wellbeing is regularly monitored and that consideration is given to where and how it is best to manage their risk of self-harm. This includes considering whether it is safe for constant supervision to end where risk is seen to have reduced, or whether any additional referrals for specialist support may be required where risk has been seen to have increased (e.g. whether it is necessary to refer the individual to a psychiatrist to consider a transfer to a secure hospital under the Mental Health Act). In order to make these decisions, a multi-disciplinary case review should be under taken.

These visits and any observations must be documented in the constant supervision handover and daily visits recording form (Annex I) and the case review team must be informed at case reviews.

When must constant supervision be reviewed?

Following the authorisation of constant supervision, each case must be considered at an urgent ACCT case review as soon as possible. If constant supervision is authorised during the core day, this first urgent case review should be held at the earliest possible opportunity following authorisation. If authorised outside of the core day (i.e. during the night state), the first urgent case review should take place at the earliest possible opportunity the following morning. Subsequent ACCT case reviews must be held at least daily for the first 72 hours. In addition to the multi-disciplinary ACCT case review team, the wing/unit manager must also attend where possible.

Given the intrusive nature of constant supervision and the counter-therapeutic impact this may have, it must be in place for the shortest time possible. If an individual remains on constant supervision for longer than 72 hours:

- the case review team must decide the date for the next review and record this in the ACCT
- the duty governor and a senior clinician familiar with the prison environment must be alerted so that they can keep the situation under review and, if necessary, provide senior input into the individual's care
- an urgent mental health assessment must take place as soon as possible, if it hasn't already – the mental health service specification (England) or Universal Mental Health Standards (Wales) can provide further details around expected time frames for urgent mental health assessments

- daily entries must be made in the ACCT using the constant supervision handover and daily visits recording form (Annex I), clearly setting out the justification for why continued Constant Supervision is needed – these entries must be made by the Case Co-ordinator, who must visit the individual daily, or the wing/unit manager in exceptional circumstances (e.g. where the Case Co-ordinator is unavailable due to leave)

This does not mean that constant supervision cannot be in place for longer than 72 hours if risk necessitates this. However, these actions will ensure every effort to reduce risk is taken and that constant supervision is in place for the shortest time possible.

If constant supervision remains in place for 5 days or longer, this should then be escalated through a joint process to the governor and head of healthcare to allow them to make arrangements for the individual's level of vulnerability to be considered further. This may reflect a range of interventions such as transfer under the Mental Health Act or escalation to a complex case review. If the governor is unavailable, the duty governor should alert the Prison Group Director's office. The Healthcare Commissioner (or Local Health Board in Wales) must also be informed.

The purpose of this escalation is to involve senior multidisciplinary partners in cases that will be complex and would benefit from the experience and perspective they can offer in finding the best way forward to support the individual. Therefore, it may be suitable in some exceptional circumstances to jointly escalate cases prior to this 5-day threshold.

During all ACCT case reviews, the case review team must consider the ACCT Care Plan and the behaviours or ideation that needs to change or reduce to allow the level of supervision to be reduced. Where the person is supported by the mental health team, consideration should be given as to whether the mental health assessment or Care Plan needs to be reviewed. As the individual is at high risk, continuity of membership of the review team will be particularly important, and will help reduce any distress that the process may cause.

What happens when constant supervision ends?

The decision to end constant supervision can only be made by the multi-disciplinary case review team supporting the individual during case reviews, and not by any one person in isolation. As with all decisions relating to ACCT and constant supervision, this decision should be made with multi-disciplinary input. If it is decided that constant supervision should be discontinued, a plan to reduce the level of supervision progressively, substituting support from alternative sources as the person's condition improves, must be formulated and documented in the ACCT Care Plan. This should include a local contingency plan for use if the risk escalates quickly (e.g. agreeing the frequency of subsequent ACCT case reviews to effectively monitor risk, discussing how to raise any concerns of escalating risk and discussing under which circumstances an urgent ACCT case review may be required).

The ACCT process should then continue to be conducted in the usual way (i.e. with regular case reviews, welfare checks and Support Actions) until the ACCT case review team feel that risk has reduced to a level where this can be closed. Please see the **'Closure of ACCTs and the post-closure process'** section for further details.

Can CCTV be used?

The use of CCTV for someone on constant supervision is not considered good practice as it significantly limits the possibility of meaningful engagement and the amount of information you are able to understand about the individual. It therefore must not be used routinely to replace face-to-face contact, and face-to-face constant supervision should always be the default option unless there are exceptional circumstances that would adversely impact the health and safety of the individual or any other person, including the member of staff undertaking the constant supervision.

CCTV for an individual on constant supervision must only be used in exceptional circumstances where certain criteria are met (see safety policy framework for further information), and must be authorised by the duty governor or director. When deciding if CCTV can be used, consideration must be given as to how this would impact staff's ability to intervene in an emergency. Staff need to be able to intervene immediately and so even a delay of a minute or two would mean that CCTV would be inappropriate.

It must be made clear to the individual that CCTV is being used and the use of CCTV must also be recorded in the ACCT (Ongoing Record and Record of Case Review forms). Where CCTV is used to monitor an individual on constant supervision, this must be monitored by staff at all times, and attempts to actively engage with the individual must still be made to reduce risk. This includes regular face-to-face check-ins and attempts to engage them in meaningful conversation and distraction activities.

Complex or challenging needs

For individuals whose behaviour is particularly concerning or complex, more specialist support may be needed. Individuals with complex needs may be supported through ACCT for multiple and severe self-harm and/or suicide attempts, and may spend lengthy periods in the segregation unit or in healthcare due to challenging behaviours. If there is a clinical need, they may necessitate multiple referrals to healthcare and the mental health team.

How should someone who has complex or challenging needs be supported?

When supporting an individual with complex needs, it is possible that they may require more intensive support over a longer period of time. They may require input from specialist services such as mental health or substance misuse interventions, or support from psychology colleagues. It may also be beneficial to consider other factors such where the individual is located and whether changing this may reduce risk. However, any agreed actions must always be relevant to addressing the driving causes of behaviour and there is no set formula here.

When supporting individuals with complex needs who are at risk of serious self-harm or suicide, an escalation path may be required. The SIM can provide support and further multi-disciplinary guidance to Case Co-ordinators and case review teams in these cases. This may include reviewing and recommending actions to reduce risk, discussing alternative interventions in a more senior multi-disciplinary forum and arranging for more senior members of staff to participate in ACCT case reviews.

What is the SIM?

The Safety Intervention Meeting (SIM) is a multi-disciplinary safety risk management meeting, chaired by the Senior Management Team (SMT), which brings together staff and expertise from across the prison. The SIM focuses on the small number of individuals who are classed as posing a significant risk to harming themselves and/or others. This can include complex cases where individuals demonstrate particularly persistent or increased severity of harm to themselves and/or others.

It provides a multi-disciplinary response to ensure and provide assurance that these individuals are identified, managed and supported appropriately so that the risk they pose to themselves and/or others can be mitigated.

However, while individuals supported through ACCT or CSIP may be referred to the SIM for consideration, this does not replace ACCT or CSIP case management and SIM meetings are not case reviews.

The purpose of the SIM is to:

- enable support and further multi-disciplinary guidance to be provided to the ACCT Case Co-ordinator/CSIP Case Manager and case review team in the case management of individuals posing a significant risk to themselves and/or others
- provide an avenue of expertise and management of individuals requiring active engagement and support, during a period where the risk is deemed significant
- provide a forum for key multi-disciplinary discussions at a more senior level, focused on the individual's needs
- improve information sharing between the relevant departments
- identify individuals who require additional input to their case management or CC/ CM's that require extra support

When referring individual cases to the SIM, consideration should be given as to what outcome is being sought that would provide additional benefit in supporting the individual and managing their risks.

