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Risk of harm in the criminal justice system

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Risk in the Offender Health Pathway

STOP THE VIOLENCE

Expectations

- Offence is Committed

Community

Police investigate

- Offence is reported
- Suspects are interviewed

- Suspect may be detained (must be charged) or released on bail
- CPS decides if to proceed

Arrest is made

Magistrates Court

- All criminal court cases start here
- Magistrates are lay people not lawyers

- If sentence might be more than 12 months in jail

Crown Court or Youth Court

Prison or Community Sentence

- Depending on offence, previous offending and mitigating factors sentence given
- Prison: Her Majesty's Prison Service (or private)
- Community: National Probation Service/CSCs

- Longer sentence(over 12 months or PPO): Released on Licence under supervision of Probation Service/CSC.

Release

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Practice models

Current strength models

The strongest models are where:

- Risk of Harm is considered at all stages of the CJS
- Systems exist to identify, report and manage risk by both front-line and specialist staff – and clear and consistent systems where this information is passed through and acted upon.
- Multi-disciplinary decision-making is evident and consistent.
- Evidence-based decision-making is supported.

Suggested reading:

Ogloff et al (2007) The identification of mental disorders in the CJS

World Health Organisation (2007) document on 'Preventing suicide in prison'

Current issues

Service provision is often based on profession or stage rather than pathway or need i.e. services commissioned separately for each ‘stage’ or ‘issue’. ‘Silo’ working – within and between professions

- Limited interactions or appreciation between stages or services
- Incompatible information systems
- Differences in remit around harm prevention
- ‘Black holes’ of information and service provision exist
- Focus on audit or ‘performance indicators’ rather than ‘softer’ quality of interactions and decision-making or a clear strategic model
- Poor consideration of impact for individual post-service e.g. ‘how will this decision affect risk of harm for this person at a later stage?’

Police and court

PRE-CONVICTION & CUSTODIAL

Risk of Harm at Police Station

Police services are the first point of contact – key in identification and response. Usually complete some form of assessment of risk of harm.

Developments:

- Many jurisdictions have improved police training and MH service provision but can be patchy and inconsistent.
- Evidence of high percentage of police referrals due to suicide and violence risk although stays were often very short (Maharaj et al, 2011)

Issues:

Ogloff et al (2015) reports in the Australian context little testing or validation of approaches.

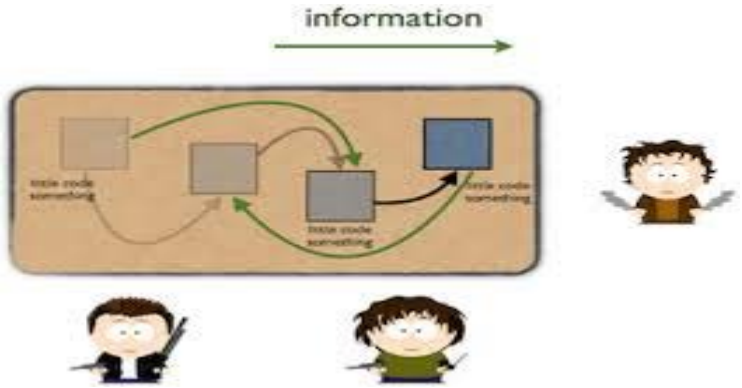
Suicidality: Often not assessed before either inpatient or imprisonment.

Self-harm: Very limited data on this internationally, usually based on behaviour.

Criminal Justice Liaison & Diversion Services (CJLD): Assessment

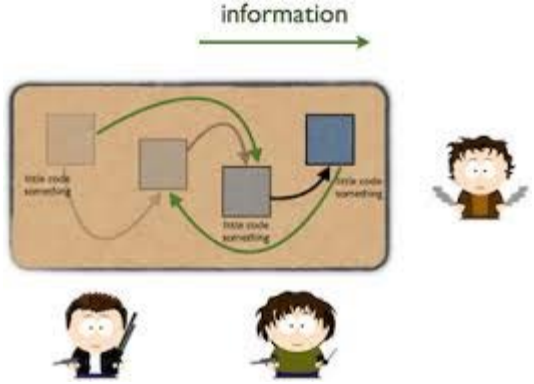
- Usually specialist mental health (usually) nurses.
- Focus on mental health assessment but also a role in risk of harm.
- Based largely in Courts but with some in Police stations.
- Role is to assess and then liaise with health and CJ services; in some cases recommend and (if accepted) organise diversion to hospital.

