SUICIDE IN PROBATION

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OVERVIEW

- Why think about suicide in probation
- Prevalence of suicide amongst people on probation
- Risk factors
- Assessing and managing the risk of suicide
- Impact on staff
- Summary

WHY THINK ABOUT SUICIDE IN PROBATION?

- Across the globe, rates of suicide are high amongst people under probation supervision
- People who leave prison and spend time under probation supervision (e.g. on licence in England and Wales) more likely to die than people in prison and people in community not under supervision
- Being in the community under supervision creates additional/different risks so we need to think about this group of people separately from prisoners and others in the community
- Being on probation is painful, punishment in the community is pervasive and intrusive (McNeill, 2018)
- There are difficult questions around where a duty of care lies – should probation services be responsible for preventing deaths? What is the role of human rights legislation? How should probation services be held accountable?

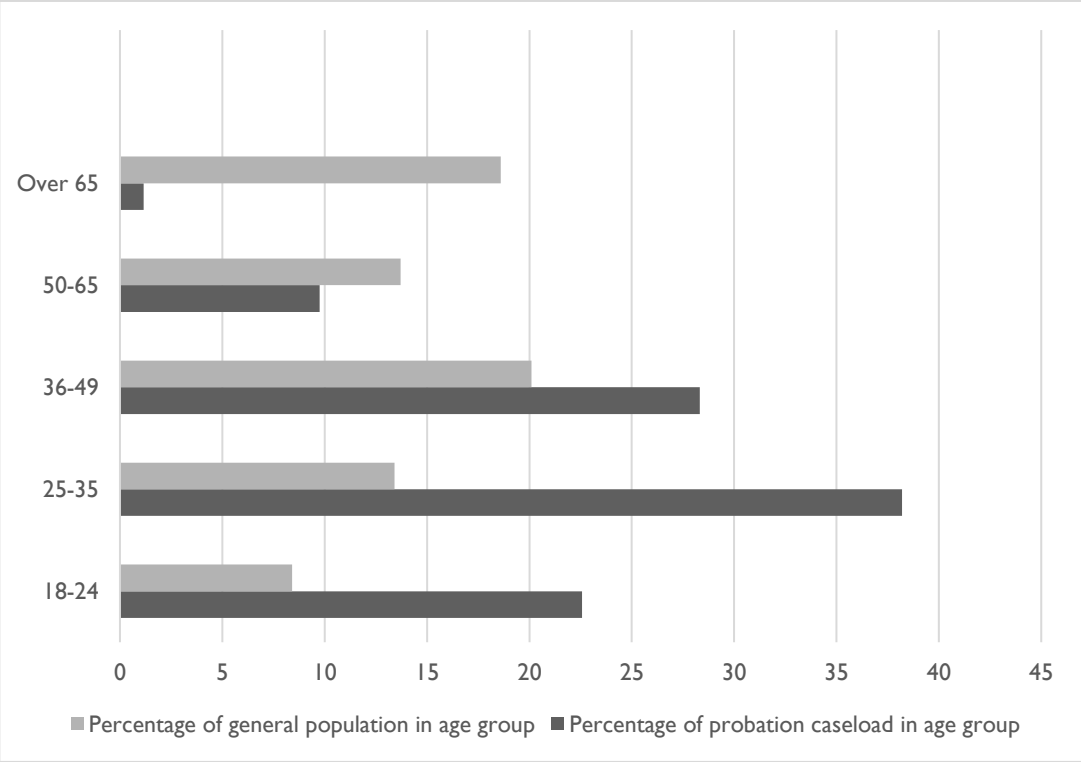
FOUR RESEARCH PROJECTS

- Dying on probation, 2010. Funded by Howard League for Penal Reform
- Post-custody deaths, 2016. Funded by Equality and Human Rights Commission.
- Staff experiences of working with people at risk of suicide and/or self-harm. 2020 – 2022. Funded by HMI Probation.
- Age-standardized mortality ratios amongst people on probation. 2021. Unfunded.

DEATHS OF PEOPLE UNDER PROBATION SUPERVISION

	All-cause deaths (2020/21)	Self-inflicted deaths (2020/21)	Percentage of deaths which were self-inflicted
Males and Females	1343	409	30%
Males	1170	341	29%
Females	173	68	40%

AGE-STANDARDIZED MORTALITY RATIOS



- ASMR: the ratio between the observed number of deaths in a cohort and the number of deaths that would be expected, if the cohort had the same characteristics as the comparison group (Kelsey, 2008).

