SUICIDE PREVENTION: AN ORGANISATION APPROACH

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Who am I?

Objectives

- To consider the known risks and protective factors for suicide in offenders and how to identify risk.
- To consider the factors required for an organisation-wide approach to reduce suicide.
- Develop awareness of assessment approaches and how to approach an assessment for self-harm and suicide.
- Consider the content of a care and/or risk management plan for suicide.

Working with Offenders

How high is the risk?

Offenders who die by suicide under supervision each year :

2007-8 : 90 2008-9: 97 2009-10: 104

Rate per 100,000?: around 50-60

General population: around 8-15 (ONS, 2013)

Prisons: around 70 (MOJ, 2014)

So, the risk is at least 4 times that of general pop and about the same as prisons.

Pratt et al. (2006) report a suicide rate of 156/100,000 in recently released prisoners

Definitions: Types of Suicide and Self-Harm

(Skegg, 2005)

Traditional methods of suicide

- Hanging, shooting, jumping from a high place
- Overdose
- Recreational drug ingestion as self-harm
- Cutting
- Burning

Self-injury with tissue damage

- Self-biting
- Scratching
- Gouging
- Carving words or symbols into skin
- Sticking needles or pins into skin (or other objects)
- Interfering with wound healing

Behaviours without visible injury

- Self-hitting
- Banging head or fist against something
- Pinching
- Pulling hair
- Exercising to hurt oneself
- Denying oneself a necessity as punishment
- Stopping medication or starving with intent to cause harm
- Deliberate recklessness

Self-harm and Suicide

Understanding & Managing Self-harm risk and Suicide risk is not the same – but they are also not totally different.

Like Apples and Oranges: but they are both fruit.

Ever heard someone say?....

But they have never self-harmed…

50% of suicides had previous self-harm BUT 50% do not (Foster, Gillespie, & McClelland,1997)

It's the responsibility of the MH services…

Appleby et al, (2001) & Linsley et al. (2007) – found that as many individuals who committed suicide had had contact with police in previous 3 months as had had contact with mental health services in previous 12 months.

Suicide is inevitable if they want to do it.. 85-90% of those who attempt suicide do not go on to commit suicide (Clark and Fawcett, 1992)

They say they aren't suicidal…

- 18% of suicidal people tell a professional of their wish to commit suicide but 69% tell a family member (Robins,1981)
- Few completed suicides in prison say that they have an intent (approximately 30%) (Shaw, Appleby and Baker, 2003)

Can we reduce suicide risk?

Rates in the community and prisons have been falling until recently and still remain much lower than previously.

Introduction of the ACCT process in HMPS in 2006/7 preceded a large drop in suicides between 2008-2012.

HMP Brixton, through introducing new local systems of working in addition to National ones (e.g. ACCT), reduced to suicide to zero for 3 years (from average of over 2) at a likelihood of 2 in 100,000!, Slade & Forrester, 2014)

What is ‘best practice’?

- Not sure yet as emerging but there are lots of indicators:
  - Prison-based research and study
  - General population

Community Offenders fall between (and often in) these two groups

London works with experienced researchers to help answer key questions and develop guidance

International Risk Factors

Community risk factors	Prison-specific risk factors
Previous self-harm	Pre-trial/remand prisoner
Substance misuse	Violent offence charge/conviction
Poor social support	Long prison sentence
Mental Health Diagnosis	Single cell accommodation

Responding as an Organisation

Managing and Reducing Suicide should not be done alone, however good you are! (and I know you are..)

Suicide management requires a good structure, multi-agency communication and integration

What do I mean by that?...

WHO guidance on correctional services

Training

Climate

Screening

Post-Intake Screening,

Monitoring following screening,

Communication Regarding High-Risk Offenders

Written Procedures

Mental health treatment

Debriefing staff and learning from incidents

Training

Questions to ask:

Are your staff trained to identify and manage suicide risk/ behaviour?

Is your training package up-to-date and reflective of current knowledge?

Are there different types of training for different roles, if needed? (e.g. staff completing screenings vs detailed assessments vs dealing with suicidal behaviour?)

……

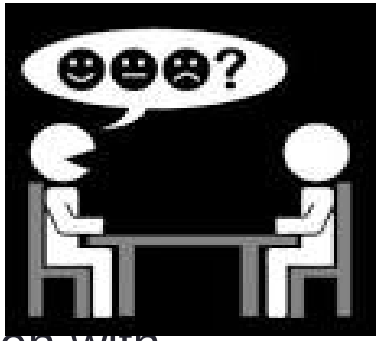
London has Training in SP and is skillsmark accredited which means it must be kept up to date.

Climate

Questions to ask

- What is the ‘climate’ in my work place?
- Is my office/AP making Suicide Prevention a priority?
- Are Senior Managers driving development in this area?
- Do our policies or procedures affect suicide risk?
- Does this organisation believe we can reduce suicide?