The type of support that the SIM can provide will vary depending on the individual referral, although it could include:

- consideration of specialist support to be put in place – particular support that a Case Manager or Case Co-ordinator may need from more senior staff or functions
- consideration of other actions which can be explored where no progress is being made with an individual where immediate and existing options have been exhausted

When should a referral to the SIM be made?

It is largely up to case review teams to decide whether referral for discussion at the SIM is required. However, two specific instances must be referred to the SIM:

- if the individual is placed in segregation (or the young person is subject to temporary separation in the youth secure estate)

- If the individual is placed on constant supervision

There may be other instances where it might be appropriate for case review teams to consider referring to the SIM, however these decisions will need to be made on a case-by-case basis. Some examples of high-risk behaviours which may be seen in more complex cases include things such as multiple incidents of fire-setting, where an individual is awarded a period of cellular confinement or where an individual engages in incidents of self-harm where there's a high degree of lethality or harm caused (e.g. ligaturing). This list is not exhaustive and it will be for the case review team to determine whether or not they feel the case is complex to a level which would benefit from a referral to the SIM.

If escalation to the SIM has been considered, it must be recorded in the ACCT Record of Case Review form, even if it was decided against.

Who must attend case reviews for people with complex or challenging needs?

This is decided by the SIM case by case, in consultation with the multi-disciplinary team and Case Co-ordinator. Any changes in personnel must be explained to the individual. If a more senior Case Co-ordinator is appointed, to encourage consistency it is good practice for the original Case Co-ordinator to attend at least the first case review with the new Case Co-ordinator, in addition to providing the new Case Co-ordinator with a full handover. If it is later necessary to return to the original Case Co-ordinator, this process should be replicated, with any changes explained to the individual, and the senior Case Co-ordinator attending the next case review with the original Case Co-ordinator where possible.

The SIM may also arrange for other specialists to participate in case reviews, if they are not already. This could include psychologists or other therapists. If the individual has moved frequently between healthcare, the segregation unit and the residential unit, representatives with experience of their behaviour from different locations should attend the case review meeting.

What should be discussed at case reviews for complex cases?

As with all ACCT case reviews, the Record of Case Review form must be updated and Care Plan (including Support Actions) reviewed.

Decisions at case reviews for complex cases may include (not exhaustive):

- whether the current level of access to the regime and activity is appropriate
- whether Constant Supervision is required
- whether alternative clothing should be used (this decision must be defensible, and how and when personal clothing will be returned needs to be documented and explained to the individual)
- whether the individual's location should be reviewed
- whether any possessions or medications should be removed or given back (this must be in consultation with healthcare, and a plan for returning these when risk reduces needs to be established)
- whether any further specialist support is required

This must all be documented in the Record of Case Review and Support Actions form.

Location in healthcare

Where an individual supported through ACCT is located in healthcare, the ACCT is to be managed in the same way as if on an ordinary residential unit. When case reviews are held, the case review in alternative location form (Annex C) will need to be used. A case review must be held before discharge from healthcare. A representative from the receiving wing must attend these reviews, alongside the multi-disciplinary team supporting the individual.

How must the ACCT process be managed when someone is in segregation or temporary separation?

Segregation and temporary separation can have a negative effect on wellbeing, so anyone being supported through ACCT must be subject to them only in exceptional circumstances.

The Defensible Decision Log (Annex E) or, in the youth estate, defensible decision making form (Annex F) must be completed if an individual is in segregation or temporary separation and is:

- on an open ACCT
- in the post-closure period of an ACCT
- has been on an ACCT within the last 28 days (i.e. segregation occurs within 28 days of the an ACCT being closed). In these circumstances the defensible decision log must be completed for a minimum of 28 days from the date of the final case review where the decision to close the document was made.

As part of the defensible decision-making process, it is important that the individual's risks, triggers, and protective factors are fully considered and that this is reflected in the documentation.

It is essential that segregation staff, the safer custody team and the relevant ACCT Case Co-ordinator are all aware of anyone on an ACCT in segregation or temporary separation.

Anyone placed in segregation will need to be observed by staff 5 times an hour at irregular intervals until the first case review has taken place. While the maximum number of ACCT observations is 4 per hour, 5 observations will need to be conducted in these limited circumstances in line with segregation policy. This does not mean that constant supervision will automatically need to be put in place for everyone on an ACCT who is placed in segregation, but that 5 observations an hour should be conducted as an interim measure until the first case review has taken place. The use of constant supervision may also be considered depending on risk (see **constant supervision** section for further guidance).

All individuals on an open ACCT who are in segregation or temporary separation must be referred to the SIM. A case review needs to take place as soon as possible, within 24 hours of the individual being placed in segregation or temporary separation, using the case review in alternative location form (Annex C). The case review team must consider the effect of segregation on the risk of the individual, and how it can be mitigated. Healthcare staff should also be invited to this review, and you must consider whether an urgent mental health referral is required – if so then the mental health referral form (Annex G) can be used. Agreed actions to mitigate risk must be recorded in the Support Actions form.

As per PSO 1700, a mental health assessment must be undertaken within 24 hours of someone on an open ACCT being placed in segregation or temporary separation. Individuals on an ACCT located in special accommodation must also have a mental health assessment carried out.

The ACCT Case Co-ordinator must also attend segregation and special accommodation review boards, with ACCT case reviews taking place at the same time wherever possible.

Where segregation is ended for an individual receiving support through ACCT, a case review will need to take place on the same day as this decision. A case review in alternative location (Annex C) will need to be completed. If timing means that a full multi-disciplinary review cannot take place on the same day (e.g. if the decision to end segregation is made outside the core day when some members of the case review team are not available), then an additional, full multi-disciplinary case review will need to take place as soon as possible the next day. If the Case Co-ordinator will not be in establishment the next day then this should be chaired by wing / unit manager and if possible, the Case Co-ordinator can provide a written contribution.
In each case, the case review team will need to consider any risks presented by the move and how to mitigate these.

How must ACCT be used when someone is placed in special accommodation?

Where someone on an ACCT is placed in special accommodation, the ACCT must be updated as soon as possible, with a case review held within 2 hours of the decision (or before unlock if the decision is made during the night state). The ACCT must make clear what alternatives to the use of special accommodation were considered, and what plans are in place to end its use, with an envisaged timeframe.

As per PSO 1700, anyone placed in special accommodation must be observed by staff at least 5 times per hour, at irregular intervals. While the maximum number of ACCT observations is 4 per hour, 5 observations will need be conducted in these circumstances in line with special accommodation policy. This does not mean that constant supervision will automatically need to be put in place for all individuals on an ACCT in special accommodation, but that 5 observations an hour should be conducted as an interim measure until the use of special accommodation is ended. However, it is also the case that individuals placed in special accommodation on an open ACCT may be observed more frequently than this (i.e. through constant supervision) if risk necessitates this (see the **constant supervision** section for further guidance).

Single case management for dual harm

Some individuals in our care will be at risk of harm to both themselves and others. Currently, individuals at risk of violence in the adult estate may be supported through a CSIP, while individuals at risk of self-harm are supported through ACCT. It is important to consider all aspects of risk when someone is on ACCT, to ensure there is consistency in the way they are being supported.

What is a CSIP?

A Challenge, Support and Intervention Plan (CSIP) is available to help manage individuals who pose a raised risk of being violent in prison, providing them with support that will help them move away from violent behaviours. It is important to note that not all individuals who engage in violent behaviour will be supported through CSIP; these decisions will be taken on a case-by-case basis. Where there is a concern that an individual is at risk of violence, a referral for CSIP should be made, and an investigation may take place to look at these concerns in more detail. If the referral is accepted, the individual will be supported by a Case Manager and a multi-disciplinary team. They will have a CSIP which sets out actions to be taken to reduce risk of violence.