Police to Court: information flow



- A Prisoner Escort Reporting (PER) paper form is completed by Police for Escort and Court staff
- This summaries the same risk information as gathered at Police station
- It also records regular checks, behaviours, visitors, assessments etc. whilst at court.
- Passed to escort staff

Court to Prison: Information flow



- If remanded or sentenced, unless diversion to hospital is undertaken, then transfer to prison.
- Further PER paper form completed by court staff – passed to escort staff
- Suicide and self-harm warning paper form completed, if required – by court staff – passed to escort staff.
- CJLD service may contact prison MH team directly (or may not). No direct link to paper system or custodial/probation electronic systems

CJLD Service Evaluations

Improvements in service provision, but with difficulties encountered across the CJS:

- variable service coverage
- communication and information flow difficulties due to incompatible systems
- differing service demands
- limited bed availability
- differing organisational cultures, with security, clinical and assessment disputes
- problems obtaining alternatives to custody.

For example, mental health treatment requirements, which can be used as part of community sentences are under-utilised partly because of difficulties in obtaining timely mental health assessment, and because **local services do not see this work as being within their agreed service remit**.

(Senior, et al., 2011; Roberts et al, 2012; Haines, et al., 2015)

In addition, concerns raised around the identification of SMI within the CJS, with **evidence of a bias towards historical mental health information** which can be unreliable or incomplete and evidence of serious screening limitations.

(Birmingham, Mason, and Grubin, 1997; Coid and Ullrich, 2011; Senior et al., 2013)

Evaluation of pre-custody services

An evaluation was completed (Slade, Samele, Valmaggia & Forrester, 2016) on prisoners with SMI.

Purpose: To evaluate the pre-custodial pathway through the criminal justice system (CJS) for 63 prisoners under the care of prison mental health services.

Secondary Aim: To consider the identification and management of suicide risk.

Police and Court services: relevance of suicide risk

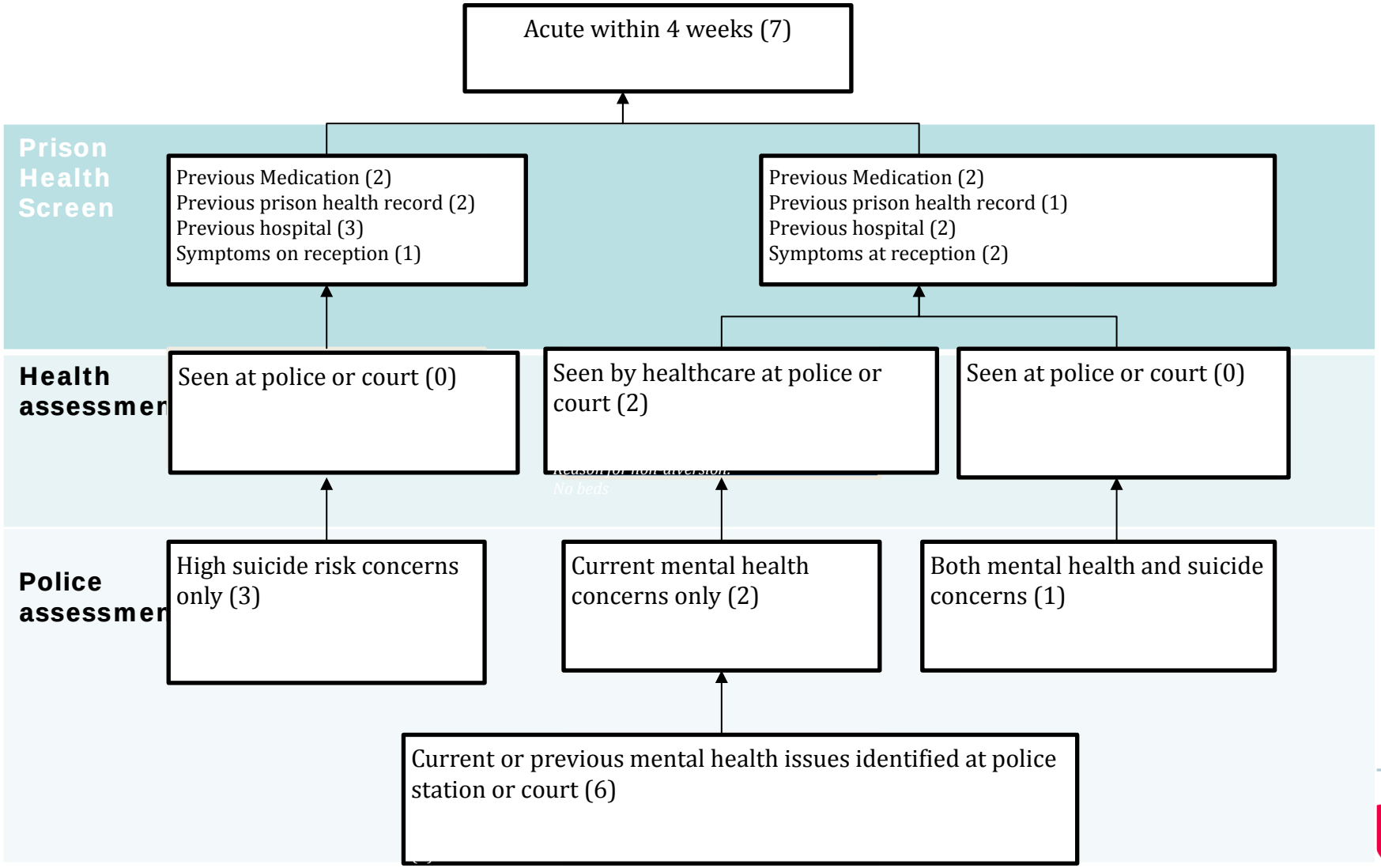
Important to intervene with suicide risk in CJS to also reduce community suicide