Screening: Initial and Continued



Screening

- Is there an evidence-based screening process being undertaken with everyone?

Post-Intake Screening

- Do my staff continue to screen even after the initial contact? What prompts it?

Monitoring following screening

- Do my staff have a process to communicate risk and continue to monitor for risk?
- Are they aware of how to identify risk reduction?

There is an OASys screen which asks about risk of SH or Suicide

If indicated should complete a risk assessment in full analysis AND address issues in Risk Management Plan

NICE guidance CG133

Aim to develop a trusting, supportive and engaging relationship with the client, and ensure that people are fully involved in decision-making about their care.

Risk assessment: When assessing the risks of repetition of self-harm or suicide, identify and agree with the person who self-harms the specific risks for them, taking into account:

- methods and patterns of current and past self-harm
- specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
- coping strategies that the person has used to either successfully limit self-harm

If you need to: REFER to someone who is trained to complete this type of assessment.

What is an evidence-based screening?

No one approach but should be consistent with community *e.g. NICE guidance* and prison approaches *e.g. ACCT/PSI* (as they are the best evidence-base we have).

- Use up-to-date knowledge of actual suicide risk factors
- Complete screening on everyone, with more detailed assessment (or referral for) for those in high-risk groups.
- Individualised assessments which are repeated.
- Don't rely on guesswork or client statements they are not suicidal.
- "Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm" NICE (2011) CG133

Communication Regarding High-Risk Offenders

Who are the people that need to be communicated with?

What hurdles are there and how to overcome them? e.g. different computer systems

Do staff know what to communicate, to whom and when?

Are they communicating risk or asking about risk from others (e.g Prisons/Police/Drs).

Are staff part of a wider network for communication and multi-agency working especially for high-risk clients ?

Complex MDT Case meetings have been proven to be effective-similar in concept to MAPPA or CPA meetings

Written Procedures

Does the organisation and staff have written procedures on the identification, management and reduction of suicide risk?

Do staff know what they are?

Some guidance towards written procedures available in National AP manual (safety knives), London practitioner guide, OASys manual, Delius Contact Code.

Mental health treatment

- Do offenders get the assessment and treatment they require?
- Do staff know how to identify MH issue and when and how to refer?
- Are offenders seen promptly and efficiently?
- Is there a system of joint care planning, close communication and/or integration between MH and Probation Services?

Later on we will be hearing from both MH and PD services…

Debriefing staff and learning from incidents

Staff are most important resource, we need to look after them.

- Does the organisation have a suitable and effective staff support and debrief system for suicidal behaviour?
- Is there a process of swift internal review, reflection and dissemination to learn from incidents?
- Are national PPO reports reviewed and local current processes reviewed?

We will hear from the PPO later…

New Probation Instruction requires internal review of a death PLUS London Suicide Prevention Forum review PPO reviews and aid dissemination.

Making a Difference –Together.

The HMP Brixton evaluation highlighted the importance of all of these things with two key themes:

Management Approach and Support – All Managers must prioritise Suicide Prevention in their decision making, policy planning and practice guidance. They must support and train staff and also hold them accountable.

"Spotlight on Suicide"

Integration and Multi-disciplinary Care – A properly integrated and single care planning process provides the best care for clients and staff support.

'Integration not Isolation'

Care Planning ‘Integration not Isolation’

- **Collaborative**
- **Multi-disciplinary**
- **Engaging the family and significant others**
- **identify realistic and optimistic long-term goals, including employment and keeping occupied**
- **identify short-term goals (linked to the long-term goals) and steps to achieve them.**

Taken from NICE guidance CG133

Intervention?

Most care plan targets can remain with any lead key worker. However…

Interventions specifically for self-harm or suicidal thinking: Refer for a suitable intervention by a trained therapist. The intervention should be tailored to individual need.

Treatment or management associated mental health/PD conditions: Refer as suitable to MH/PD service.

There are lots of options already available which may help:

Problem solving, Coping skills, drug/alcohol treatment, mental health referrals.

See later presentations for more details…

Key Messages

1. 'Integration not Isolation':

- Work with others to help identify and manage risk – *pass on information and risk plans and ask about risk from others.*
- Make your risk planning collaborative
- Help (at least advise) the client to find support and someone to talk to.

2. "Spotlight on Suicide"

- Integrate SP into your wider role – and into your RM plans.
- Be sure to know your SP policies and consider SP when developing new ones.
- SP development needs to be prioritised and given support if going to make the biggest difference.

3. Don't be afraid to ask…..

- If you need training
- If you don't know what to do
- The client how they are and identify risk
- Others for support and for information

Questions?

Guidance

Use local and national documents to guide you (see earlier and later presentations)

For: NICE guidance CG133
http://www.nice.org.uk/guidance/CG133

For WHO (2007) guidance

http://www.who.int/mental_health/prevention/suicide/resource_jails_prisons.pdf

To contact me for Brixton evaluation, or any other questions:

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