How does a CSIP relate to ACCT?

ACCT and CSIP are different processes that have been designed for separate purposes. There are some intentional similarities between the two, as both are multi-disciplinary case management approaches, and have similar processes of oversight and quality assurance.

The risks and triggers for self-harm will often be related to the risks and drivers of harming others. It is important that supporting individuals who dual harm (are both violent and self-harm) is not done in isolation. Where risks and triggers differ, it is still important to consider risks relating to both as part of both processes.

How can ACCT and CSIP be managed simultaneously?

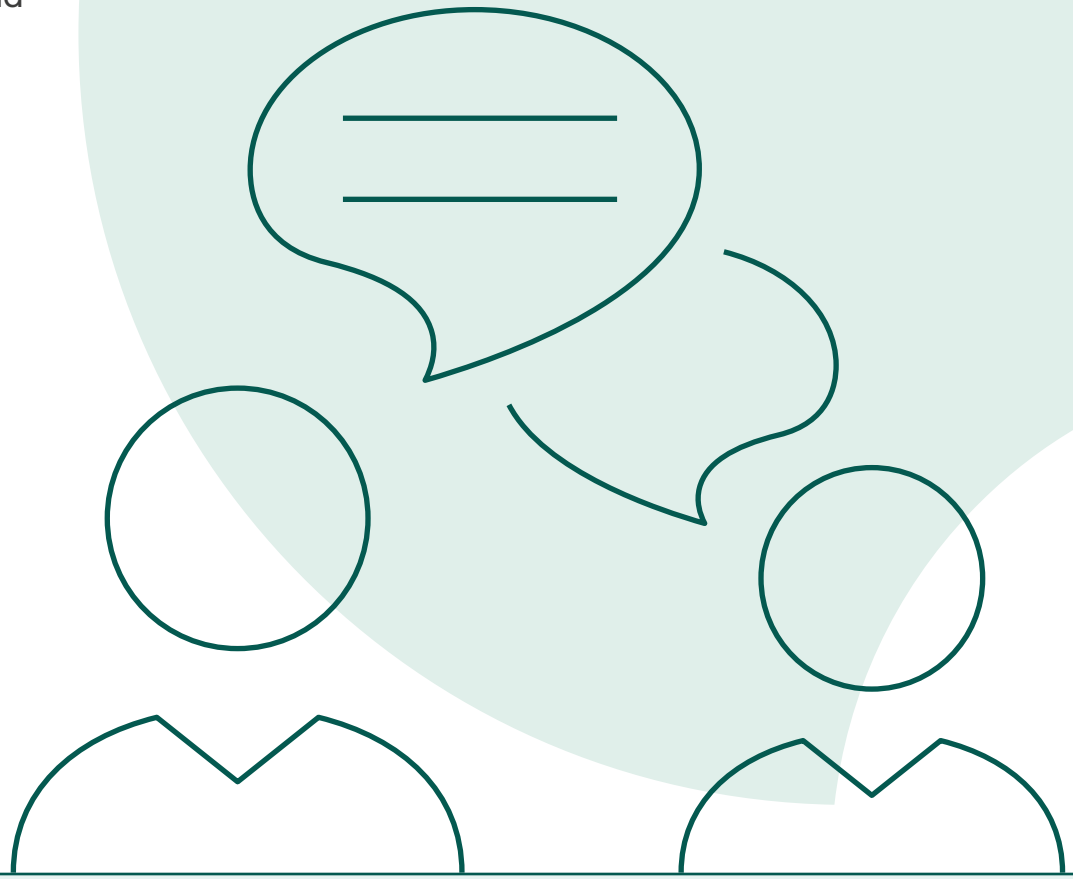
Given that there are some similarities between ACCT and CSIP, as well as potential overlapping risks and triggers, where an individual is on both a CSIP and an ACCT, they must have the same staff member acting as Case Co-ordinator for ACCT and Case Manager for CSIP.

It is expected that where a review takes place for either the individual's ACCT or CSIP, the other should be considered at the same time. Documentation from each process must be completed fully and separately and cannot be substituted for the other. However, CSIP reviews may still happen outside of ACCT case reviews as required, and vice versa. Where CSIP or ACCT reviews do take place between reviews of the other, any significant events or updates should be considered at the next ACCT or CSIP case review.

This will help ensure that CSIPs and ACCT Support Actions are effective and consistent. It will avoid duplication or actions that might unsettle the individual, undermine their progress and wellbeing, or increase the risk of harm they pose to others in the prison. It will also ensure that staff resources are used effectively.

What if the CSIP Case Manager is unavailable when an ACCT is opened?

Where an individual is already on a CSIP and has an ACCT opened, their CSIP Case Manager should also be appointed as the ACCT Case Co-ordinator. Where the CSIP Case Manager is unavailable (for example, due to leave or being away from the prison), whoever is overseeing the CSIP in their absence should also oversee the ACCT. This is also the case where an individual is on an ACCT and then a CSIP is opened while the ACCT Case Co-ordinator is away. In these instances, the individual must be made aware that their existing Case Co-ordinator will manage both processes upon their return. If known, the individual should be given an indication of when this might be.



6. Supportive daily actions and completing the Ongoing Record form

What?: The purpose of the Ongoing Record is to record:

- key events that may affect the individual's ongoing risk (e.g. an incident of self-harm or violence, court hearing (including video-link), upgrade or downgrade of incentive level, cancelled, negative or positive visit, failure to collect medication)
- relevant information on the individual's mood, behaviour and situation (e.g. changes in behaviour or mood, information about how they are coping with the Support Actions, engagement with regime/activities/others)
- the content of ongoing conversations with the individual to support them or evaluate their progress and care (related to Support Actions)

Who?: This should be completed by wing staff or staff present at activities (e.g. work, education, chaplaincy, healthcare) where the individual is present for a sustained period (note this requirement differs for the open estate – see **p. 58**). The unit supervisor must fill in the Supervisor Daily Check daily.

When?: Daily, in line with the levels set on the first page of the ACCT document. A member of staff must transport the ACCT document discreetly along with the individual whenever they move location within the establishment. This form cannot be completed electronically, and must be completed by hand.

The way we manage ACCTs can increase stigma. When transporting and storing ACCT documents we should always be mindful of the need to maintain confidentiality. Carrying or storing ACCTs in a way that is easily visible to other individuals in prison or the youth secure estate may make the individual feel exposed and increase feelings of vulnerability. It may increase self-stigma and lead to feelings of anxiety, guilt or anger, which could result in further self-harm. Consider, for example, concealing the ACCT document in a mail bag or similar when accompanying the individual around the prison.

Observations and conversations must be recorded in line with the requirements on the first page of the ACCT document. Observations are checks to ensure the welfare of the individual. You need to **satisfy yourself of the individual's safety** in all checks that you make and you must record that you have done this in the Ongoing Record form. This is done by printing your name and writing the time in the grid box provided. You must also document anything significant in the summary section, as well as any action taken as a result. Observation levels will be set out on the first page of the ACCT and checks must be completed in line with these instructions. Checks must be taken in line with the frequency on the first page and must be made at **sensible irregular intervals** so as not to be predictable.

Observations can feel intrusive, and it is important to remember this. If observations are carried out during the day, engaging with the individual is important. It is less likely to be appropriate to engage in conversations with the individual when conducting night observations; this is particularly important given the positive effect sleep can have on mental wellbeing.

When conducting night observations, you can consider:

- telling the individual before they go to bed that you will be conducting observations throughout the night – although observations need to be at unpredictable times this will help to set a level of expectation and give them the opportunity to ask questions
- whether it would be appropriate to give the individual an eye mask or earplugs
- use of torches and light levels – are you able to safely conduct observations without turning on lights or pointing a torch directly at the individual?
- minimising noise when opening and closing doors, gates and observation panel flaps

Conversations must be meaningful, and the power of everyday interactions must not be underestimated. Giving the individual the chance to raise any issues that are worrying them and to talk and off-load can be invaluable. You must be aware of the individual's Care Plan, so you have the context for the conversations you undertake. Getting to know the individual, and making them feel cared for and valued, are key to fostering a supportive and open relationship. **Five Minute Intervention (FMI) techniques** may be useful in this context.