In the UK:

Appleby et al, (2001) & Linsley et al, (2007) found that one-fifth of individuals who committed suicide had contact with police in previous 3 months.

This was as many as had contact with mental health services in the previous 12 months.

Pathways through police, court and prison reception for acute (<4 weeks)cases



Results

The evaluation identified that:

- Prevalence of acute SMI at prison reception was very low (3%); rising to 33% displaying acute symptoms at later stages.
- Cases displaying suicide risk at arrest along with a history of inpatient care were at increased risk of acute SMI in first weeks of imprisonment; with health assessment prior to prison generally absent.
- Inconsistencies in the transfer of mental health information to health files may result in overlooked at-risk cases.
- Lack of standardisation across CJS makes information flow and evaluation/audit difficult

Recommendations

- Consistency in access to pre-prison health services in the CJS, especially for those with pre-existing vulnerabilities to prevent subsequent deterioration.

- Review of assessment and response to suicide risk within early stages of CJS.

- Development of a single system for health information flow through the criminal justice system.

Imprisonment

CUSTODIAL RISK


TURN
ENGINES
OFF
WHEN STATIONARY
CAUTION
CAUTION

Prison Reception: Risk of Harm

Suicide

- Screening for suicide risk appears to be widely attempted on prison receptions internationally – no standardised tool.
- Many jurisdictions offer ad hoc reassessments as a need is identified.

Violence

- Assessments for violence risk are much less likely to be completed by or clearly with health staff. Generally, completed by prison staff based on past behaviour.

MH in Australian context: Ogloff et al (2015)

Interesting discussion on tools and Canadian context (Daigle, 2007)

For more information on UK see Ministry of Justice website PSI 64/2011 (revised 2013) for 'Management of prisoners at risk of harm to self or others'.

Issues with Risk Assessment Approaches

Poor system integration to capture the swift dynamic nature of risk

- Few formal ongoing assessment or screening completed past 48 hours.
- Reliance by some screens on ‘risk groups’ and ‘suicide ideation’ may be limiting identification of dynamic risk.
- Approaches rely on prison staff identifying risk after reception
- Unclear how risk of violence is assessed or integrated

Wide variations in practice – prison to prison; internationally

- Variation in the distinctions made between self-harm and suicide.
- Wide variations in what is considered a full risk assessment– few standardised or comprehensive assessment approaches used routinely.
- Striking similarities in risk population.

Recommendations

- Enhanced staff training on the identification and management of risk
- Clarity in the purpose and response to screening
- Repeated screening at later stages of imprisonment
- Utilisation
- Utilisation of case formulation approaches, based on solid theoretical basis, to understand (and manage) the breadth of risks posed.

Prison reception: Assessment UK

Prison Officers

1. First night: standard interviews including assessment of risk of self-harm, suicide, violence, prison security (e.g. gang membership), and cell-sharing (e.g. previous racist or homophobic behaviour).
2. Induction: Information on the prison regime, rules and support services.

All data inputted onto prison electronic system (known as PNOMIS)

Two stages to the health assessment provided on entry to prison.

1. During the first night in custody the mandatory screening tool (known as the F2169A or Grubin tool) is completed by a nurse. This 12-item health screening questionnaire involves a structured clinical interview with the prisoner covering key concerns.
2. The second part of health screening occurs within the first few days of custody and is a follow-up interview aimed at performing a more comprehensive health assessment.

All data inputted into prison health electronic system (known as SystmOne)

ACCT process

Assessment, Care in Custody and Teamwork (ACCT) is the current system in E & W prisons for suicide and self-harm prevention.

It's principles can be considered under the simple banner of '**Suicide is Everyone's Concern**' (HMCIP, 1999)

For more information see UK Ministry of Justice website PSI 64/2011 (revised 2013) for 'Management of prisoners at risk of harm to self or others'.

Additional policy documents on adult safeguarding, early days in custody, healthcare amongst others.

ACCT process

Identification

- Concern identified by any member of staff or by external person
- ACCT opened

Initial Actions

- Concern and Keep Safe Form (urgent actions) and monitoring level determined.