- Enables the comparison of rates of death between populations which have different characteristics – such as different age profiles – in a more accurate manner than crude mortality rates (Inskip et al., 1983; Naing, 2000)

AGE-STANDARDIZED MORTALITY RATIOS

2019/20		Standardised mortality ratio (95% CI)		
Cause of death	Gender	All supervision	Court orders	Post-release supervision
All causes	Males and females	2.37 (2.51 – 2.83)	2.37 (2.17 – 2.57)	2.52 (2.29 – 2.75)
	Males	2.57 (2.40 – 2.73)	2.23 (2.02 – 2.43)	2.49 (2.25 – 2.73)
	Females	5.36 (4.49 – 6.22)	4.62 (3.70 – 5.54)	6.21 (4.28 – 8.13)
Self-inflicted	Males and females	7.40 (5.94 – 8.86)	6.11 (4.91 – 7.31)	7.02 (5.28 – 8.75)
	Males	5.31 (4.22 – 6.40)	3.89 (3.09 – 4.69)	4.46 (3.30 – 5.62)
	Females	8.55 (2.62 – 14.47)	12.72 (3.91 – 21.54)	19.70 (3.94 – 35.47)
Homicide	Males and females*	17.63 (11.87 – 23.39)	21.18 (13.04 – 29.32)	N/A
	Males	12.97 (8.54 – 17.39)	15.76 (9.32 – 22.21)	10.13 (4.14 – 16.11)
	Females*	18.34 (-2.41 – 39.09)	24.23 (-3.19 – 51.64)	N/A
Accident	Males and females	1.85 (1.35 – 2.34)	1.95 (1.30 – 2.61)	1.66 (0.93 – 2.38)
	Males	1.27 (0.91 – 1.62)	1.46 (0.95 – 1.96)	1.01 (0.53 – 1.50)
	Females	2.94 (0.36 – 5.52)	1.56 (-0.60 – 3.71)	7.24 (-0.95 – 14.44)
Drug overdose	Males and females	15.80 (13.53 – 18.07)	12.34 (9.76 – 14.92)	20.77 (16.68 – 24.87)
	Males**			
	Females**			

*No women died from homicide after release from prison

** The drug-related mortality rate for five-year age bands broken down by gender is not available and so it is not possible to calculate separate ASMRs for drug overdoses for males and females separately.

FACTORS ASSOCIATED WITH HIGH SUICIDE RISK IN GENERAL POPULATION

- Previous suicide attempt
- Mental illness, such as depression
- Social isolation
- Criminal problems
- Financial problems
- Impulsive or aggressive tendencies
- Job problems or loss
- Legal problems
- Serious illness
- Substance use disorder
- Adverse childhood experiences such as child abuse and neglect
- Bullying
- Family history of suicide
- Relationship problems such as a break-up, violence, or loss
- Sexual violence
- Barriers to health care
- Cultural and religious beliefs such as a belief that suicide is noble resolution of a personal problem
- Suicide cluster in the community
- Stigma associated with mental illness or help-seeking
- Easy access to lethal means among people at risk (e.g. firearms, medications)
- Unsafe media portrayals of suicide