You must follow the frequencies of conversations and observations that are stated on the first page of the ACCT. You must record them immediately or as soon as practicable afterwards. These entries must never be recorded retrospectively.

All entries in the conversation and summary sections of the ongoing record must be meaningful. Recording 'no change' or 'appears okay' etc. is not acceptable. While less activity is expected at night, night summaries must focus on observations of perceived quality of sleep, demeanour, any interactions etc. that can indicate level of risk. Pages of meaningless comments such as 'correct when checked' would not communicate as much relevant information as an entry which focuses on meaningful observations such as the factors outlined above. Some examples of good interactions are outlined on the next page.

Observations and conversations in the open estate

ACCT is used across the prison estate, including in both closed and open prisons. While managing ACCTs in open conditions can be challenging, individuals should not be returned to closed conditions just because they are at risk of self-harm. Such a move would be acceptable only in exceptional circumstances, for example where the individual is considered at high risk of suicide or serious self-harm and requires frequent observations that cannot be managed in open conditions, or where they require the support of a specialist team that is not available in the open prison. For further guidance on managing ACCT in the open estate, see the **'Related policies and considerations'** section.

Unlike the closed estate, free movement in the open estate presents challenges to the confidentiality of the ACCT. In the open estate, ACCT documents may need to be kept at a locally agreed secure central location, accessible only to staff (e.g. on their residential wing). As a staff member will not be escorting the individual to all activities, the document may not be travelling with them. However, information sharing must be a priority. For example, if the individual is due to attend an education session, the education staff involved in the session must be aware of the open ACCT and be familiar with the Care Plan. They must update the Ongoing Record, particularly on observations or conversations relating to risk, as soon as possible or once the session is completed.

Examples of good Ongoing Record conversation entries:

When speaking with Kevin today he said that he has had a visit from his family this afternoon and is feeling much more positive. He and his wife have had a bit of a heart to heart and have been able to work through some of their issues. He could ask her some questions that have been worrying him and he's feeling less anxious about their relationship. His daughter gave him some pictures that he has put up on his wall. He seems much more cheerful.

Kelly started work in industries today, and I caught up with her at the end of the day. She said that she had really enjoyed being off the wing and that she had got on well with the instructor and the other women in the workshop. She feels quite tired after a full day of activity which she says she is glad about as she has trouble sleeping when she hasn't been able to burn off enough energy. She thanked me for my help finding her employment and is looking forward to having something to fill her time. She said she feels keeping busy will help her cope with her issues much better.

Gemma is currently on constant supervision. I have spent the morning with her. It has been very difficult to engage her in any activities or much in the way of conversation as she is very down, tearful and withdrawn. With lots of encouragement we have been playing some board games, but she is struggling to concentrate and it felt like she was going through the motions rather than being engaged in the game. I have been trying to engage her in conversation without much luck. She did eat some lunch though, which is much better than the last few days where she has refused to eat.

Nigel seemed very down today and when I spoke to him he said that he was feeling very low and is struggling to cope. He couldn't really give me any specific reason for the deterioration in his mood, but thinks that the reality of his sentence might be getting him down. He said he feels it's all pointless because he's got so long to serve. I have contacted his ACCT Case Co-ordinator, who is going to visit him over lunch to see if there needs to be any changes to the support offered through his ACCT. Nigel is currently in with a Listener and I will check on him once they have finished their conversation.

Samantha told me today that her mother and partner have sent her an email saying they have booked a visit for Thursday. They are going to bring her daughter with them, who she hasn't seen since she came into custody. She said she was really looking forward to seeing them all, but is a bit nervous about how she will feel seeing her daughter as she thinks this might be really upsetting, especially when they must leave. I have reassured her that we will be here to help her after the visit and she thanked me and assured me she would ask for help if she needed it.

I caught up with Abbas this lunchtime. He's been out of his cell on association and has been interacting well with his peers. He has a new cell mate, who he is getting on with well. He said they have lots in common and he feels better having someone to talk to when he is locked in his cell. They have been out playing pool this morning and Abbas really enjoyed this. He was chatty and jovial when I spoke with him and said he was feeling well.

7. Post closure

7.1, 7.2, 7.3 Closure of ACCTs and the post-closure process

What?: The ACCT post-closure process is in three sections:

- Post-closure review (7.1)
- 7-day post-closure monitoring form (7.2)
- ACCT questionnaire (7.3)

The post-closure review includes prompts for discussion with the individual to see how they are coping following the ACCT closure and helps identify any further action required to support them. The ACCT questionnaire allows them to reflect on the process in their own words, and is a useful tool for safer custody teams in evaluating the efficacy of ACCT processes. The individual can take it away and complete it in their own time.

Who?: Case Co-ordinator (who, with the multi-disciplinary case review team, decides on the point of closure of an ACCT) and the individual. The Case Co-ordinator continues to co-ordinate the post-closure process. Attendance of the wider case review team should be a collective decision based on individual circumstances. For example, if the individual is more likely to talk openly and honestly in a one-to-one setting then this should be facilitated, however others may feel more supported by having consistent members of the case review team present for the post-closure review.

The 7-day post-closure monitoring form is to be completed by unit/wing staff, and/or any member of staff with contact with the individual during the day (e.g. education, chaplaincy, where appropriate).

When?: An ACCT can be closed at a case review when all Support Actions have been completed, and risk is perceived to have adequately reduced. The first post-closure review must be completed as soon as is practically possible following a 7-day post-closure monitoring period, and the 7-day post-closure monitoring form must be completed during this time (and up until the post-closure review takes place). Further reviews are optional, and their number and timings must be decided case by case. The post-closure period can last up to 6 weeks.

When considering closing an ACCT, remember:

- An ACCT must not be closed until **all** the Support Actions have been completed and outcomes achieved, and the multi-disciplinary team are content that the risk has reduced enough for closure to be appropriate.
- Some risks may be long-term and may not be resolved when the ACCT is closed. However, appropriate actions must be in place for the individual to mitigate these risks, such as receiving ongoing treatment for a mental illness.
- An ACCT must never be closed to facilitate a transfer to another prison or within 72 hours of a planned transfer. Where a transfer takes place within the post-closure period, the receiving prison must be informed about the recent ACCT and the need for them to undertake the post-closure review. More information on transferring prison individuals on ACCT can be found **here**.
- Similarly, where the individual is located elsewhere (e.g. if they are in healthcare or segregation) and a transfer to a normal location is planned or likely in the near future, then the case review team should consider whether this move is likely to impact risk. If so, the ACCT must be kept open until the move has taken place. This allows the case review team to monitor and respond to any change in risk level, as moves to another location may cause anxiety and concern for the individual.
- The decision to close the ACCT must be recorded in the case notes section of NOMIS giving a summary of the reasons for the decision.
- The Case Co-ordinator must explain to the individual why the ACCT will be closed and ensure they understand any ongoing support available (e.g. for long-term risks). It may be beneficial to involve the individual's keyworker or CuSP worker in this conversation.
- The Case Co-ordinator must ensure that the central registration point (e.g. control room), healthcare, offender managers and staff undertaking ACCT-specific administrative support duties are all informed of the closure.
- Once closed, the 'ACCT Open' alert must be closed on NOMIS, and the post-closure ACCT alert opened.

The closed ACCT must remain on the wing and follow the individual when moving to different areas of the prison, until completion of the post-closure review(s). Once it is confirmed there are to be no further post-closure reviews, the closed ACCT must be stored safely in the F2050 core record.