Assessment and Care Planning

- Full Assessment by trained assessor (of any profession)
- Care Plan development

Review

- Reviews led by case manager with Multi-disciplinary professionals across all relevant professional groups.

Closure

- Closure with 7 day review

Organisational approaches to reducing suicide risk

The human element is important if we want staff to not just follow a ‘procedure’ but also:

- Make good decisions
- Reflect a positive attitude towards organisational priorities
- Show care and concern
- Work together effectively

This requires a strong organisational culture and structure

History still relevant today.

Liebling (UK) and Howells (Australia) in the 1990s argued for the importance of an organisational and integrated approach.

Rather than an exclusive focus on the ‘vulnerable’ prisoner- it is important to focus on the regime, culture and atmosphere of a prison – promoting a healthy and protective environment.

But also and most critically…

It can significantly reduce suicide even when no specialist suicide-prevention interventions are available

Prison suicide reduction

- A Remand prison devised and implemented a new and radical strategy to suicide prevention and experienced an exceptional sustained reduction in suicide

calculated at a 2 in 100,000 chance to occur by chance.

- The study retrospectively considered staff perceptions (and external opinions) on the vital ingredients for this outcome…
- The usual aspects were present…screening, good training, frequent and good quality assessment but with the strongest elements being around **prison culture and integrated working**.

SLADE, K. and FORRESTER, A. (2015) Shifting the paradigm of prison suicide prevention through enhanced multi-agency integration and cultural change. The Journal of Forensic Psychiatry & Psychology, 26 (6), pp. 737-758.

Senior Management support for cultural change

Specific examples

Underlying culture of integration

- Shift from a security to a case management focus including..
- Highly limited use of segregation
- Integration of suicide prevention as a central concern in all strategic decisions.

Management and leadership approach

- Positive and optimistic attitude with clear prioritisation: ‘Suicide is not inevitable’
- Supporting innovative approaches and individualised risk management
- Swift, critical and wide-reaching learning from incidents
- Clear expectations
- Staff held accountable BUT only with constructive guidance, feedback and emotional support (not just issuing guidelines but personal and flexible).

"Previously it had felt inevitable ….but [we] gave this prison hope that we could stop it"

Cross-professional collaborative working

Specific examples

Communication and pro-active partnership working

- Complex cases meeting and framework for wider integration
- Joint and open case management system across services

Specialist knowledge and experience for strategic management

- Understanding of the nuances of the research; risk management; the environment, client group and the key services allowed for practical and effective strategy.

Work still to be done...?

Howells et al. in 1999 argued on research evidence that prevention strategies need to demonstrate the following 'best practice' guidelines:

- Provide a range of crisis-management options
- Minimise use of seclusion
- Provide therapeutic interventions with a chronic, longer term risk
- Adopt a case-management approach with clearly defined reporting or communication mechanisms" (Howells et al., 1999 p. 162).

QUESTIONS?

Activity: Reviewing current services

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Identifying and managing risk of suicide

PREVALENCE

Rates of SID in Forensic Populations (per 100,000) vs community

Per 100,000	Comm UK[1]	Comm Aust[2]	Prison: E & W[3]	Prison: Aus[4]	MH inpatients UK[5]	Release from prison (Aus)[6]
Overall	12	10	98	41 - 204	88	13.7

'Self-inflicted death'
May or may not include suicide intent & suicide only decided at inquest– Most jurisdictions are really referring to 'self-inflicted death' in statistics

[1] Samaritans (2015) [2] Varnick (2012) [3]Ministry of Justice (2015) [4] Austin et al , 2014 [5] National Confidential Enquiry into Suicide and Homicide by People with Mental Illness (2013) [6]

What's so different?

Prevalence of risk

Risk factors: Distal

Prison Self-Harm[7]

- Any mental disorder
- Prior psychological /psychiatric treatment
- Prior self-harming behaviour
- Prior suicide attempts
- Self-injurious behaviour by others
- Misuse of alcohol
- Misuse of other psychotropic drugs
- Violent crime
- Prior incarceration
- Female
- Small support group or a severe lack of support

Prison Suicide (WHO, 2007)

- Young males (15-49);
- Elderly people, especially male
- Violent offending (especially against family)
- Indigenous peoples
- Persons with mental illness
- Persons with alcohol and/or substance misuse;
- Persons having made a previous suicide attempt
- Poor social and family support.
- Adverse life events including childhood abuse
- Prior incarceration (also for release: Spittal, 2014)

Risk factors: Proximal

Inpatient Suicide

Severe psychic anxiety, panic attacks and severe anhedonia

Worry and agitation

Suicidal ideations

Greater insight into having a mental disorder

Current substance misuse

Medication non-compliance

High level of stress and dysfunction

Loss of social support

Coping styles (low level of problem-focus)

Hopelessness

Prison Suicide

Persons with mental illness

Persons with alcohol and/or substance misuse;

Poor social and family support.