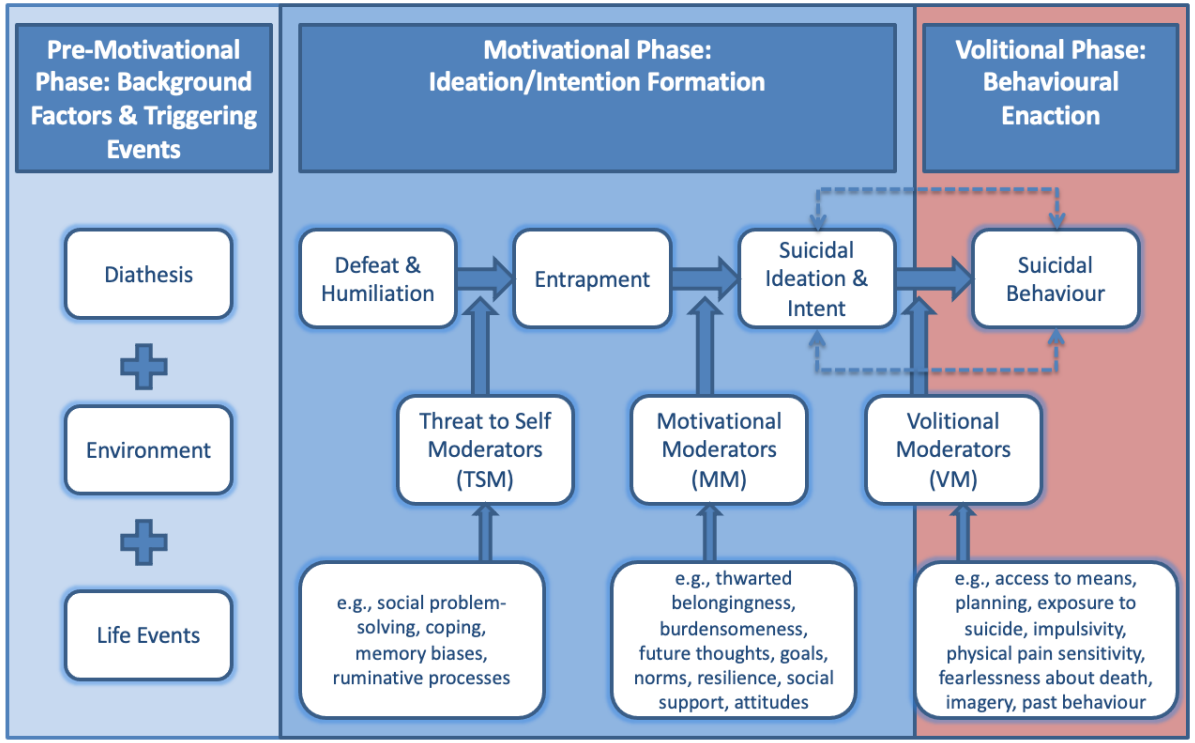
WHAT ABOUT THE ROLE OF PROBATION?

Factors associated with being on probation which increase risk:

- New legal proceedings
- Transition from custody into community
- Threats of recall
- Limited access to family/other sources of support in community (perhaps due to risk)
- Experiences of trauma

(Cook and Borrill, 2015; Mackenzie et al., 2015; Borrill et al., 2016; Mackenzie et al., 2018; Phillips et al., forthcoming)

THE INTEGRATED MOTIVATIONAL–VOLITIONAL MODEL OF SUICIDAL BEHAVIOUR (O'CONNOR & KIRTLEY, 2018)



https://suicideresearch.info/the-imv/

SUICIDE RISK IS HARD TO ASSESS

- ‘The reliance upon risk factor identification fails both clinicians and patients’ (Royal College of Psychiatrists, 2020)
- Demographic factors are unable to predict suicide risk accurately and should not be relied upon (Bolton, Gunnell & Turecki, 2015)
- As seen in IMV model – suicide is the culmination of a complex range of factors which interact in different ways for different people

ASSESSING RISK OF SUICIDE IN PROBATION

- Probation officers are not mental health practitioners – need more training but also are not, and cannot be, the experts
- Obtaining information ahead of assessment is difficult, especially for people leaving prison
- Working relationship seen as important but requires time to develop – difficult in context of high workloads

MANAGING RISK

- In hostels, mostly amounts to 'situational crime prevention' techniques (such as those observed by Wincup (2001)) including:
  - Regular observations (as in prison)
  - Removal of potentially harmful objects
  - Control of medication
- Managerial: 'if people are talking about suicidal ideation, self-harm, you put a little flag on Delius that says mental health issues, suicide/self-harm. You can't recommend them into mental health and counselling services because we don't have those links anymore' (PSO1, Community)
- Harm minimisation
- In community – very difficult due to lack of regular contact.:
  - '….*in the community you're on your own really*'. (PO, Focus Group 2, Community)
  - *'So, you know, we just have to Google mental health services in the borough that someone lives in.' (SPO1, CRC)*
- Tension with aim to support resettlement and greater independence.