Re-opening an ACCT

An ACCT can be re-opened at any point during and up until 6 weeks following closure if risk is deemed to have increased. This is regardless of whether post-closure support is still being provided. If more than 6 weeks have passed since the ACCT was closed, then a new ACCT will need to be opened and managed in line with the requirements set out in this ACCT guidance and in the safety policy framework.

When an ACCT is re-opened during the post-closure period, the reasons for this must be documented in the 7-day post-closure monitoring form and an Immediate Action Plan must be completed within one hour of the decision to re-open the ACCT. The Immediate Action Plan must be completed by the wing/unit supervisor or orderly officer within 1 hour of the decision to re-open the ACCT. The Immediate Action Plan will outline how the person will be kept safe in the short-term until a case review can be held.

The wing/unit supervisor or orderly officer must determine whether the circumstances for re-opening are different from those addressed in the original plan. If they are, a new assessment will need to be undertaken within 24 hours of the decision to re-open the ACCT. A case review will need to be held as soon as possible following completion of the Immediate Action Plan (and assessment, if required), no longer than 25 hours after the decision to re-open the ACCT. An 'ACCT Open' alert will need to be opened on NOMIS.

Post-closure support

The date of the first post-closure review should be decided by the case review team, and must be scheduled as soon as possible following a minimum 7 days of post-closure monitoring.

The case review team should also consider whether the individual is more likely to talk openly and honestly in a one to one setting or may feel more supported by having consistent members of the case review team present for the post-closure review. When deciding on the timing of the review, the case review team should consider individual circumstances (e.g. is there any reason you would want to review progress sooner rather than later?) as well as practical considerations (e.g. when the Case Co-ordinator will be available to chair the review, along with any other members of the case review team that may attend).

The 7-day post-closure monitoring form must also be used to monitor progress immediately after the closure of an ACCT. It should comprise daily summaries noting any significant events, notes from conversations with the individual, and any signs of concern. This can then be used to inform the post-closure review (and therefore needs to be completed up until the post-closure review takes place).

When an individual has been transferred during the post-closure phase, the receiving prison must allocate a Case Co-ordinator and arrange for the post-closure review to take place. The new Case Co-ordinator must familiarise themselves with the transferred ACCT document.

The post-closure review must review the Support Actions and the progress made by the individual since the ACCT was closed. This must be recorded in the post-closure review.

In all cases, the Case Co-ordinator must decide at the end of the post-closure review whether there needs to be any further reviews and their frequency, or whether the ACCT needs to be re-opened.

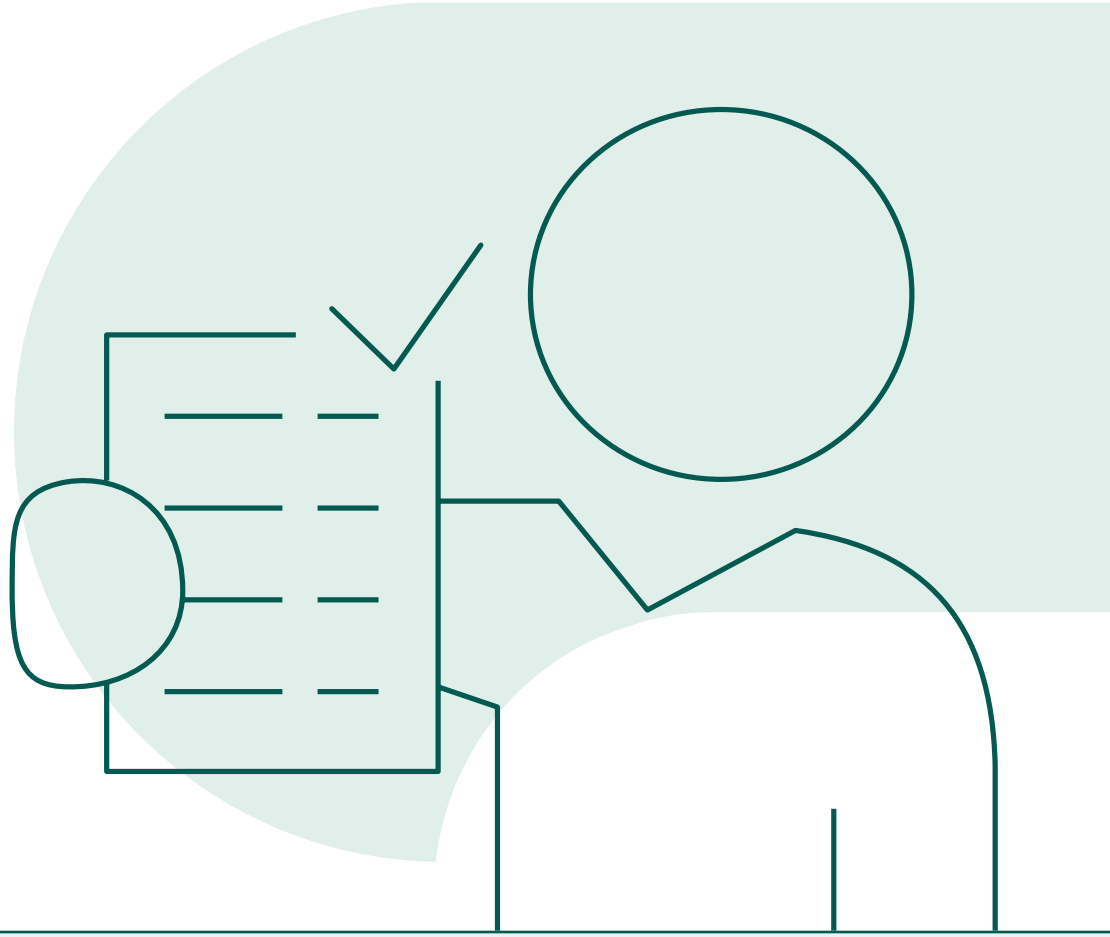
If the post-closure period is ended and the ACCT fully closed, the ACCT document must then be stored in the core record, after any required quality assurance is undertaken. The post-closure ACCT alert on NOMIS must be closed.

The post-closure period can be an opportunity for the individual to revisit their Wellbeing Plan, or complete one if they chose not to earlier in the process. This will give them the chance to reflect on progress made, and consider healthy coping mechanisms that can be used if they face difficulties in the future. This could be completed by the individual themselves, or with the support of the Case Co-ordinator, their key worker or any trusted source of support.

The purpose of the post-closure period is to track the individual's progress following the closure of the ACCT, and ensure there is no decline in their wellbeing. This is done by checking that adequate support mechanisms are in place to ensure the individual is able to cope without the formal ACCT structure. No longer having support from the case management team can be difficult for some individuals, and there have been cases where people have taken their own lives shortly after their ACCT was closed.

Remember to:

- Encourage the individual to build up their own support networks and coping strategies over the course of the reviews. Reduce levels of support gradually.
- Close the ACCT only when all Support Actions have been completed and outcomes achieved, and when the case review team judges that the level of risk is no longer considered raised and that the individual's resources and ability to cope are adequate.