Single cell

Early stage of custody

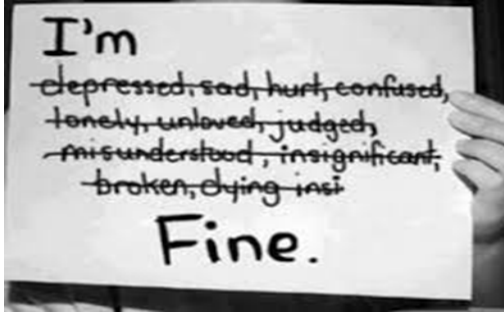
Early stage of release

<1 month of SH esp. lethal methods

Over 5 incidents of SH in women

Recent suicide ideation

A few Service issues



- Reliance on historical information e.g. previous SH/suicide attempt

Why not? Only 50% of suicides have a previous SH incident; dynamic factors e.g. 'signs of distress' have repeatedly been found to be more useful 'on the wing' (e.g. Dear et al, 2001).

- Reliance on reporting of current suicide ideation

Why not? Only 18% of suicides report ideation to a professional (Robins, 1981)

Suicide ideation high in those who never attempt suicide (28-72% of prisoners report it) and only self-harm (Slade et al,. 2014)

- Push for screening/assessment tool as solution

Why not? Baseline is too low (less than 0.6%). Screening tools will never identify those at individual risk [1]. Best available screen is only just above chance. Risk assessment is about prevention not about prediction[2].

- Seeing risk factors as explanatory or cumulative

Why not? Correlational only – the REASON is not a risk factor and so are indicators only of high-risk groups not of individual risk.

So what can we do?

Consider integration of explanatory models to guide defensible decision-making and individual case formulation.

Pros: Defensible decision-making

Provides a structure to place risk into context

Easier to remember than lists of risk factors

Individualised formulation, intervention and care can be developed

Moves away from a medical to a behavioural model

Cons: There are more than one to choose from

They are all theories although they make sense and are research-supported; they are still just theories.

Question?

Which theories of suicide are you aware of and/or use in your practice?

Widely available models

Interpersonal –Psychological Theory (IPT)

- Thomas Joiner (2005) USA

Cry of Pain Model (or Arrested Flight Model)

– Gilbert & Allen (1998) / Williams & Pollock (2001) UK

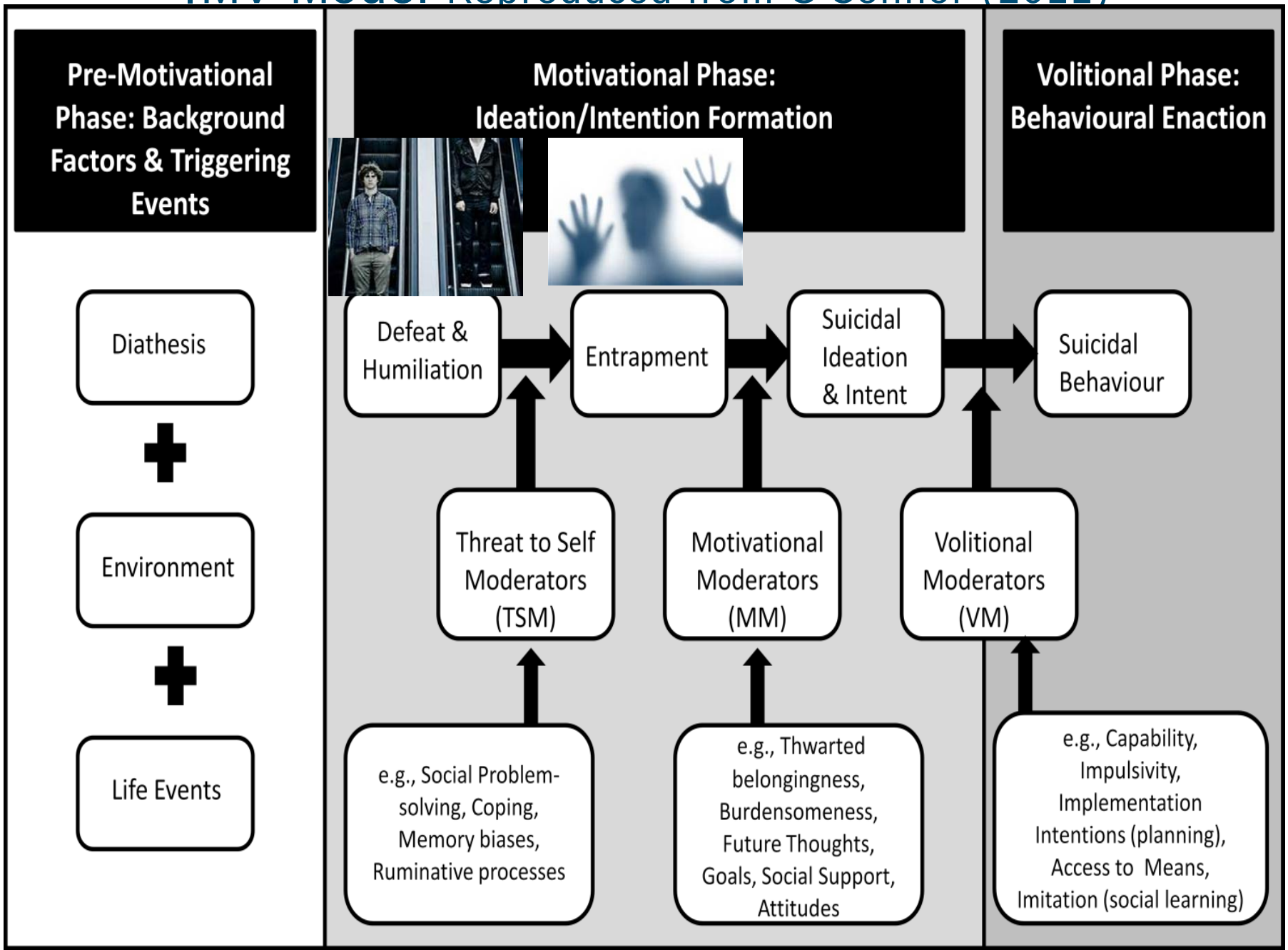
The Schematic Appraisals Model of Suicide (SAMS)