MANAGING RISK

- Meaningful conversations – informal, *ad hoc* intervention
- Arrangements for MH practitioners to come into probation settings to provide support or treatment to residents

- <u>But:</u>
  - Staff don't feel **trained** in supporting people at risk of suicide: 'It feels like there's a lot of pressure on staff to open wounds of mental health with a resident' (RW1)
  - Arrangements for practitioners such as CPNs to come into APs not widespread nor systematic
  - Many highlighted difficulties in referring to **under-resourced community MH provision**, challenging for some people to get and attend appointments in community

SO WHAT CAN WE DO ABOUT IT?

Protective factors:

- Coping and problem-solving skills
- Cultural and religious beliefs that discourage suicide
- Connections to friends, family, and community support
- Supportive relationships with care providers
- Availability of physical and mental health care
- Limited access to lethal means among people at risk

IMPACT ON STAFF

- Highly emotive experiences with enduring impact:
  - 'If you find someone who has hurt themselves how can you then effectively complete your shift and your good work with the other people? So, I think in a lot of ways staff can be let down and certainly by senior management, forgotten by them.' (RW, FG1)
  - 'I didn't sleep last Christmas just worrying about it all really and the death of a resident is really traumatic so that doesn't go away. That is part and parcel of the job really, isn't it, so that's there.' (SPO7)
  - 'It's all right until you get that email from the probation solicitor telling you that [the inquest is] going to happen and then it kind of drags it all up again.' (PSO, FG1)

FINDING SUPPORT

- Support from organisation highly **variable** and **contingent on manager**:
  - 'We can speak to our manager who has a smile, listens and then says I'll give you the number for PAM Assist.' (RW1)
  - 'I will say there's been incidences of residents self-harming where the staff member who has dealt with it has not even been asked if they're okay and that's happened quite a few times. … It sometimes feels like management wise there's a wide focus on residents and staff might come as an afterthought.' (RW, FG1)

- Gaps in formal support often filled by support from **colleagues**:
  - 'We're quite a tight knit team so we do talk frankly about any issues or any struggles that we're having about how we've approached different situations.' (RW5)
  - 'I'm getting support from my colleagues because we're very tight. I'm getting a lot of support from my colleagues but not from my manager.' (PSO, FG1)

POST-DEATH INVESTIGATIONS AND BLAME

- Potential to be blamed for a person's death was mentioned by many
- Small number reported experience of PPO investigations and/or inquests
- Substantial **fear of investigations** → blame:
  - 'Sometimes I think probation, the whole sphere of probation, it feels a bit blamey so if something goes wrong someone's on the chopping block and all you can think is, please, not me. Then on top of that if there was an incident of suicide, I know in myself I'd be devastated by that and then you'd have the inquest and then - I imagine that would make you start thinking, well, did we do everything we could do? Are we partly to blame? (RW, FG1)
  - 'It feels to me like the overall culture is one of accountability as opposed to lessons learned. I said this recently to someone. [...] You've got a culture of accountability as opposed to a culture of lessons learned, that's the point I'm making. Not just accountability, it feels like scary accountability.' (SPO4)

BLAME AND PAPERWORK

- Awareness of potential for individually blame
  - ‘Now we have this long, drawn-out system of filling in certain pieces of paperwork first, uploading certain pieces of paperwork on to Delius and I feel like that is a direct result of this, of this accountability, this like we've got to make sure that everything's done like this or else we'll get blamed for it. I feel like that's a real shame, it should not be like that. We should be worrying first and foremost about their welfare, especially if they're suicidal or threatening to harm themselves, that should be the first worry but because of the way the system works, like this system of accountability and this sort of, you know, you do worry about it.’ (RW5)

CONCLUSION

- People on probation experience many risks associated with suicide
- Time spent in prison, transition into the community as well as the risks of being in the community under supervision all raises these risks
- There are things that can be done, but limited in the context of high workloads
- Assessing risk of suicide is hard, and probation officers find it very difficult
- Options for managing risk are limited in community settings but there is evidence around how to reduce suicide – this needs to be the focus of future work in this area.
- Challenges for staff
  - Dual, sometimes competing aims of public protection and rehabilitation
  - More training needed – but within staff role ('We're not mental health practitioners')
  - Developing relationships, assessing risks and making referrals
  - Deaths and investigations are stressful experiences – lack of support