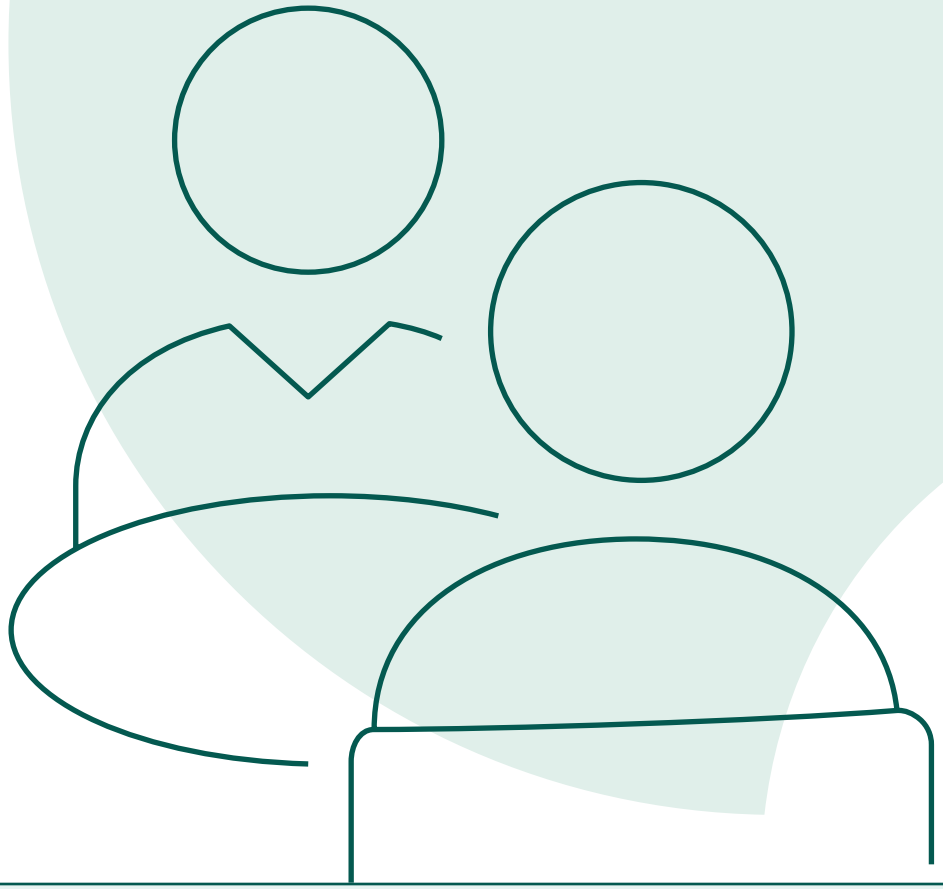


At the closing case review, check that:

- the issues that caused the ACCT to be opened have been resolved or reduced in intensity
- the individual has access to at least some resources that they find are meaningful and give them purpose

At post-closure review(s) discuss:

- how the individual is feeling now and whether they are having any difficulties
- how the individual is managing with the problems that led to their distress
- whether the individual is now in contact with friends, family or some other support and if that is helping
- whether the individual has now got something in their lives that they feel positive about (e.g. work, art, exercise, education, hobby, something they enjoy or gives them a sense of purpose)
- whether the individual can see alternative ways of dealing with a similar problem, should it arise in the future
- any thoughts or acts of self-harm or suicide behaviour since the ACCT was closed



Quality assurance

What?: Quality assurance is the process used to ensure that ACCT is being delivered at a consistent high-quality level across an establishment. This includes effective risk identification, defensible decision making, if outcomes are meaningful, areas of good practice while also reflecting feedback from the individual supported through ACCT.

Quality assurance processes should ensure that general learning is being taken from ACCTs and used to promote good practice, assess trends and identify where further upskilling is required.

Quality assurance must be carried out using the ACCT quality assurance tool.

Who? The governor/director of the establishment is directly responsible for the oversight and upkeep of an ACCT quality assurance process that is fit for purpose, and analysis that is meaningful and tailored to the needs of the establishment. This must be centered on use of the mandated ACCT quality assurance tool. Where possible, quality assurance should be carried out by members of staff with a good knowledge of ACCT principles, but who have not undertaken a key role in delivery of support for the individual whose document is being reviewed (i.e not Case-Coordinators or Assessors who are involved in that case).

When? There are three stages of checks using the ACCT quality assurance tool. These are:

- Check A (within 72 hours): focuses on information gathering, risk assessment and care-planning – this should be completed after the assessment and first case review
- Check B (weekly): focuses on ongoing risk and care management
- Check C (post closure): focuses on the closure, assuring risk management and decision making

Related policies and considerations

Individuals supported through ACCT may be affected by many challenging situations during their time in custody (e.g. location in segregation, subject to an adjudication or moving down an incentive level). While there are separate policies in place to govern these processes, and how individuals at risk of self-harm must be considered as part of them, the ACCT case review team will still need to consider how they manage the ACCT process in specific circumstances.

How should the ACCT process be managed when someone is subject to an adjudication?

Adjudication awards may raise an individual's risk of self-harm. It is therefore important that ACCT case review teams consider the occurrence and outcome of any adjudications during case reviews.

In line with PSI 05/2018, adjudicators must consider the risk factors of those on an open ACCT plan or who have had an ACCT closed within the last three months. Therefore, adjudicating governors must have access to the individual's ACCT document (which will accompany the individual to the adjudication if it is still open) prior to an adjudication to consider any risks when making decisions surrounding the outcome of the adjudication and/or adjudication awards. Particular attention should be paid to: Support Actions; risks, triggers and protective factors; recent case reviews; and the Ongoing Record. This information may also be reflected in the conduct report. This information enables the adjudication to be carried out in a fully informed way, ensuring that risks, triggers and protective factors are considered. This will also enable supportive actions to be put in place to mitigate risks.

The adjudicating governor should also consider whether an urgent case review is needed in consultation with the Case Co-ordinator (or wing/unit supervisor in their absence). This will likely depend on the outcome of the adjudication.

Given the potential for adjudication awards to have an impact on someone's risks, triggers and protective factors, any adjudications must be recorded in the Ongoing Record by the adjudicator, including the award given, and any action taken to reduce or mitigate risk as a result of the award (if applicable). The risks, triggers and protective factors form must also be updated accordingly. For example, where an individual's adjudication results in the loss of canteen, this may raise risk if they cannot use established coping mechanisms such as vapes.

For individuals who may be given a period of cellular confinement, an Initial Segregation Health Screening must be conducted before an adjudication. Information in the ACCT must be considered as part of this.

How should ACCT be managed alongside incentives policy?

The use of incentive levels is set out in the **Incentives Policy Framework**. There will be cases where individuals supported through ACCT have to be moved down an incentive level. In these instances, it is important that we consider how this may impact risk. Individuals who have been identified to be at risk of suicide or self-harm must be supported while on Basic level.

During case reviews, the case review team must consider how any change in incentive level may affect risk, using the information in the risks, triggers and protective factors form, and recording any new risks or protective factors identified. It is then for the case review team to identify any actions that can be taken to mitigate risk, and record them in the Support Actions form. For example, where a move down an incentive level would take away a coping mechanism or access to a protective factor, the case review team must consider whether any other provision can be put in place to mitigate risk (e.g. a distraction pack or activity).

Incentives policy states that for individuals on an ACCT and on Basic incentive level, a review of their incentive level must be carried out within a maximum of 7 days of them going on to basic level, and at least every 14 days after that. However, a review and upgrade to standard incentive level can take place at any time within these timescales should the individual demonstrate the expected behaviour. For further information on the management of incentive levels for people supported through ACCT, please refer to the **Incentives Policy Framework.**

What happens when someone on an ACCT is subject to use of force?

Any use of force used on an individual supported through ACCT must be carried out in accordance with PSO 1600 and published guidance on **Minimising and Managing Physical Restraint within Young Offenders Institutions**.

Being subject to use of force can be distressing and potentially triggering. If physical interventions are planned for individuals supported through ACCT, this risk must be taken into account.

- Due to the negative impact that use of force may have on risk, a member of staff – preferably the Case Co-ordinator or a member of staff whom the individual trusts – should visit them following a use of force (including restraint and alternative clothing) to check their wellbeing, and document this in the ACCT Ongoing Record. The discussion should:
- acknowledge the individuals emotional responses to the event
- promote relaxation and feelings of safety
- facilitate a return to normal patterns of activity
- ensure that all appropriate parties have been informed of the event
- begin to consider whether there is a specific need for emotional support in response to any trauma that has been experienced
- begin to consider whether any learning can be taken from the event

The Case Co-ordinator (or, if unavailable, the wing/unit manager) should consider whether an urgent ACCT case review is required.