- Johnson et al (2010) UK

Interpersonal Motivational Volitional (IMV) model

- O'Connor (2011) UK

IMV Model Reproduced from O'Connor (2011)



The progression to suicide

Background & Their History

Vulnerability

Experiences

Current environment

Feeling Defeated

Risk is helped or hindered by:

coping with emotions

Rumination

Focussing on unhelpful things

Ability to solve problems

Feeling Trapped

Risk is helped/hindered by:

Feeling a burden
Not feeling you belong/connect

Not seeing any positive in the future

Attitudes to suicide

Having future goals

Feeling supported

Suicide Ideation

Helped/ hindered by:

Overcoming fear of pain/death

Impulsive

Suicide Plan

Access to method

What learnt from others

Suicidal behaviour

Based on the IMV model
O'Connor (2011)

Evaluation of IMV in prison

- Ongoing- but evaluations of earlier models provide evidence to support key aspects.
- **Entrapment and previous self-harm / suicidal behaviour are two of the most predictive factors for later self-harming or suicidal behaviour in prospective studies.**
- **Notably, 'top-line' factors more predictive than hopelessness, depression or level of ideation at previous suicide attempt (O'Connor et al. 2013; Slade et al., 2013;2014)**

Additional (and free) Resources

http://www.psy.fsu.edu/~joinerlab/ Includes some of the evaluation papers and access to the 'Interpersonal needs questionnaire (INQ)' to measure the 'desire for death' & the Acquired Capability Scale.

www.compassionatemind.co.uk (Entrapment and Defeat Scales available under 'Scales')

Zero suicide in health and behavioural care toolkit:

http://zerosuicide.sprc.org/toolkit

The link below also includes the 'Reasons for Living Inventory' (in a range of languages)

http://blogs.uw.edu/brtc/publications-assessment-instruments/

Reflections and Actions

How do the risk factors link in with the IMV model?

DUAL HARM

Prison Violence

The link between violence and self-harm or suicidal behaviour

Community Violence

- Exposure to violence increases risk of SH and suicide ideation (Vermeiren, et al. 2002)
- ‘Violent offences have consistently been the most serious offence associated with the deceased person’s detention (53%)’ (Australian Government, 2015)
- BUT **conducting** repeated violence is a stronger risk of suicidal behaviour (Jordan & Samuelson, 2015)

Prison Violence

- Those who engage in institutional physical violence has been demonstrated to be linked with suicide and self-harm behaviour (e.g. lifetime link: Mann et al., 1999)
- USA study (Young et al, 2006) suggested that prisoners in healthcare units who self-harmed were 8 times more likely to assault a staff member.
- USA: Lanes (2011) demonstrated that prisoners who self-harm were more likely to be violent and be in segregation.

Service issue: Underlying Assumptions and Response

Zero Tolerance

Punishment

Individualised Supportive Care

Self injury Support

Segregation or Care Suite?

Recent in-prison research: violence & self-harm

- *Utilising detailed incident, demographic and offence data*

Prison A: Medium Remand + Low/Med Resettlement

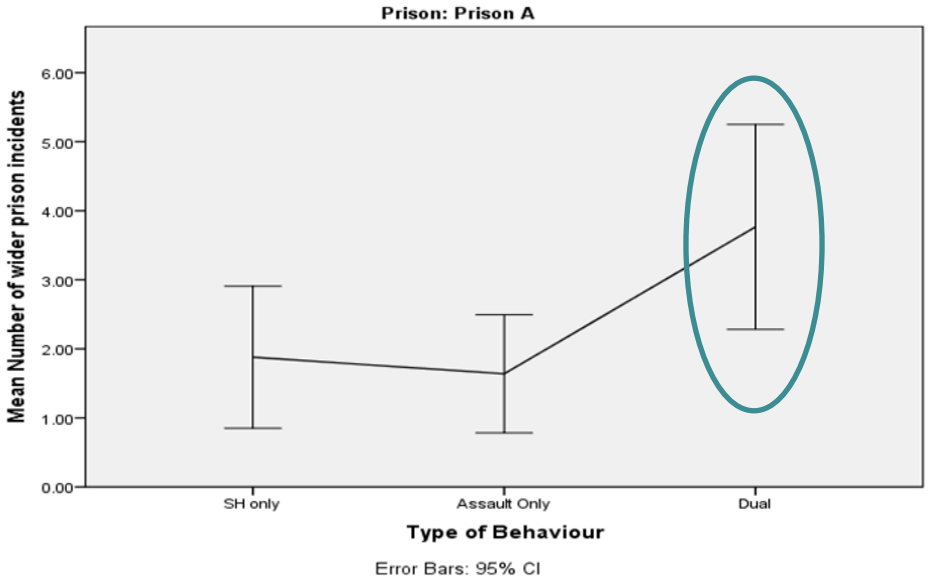
Prison B: Medium Long-term (4+ years violent offenders)

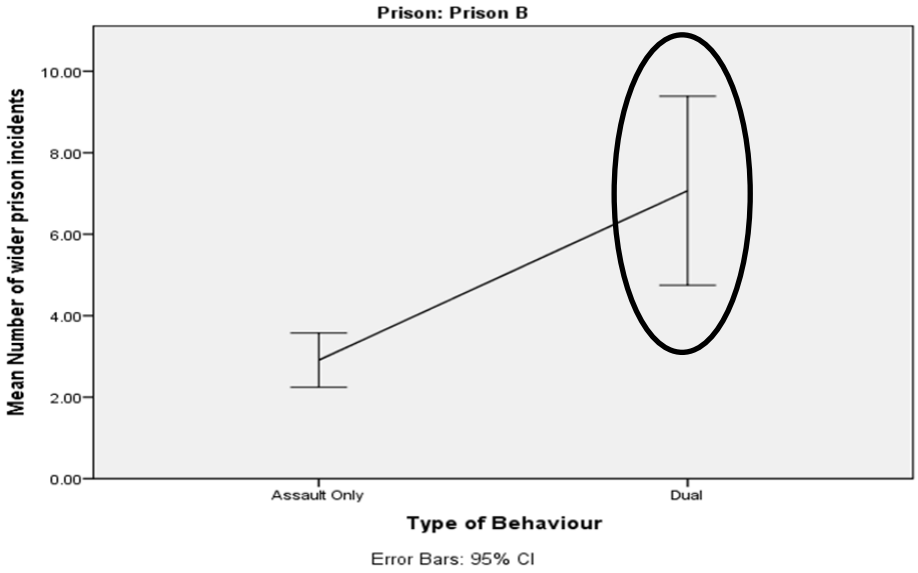
		Dual Harm	Assault only	SH only
Prison A	2 incidents of either Assault & SH	**41%**	31%	28%
Prison B	Assaulters only	**28% ***	72%	n/a

- So, if have assaulted in prison, there is between 28-60% chance they will (or have) self-harmed
- No difference in whether started with assault or self-harm.

** within the last 4 years only*

Wider prison behaviour





Dual-harm prisoners, in both settings, had a much higher number of wider prison incidents (2x), especially deliberate damage to prison property and fires.

Adjudication by Group

		Placed on Report (Mean, SD)	Guilty verdict (Mean, SD)
Prison A	Repeated self-harm	6.9 (13.7)	4.2 (2.2)
	Repeated Assault	15.9 (20.1)	7.5 (2.1)
	Dual Harm	25.2 (29.4)	13 (1.8)
Prison B	Any Assault	24.5 (20.7)	16.7 (13.8)
	Dual Harm	50 (44.8)	32.8 (32.2)