After use of force has occurred, the ACCT Ongoing Record must be updated. The use of force and circumstances surrounding this will need to be discussed with the individual at the next case review, and reflected in the ACCT, including the risks, triggers and protective form. This includes considering what led to the use of force and how this may have impacted risk. This will help staff consider whether there is anything that can be done through Support Actions to minimise the chances of force being needed in the future, and ensure that the effect of the use of force on the individual's risk of self-harm is minimised as far as possible.

Use of body belts

As with force, restraint can also be distressing, and must always be carried out in line with PSO 1700. This includes the requirement for the ACCT Care Plan to be consulted – if not before, then as soon as possible after the decision to use the body belt. It also includes the requirement for the duty governor/director to chair a case review within 60 minutes of the decision being made.

It is important for the ACCT Ongoing Record to be updated following any use of a body belt. Support Actions and records of case reviews must make clear what alternatives to use of the body belt have first been considered, and what plans are in place to end its use.

If a body belt is used, regular reviews of its use will be held (requirements of which are set out in PSO 1700) and ACCT Case Co-ordinators must attend (or wing/unit managers if unavailable). The ACCT Case Co-ordinator (or wing/unit manager) should also consider whether an urgent ACCT case review is needed. Where ACCT case reviews take place while a body belt is being used, the designated manager overseeing the use of the body belt must attend. They must also attend the first ACCT case review that takes place once the use of the body belt has ended.

Use of alternative clothing

Alternative clothing must only be used as a last resort, with consideration given to whether alternative options would be sufficient to mitigate risk of self-harm or suicide (such as placing the individual in a safer cell).

The decision to use alternative clothing should take into consideration the potential impact it may have on the individual, including whether these measures may increase an individual's risk levels rather than decrease them. If alternative clothing is used an urgent case review must be held, with case review teams considering any impact on risk and how this can be mitigated through Support Actions with a view to ending its use.

The removal of normal clothing must be done through persuasion and negotiation. If an individual refuses, consider other ways that risk could be mitigated (e.g. do observation levels need to be increased, is constant supervision necessary?).

As with the removal of other items, decisions to remove normal clothing must be recorded in the ACCT at the point the decision was taken. If this decision is taken outside of the case review, this must be documented at the point it was taken (clearly stating why they have been removed, and how and when these may be returned), and the Case Co-ordinator must be informed as soon as possible. Where items are returned, this must also be documented in the Record of Case Review, clearly stating how risk has been mitigated.

The Case Co-ordinator or the wing/unit manager should visit the individual following alternative clothing being put in place to check their wellbeing, and document this in the Ongoing Record. This should take place when the individual is able to discuss their wellbeing.

To ensure their privacy and dignity, the individual must not be left in alternative clothing during any activities that bring them in contact with other individuals in prison. In these circumstances, normal clothes must be re-issued and observation and conversation levels adjusted accordingly (it will be for the ACCT case review teams to set out what these levels will need to be).

Dirty protest

Where an individual supported through ACCT is on a dirty protest, this must be managed in line with PSO 1700 and reflected in the Ongoing Record.

The ACCT Case Co-ordinator (or wing/unit manager) must consider whether this impacts the individual's risks, triggers and protective factors or Care Plan and respond accordingly if so (i.e. consider whether an urgent case review is required). For example, risk might be impacted if the dirty protest prevents the individual receiving peer support, and this is a protective factor for the individual.

Removal or restriction of items

Where defensible decisions are made relating to the removal (or restriction) of items from an individual supported through ACCT, these must be recorded in the ACCT at the point the decision was taken (e.g. on the IAP, Record of Case Review or Ongoing Record). This is because of the negative impact that removing items may have on wellbeing. If this decision is taken outside of the case review, this must be documented in the Ongoing Record (clearly stating what items have been removed, and how and when these may be returned), and the Case Co-ordinator must be informed as soon as possible.

Where items are returned, this must also be documented at the point the decision was taken e.g. in the Ongoing Record or Record of Case Review, clearly stating how risk has been mitigated.

Healthcare must always be consulted on decisions relating to removing in-possession medicines.

All decisions to remove items must fully consider any potential negative impacts of removal of items.

Defensible decision-making means having a clear rationale to make a justified and defensible decision and documenting it. In practice this means the decisions you make are based on:

- Policy: what the policy is and what it instructs, including any legal requirements
- Evidence: relevant evidence and information available at the time
- Good practice: successful or positive approaches that have worked before
- Views of others: the views of those with relevant knowledge and experience

Confidentiality

The ability to share risk-pertinent information is vital to keeping people safe. This takes priority.

However, we know that there can be stigma in prisons and the youth secure estate around self-harm and suicide, and individuals may be reluctant to disclose information if they feel it will be shared inappropriately or put them at risk.

It is important that the ACCT process is carried out confidentially. Notice boards or other information sources showing individuals who are on an ACCT must not be widely available or visible, and the ACCT document must always be carried discreetly. Individuals' names should not be called out for all to hear when they are needed for ACCT reviews, and meaningful conversations should be carried out as privately as possible.

If the individual does not wish to sign the 'Agreement to sharing of information' or is unable to, this must be documented on the form, and the Assessor must share only information that relates to the risk and how to reduce it (and must share this only with other staff involved in the persons care). For example, this may include: relevant parts of the Support Actions for staff involved in actions; known risks, triggers and protective factors for those interacting with the individual; and observation and conversation levels.

Consideration of placing or keeping someone on an ACCT within the open estate

While managing ACCTs in open conditions can be challenging, an individual should not be returned to closed conditions solely because they are at risk of self-harm. Where an individual is open about their level of risk and can be safely managed in open conditions, this must be supported.

A move from open to closed conditions would only be acceptable in exceptional circumstances, for example where the individual is considered high risk of suicide or serious self-harm and requires frequent observations that cannot be managed in open conditions, or where they require the support of a specialist team that is not available within the open establishment.

Whether this can be safely managed will be considered by the ACCT case review team or by another appropriate multi-disciplinary meeting as per local arrangements (e.g. a special circumstances risk review board).

A move back to closed from open conditions may escalate risk and discourage individuals from disclosing harmful thoughts. Any return to closed conditions must be fully explained to the individual, with it made clear that this is not because they are at risk of self-harm but because this is where they can be supported and their needs best met. The individual must also be returned to open conditions as soon as it is safe to do so.

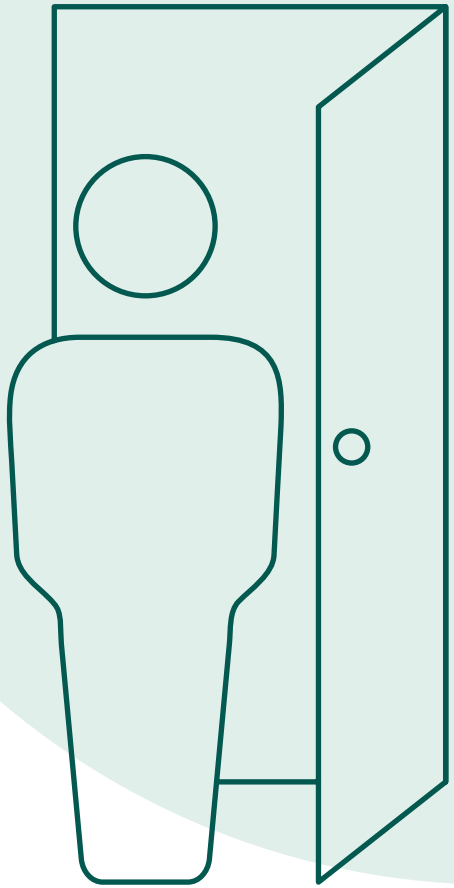
A representative from the open estate establishment the individual has transferred from must engage with the first case review that takes place following a move back to closed conditions, as well as any case reviews that discuss their return to that open establishment. If this is not feasible in person, conference calling, written contributions and the sharing of meeting notes should be used.