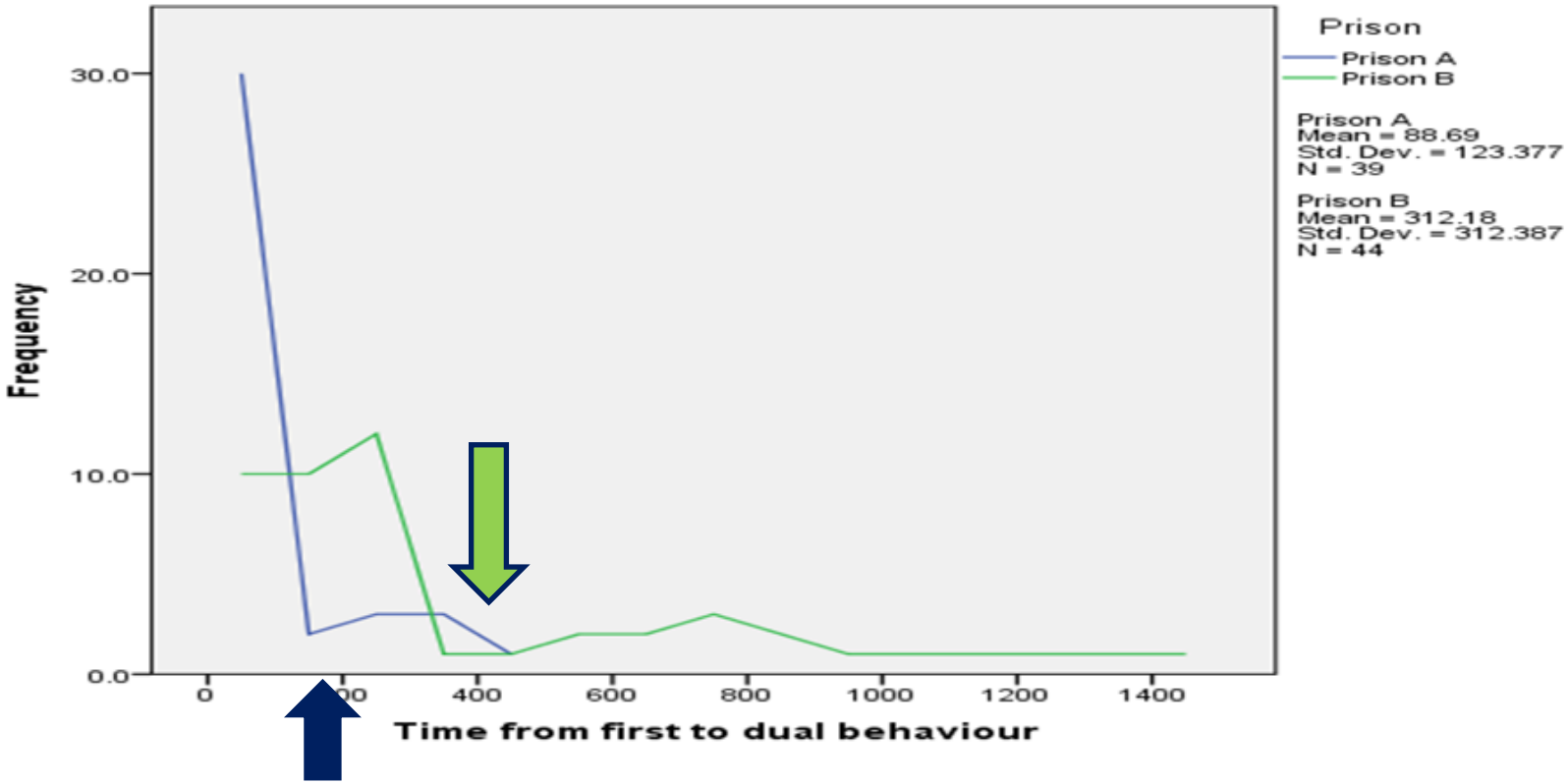
Conclusion: Dual harm prisoners will have twice as many adjudications than assault prisoners and 4 times than self-harm only prisoners.

Implications

Dual harm prisoners are:

- experiencing greater levels of punishment than even assault-only prisoners
- Are likely to be the most resource-intensive prisoners
- Likely to be managed by 2+ professional groups
- more likely to be spending extended periods in segregation

Time from single to dual harm



In Remand prison: within 3 months of first incident

Across both prisons almost every 'Dual' behaviour was within 420 days of first incident.

Conclusions & Recommendations

- **Violence in prison is a prominent behaviour in a large number of prisoners who self-harm and attempt suicide in prisons**
- **Dual-harm often means multiple destructive behaviours; with methods of management having underlying conflicts:**

i.e. ‘Zero tolerance’ for violence conflicts with ‘care in custody’ for suicide risk.

Critically– there is no current guidance on how to manage dual risks effectively. Therefore,

- **We should include recent violence in our research to understand suicide risk in offenders**; especially since recent self-harm is one of the strongest indicators for suicide in prison.
- **We need to implement joint assessment and care pathways for the sizeable dual harm risk population.**
- **We need to understand the underlying mechanics, risks and develop effective guidance for staff managing dual risks.**

QUESTIONS?

Activity: Service application and design improvements?