Release on Temporary Licence (ROTL)

Where an individual supported through ACCT is Released on Temporary Licence (ROTL), staff must continue to safeguard the individual while they are outside the establishment. ACCT is a process for which responsibility resides with prison staff, and it is therefore not appropriate for the individual, or someone who is not a member of staff, to transport or complete the document.

Safeguards must be agreed and put in place before the individual leaves the establishment, with a case review undertaken when an individual is first granted ROTL. The case review team will need to decide an appropriate level of checks throughout the ROTL period and how these will be made (e.g. by calling the individual, or having the individual call staff, at intervals if deemed appropriate). A case review will also need to be undertaken if there is any change in circumstance while on ROTL which may impact these safeguards.

The prison must have a locally agreed central location for ACCT documents. This must be secure (the document must not be accessible or visible to other residents), and accessible for all staff to complete following the necessary welfare checks.



Release preparations for people requiring support

What?: Final case review before discharge from custody, and the support put in place for individuals prior to release. An individual's ACCT should not be closed due to release, if their risk has not reduced.

Who?: Multi-disciplinary case review team, led by Case Co-ordinator.

We sadly know that the period after release accounts for a high proportion of deaths by suicide. Where feasible, serious and thorough consideration must be given to where the individual is being released. Our duty of care for an individual does not end just because they have left the prison gates. We have a responsibility to ensure that transition arrangements are in place and relevant information is shared with professionals in the community so that they can undertake their own risk assessments and offer the right level of support.

When an individual on an open ACCT is discharged from custody, the final case review must consider what support can be offered in the community from other people and agencies e.g. NPS, Community Rehabilitation Companies (CRCs), drugs services, healthcare professionals, social services, Youth Offending Teams (where applicable). Relevant information must be shared with the appropriate agencies and Support Actions must be updated to record the actions taken, and a copy given to the individual. Use Annex D for the final case review before release.

If a release is not planned (e.g. if a an individual on remand is released from custody following a court appearance) then it may not be possible to complete the actions detailed below. In these cases, probation may retrospectively contact the prison to request relevant information. It is important that the ACCT is considered as part of this, as you would expect for planned releases.

Release preparations where an ACCT is currently open

When an individual supported through ACCT is going to be released, it is the Case Co-ordinator's responsibility to:

- Liaise with Offender Management Unit (OMU) to identify the relevant community professionals to invite to case reviews (e.g. if the resident is going to be released to an AP, the AP staff must be invited to take part in the review before release). This may be via telephone or written contribution if not in person.
- Invite probation/YOT staff to case reviews (e.g. prison offender manager, community offender manager, Community Rehabilitation Companies (CRC), AP staff if applicable).
- Involve professionals who can provide through the gate services, such as mental health and substance misuse providers who can liaise with services on the outside, the local authority etc. at the earliest opportunity.
- Discuss with the individual what information will need to be shared to continue supporting them on release.
- Consider any oversight bodies that need to be aware of any risk posed to self (e.g. MAPPA, local safeguarding children boards/vulnerable adults committees) and liaise with OMU to contribute accordingly.
- Involve healthcare at the earliest opportunity to discuss any handover between prison and community healthcare, and any issues around maintaining access to prescriptions etc. and how they may affect risk.
- Ensure a copy of the key information from the ACCT is shared with probation colleagues as appropriate (e.g. the offender manager, AP or Bail Accomodation and Support Services (BASS) accommodation team if relevant). This includes: the Care Plan; risks, triggers and protective factors; and the case review before release from custody form (Annex D). The contact details of the Case Co-ordinator or safer custody team should also be shared, and this can be recorded in the Review before release from custody form (Annex D). While it is the Case Co-ordinator's job to ensure information from the ACCT is shared, this will involve discussing and agreeing with OMU how information will be shared with relevant community professionals (e.g. probation staff, AP staff) and ensuring they have the necessary information from the ACCT.
- Discuss/confirm with the individual (in conjunction with the relevant professionals):
  - that relevant risk information will be shared with probation staff to keep them safe
  - that they have somewhere to live on release
  - whether they have a source of support who can meet them at the gate – encourage them to have someone (supportive friend, family or other) meet them when they leave the establishment (prisons with under-18s must seek advice from YOTs; they must not be left to make their own way to accommodation)
  - any ongoing treatment and necessary arrangements (e.g. GP registration)
  - that they are aware of emergency contact details for organisations that can help in a crisis within the community (e.g. Samaritans, local substance misuse organisations, housing support organisations such as Crisis and Shelter)

If any gaps in support are identified this should be followed up with the relevant team.

It's important to help the individual plan how they will deal with life on the outside. Aim, where possible, to facilitate comparable support outside (e.g. as they won't have access to Listeners in the community, ensure they have the national Samaritans telephone number). It may be helpful to complete new Support Actions pre-release, or a Wellbeing Plan that the individual can take with them.

It would also be helpful to ensure the individual understands what they need to do upon release to obtain accommodation through probation and the Offender Management Unit (OMU).

Encourage them to use any sources of support that they do have (e.g. family, friends). If they are under 18, highlight agencies that focus on children (e.g. NSPCC, Childline, Barnardo's).

Providing an information pack about the support available in the area where they are being released can be helpful.

Release preparations where an ACCT has been open in the previous 12 months

If an individual is due to be released who is not currently being supported through ACCT, but who has been in the 12 months preceding release, relevant risk information from their most recent ACCT must be shared by the OMU with probation colleagues as appropriate (e.g. the community offender manager, AP or BASS accommodation team) prior to release wherever possible (e.g. where advance notice of release is given). Relevant risk information includes the following ACCT sections:

- Risks, triggers and protective factors
- Care Plan
- Final Record of Case Review form

Staff support and useful resources

Staff wellbeing

Your wellbeing is important. Emotional, practical, social and health problems can affect us all, and encountering distressing situations in the workplace can have a knock-on impact on wellbeing. If you are ever struggling, there are support systems available to you:

- Speak to your local care team or your line manager.
- **Speak to a Mental Health Ally**.
- Speak to your GP.
- Contact the Employee Assistance Programme (EAP) – they are available 24 hours a day, 7 days a week:
  - call the support line on: 0800 019 8988
  - log in to the website: **https://www.pamassist.co.uk/** (Username: HMPPS; Password: HMPPS1)
  - download the PAM Assist app – login details as above
- EAP can provide support following traumatic incidents – such as witnessing self-harm or being the first to respond to a suicide attempt – through group or one-to-one counselling support. The sessions are confidential and aim to help you process your feelings and move forward. If you'd like to arrange a trauma support session, call the EAP helpline on the number above.

If you have been involved in a traumatic incident and TRiM is available to you, you can contact a TRiM practitioner.

The Samaritans also have advice for **what to do if you think someone you know isn't okay**. Anyone can get in touch with The Samaritans, no matter how large or small the issue feels – if it's affecting you then it's time to talk.

Useful resources

HMPPS safety intranet pages
Safer Custody learning bulletins
Safer Custody policy (PSI 64/2011)
HMPPS: Suicide and self-harm prevention in prisons
PHE: Local suicide prevention planning
National Suicide Prevention Alliance
NICE guidance: Preventing suicide in community and custodial settings
NHS England: Service specification: Integrated mental health service for prisons in England
Self-harm guide for HMPPS staff
Wellbeing Plan and other wellbeing resources
Conversation playing cards