Her Majesty's Inspectorate of Probation

Probation staff experiences of working with people at risk of suicide and/or self-harm

HM Inspectorate of Probation

Research & Analysis Bulletin 2022/04

JULY 2022

HM Inspectorate of Probation is committed to reviewing, developing and promoting the evidence base for high-quality probation and youth offending services. Our *Research & Analysis Bulletins* are aimed at all those with an interest in the quality of these services, presenting key findings to assist with informed debate and help drive improvement where it is required. The findings are used within the Inspectorate to develop our inspection programmes, guidance and position statements.

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We would like to thank all staff who participated in the research. Without their help and cooperation, this project would not have been possible.

This publication is available for download at:

www.justiceinspectorates.gov.uk/hmiprobation

ISBN: 978-1-915468-06-2

Published by:

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People on probation are more likely to die from self-inflicted deaths and to present with risks associated with suicide and self-harm when compared to the broader population. They are more likely to present with mental ill health, to be isolated, to use drugs and alcohol, and to live in deprived conditions: all factors which are strongly correlated with elevated rates of suicide and self-harm. Moreover, being subject to probation supervision can exacerbate these risks and create new ones.

Approach

The findings presented in this bulletin are based upon interviews with 51 members of probation staff, including interviews with frontline practitioners in approved premises (APs) and in the community. These interviews were focused on how confident staff felt around working with people at risk of suicide and/or self-harm, what training they had received, how they assessed and managed peoples' risks and what challenges they faced in doing so, and, finally, what support they received from the organisation. We also interviewed Senior Probation Officers (SPOs) in APs and people who had some strategic responsibility for this area of work. The themes presented below were generated through a process of reflexive thematic analysis.

Key findings and implications

Key findings are as follows:

- Participants suggested that self-harm, suicidal ideation, attempted suicide and suicide are highly prevalent amongst people on probation caseloads. Key risk factors raised by participants include drug and alcohol use, mental ill health, and isolation. Participants also highlighted transitions to and from custody, new legal proceedings, and relationship breakdowns as triggers which could increase the risk of people self-harming and/or being suicidal.
- Participants had a number of techniques for assessing risks, ranging from using formal risk assessment tools to gathering information from differing sources and speaking to people on probation. Concerns were expressed regarding the ability to access all relevant information in a timely manner, as well as having the necessary time to build the all-important relationships with people on probation.
- Risk management in APs appeared to be more robust than in community settings, with participants having a good knowledge of what they could do to help people. These techniques included short-term and long-term interventions. In the community, participants mainly relied on external services such as NHS mental health services and charities. Participants raised many barriers to using these services, including long waiting lists, insufficient services, difficulties for people leading chaotic lives in accessing mainstream services, and a tendency for such services to be ill-equipped to respond to the complex needs with which many people on probation present.
- Across the board, staff would like more training although they also stressed that they were not and should not become mental health practitioners. Participants preferred face-to-face, practical and applied training, and suggested training around suicide and self-harm should be regular and ongoing rather than one off. There is currently

more training around suicide than self-harm, leaving a real gap in knowledge and training around the latter.

- The death of someone on probation has a real impact on staff. Some support is available to staff after someone dies but for many this felt more procedural than supportive. Participants also suggested that support is needed after a self-harm incident or attempted suicide. On the whole, staff were negative about PAM assist,[1] believing that it was insufficiently specialised to respond to concerns they had in this area. Managers feel the responsibility to support staff keenly but do not always feel that they are able to do so sufficiently.
- A small number of our participants had experience of attending inquests. They felt unprepared for them and experienced them as stressful events which were more about apportioning blame than learning from the circumstances of a death.

[1] PAM Assist is an employee assistance programme provider offering counselling, support and information, including signposting to external sources of support.

Based upon the findings in this bulletin, we make the following recommendations:

Information sharing	• improving processes for information sharing about the risks that people face, especially for people leaving prison on an open Assessment, Care in Custody and Teamwork (ACCT) care plan
Positive, trusting relationships	• providing staff with the time to develop and nurture strong relationships with people on probation
Community services	• creating strong links with community provision, such as engaging community psychiatric nurses in APs • making counselling available to people on probation
Staff training	• providing more face-to-face, practical and applied training • hearing from people with lived experience
Staff support	• implementing a more consistent approach to line management support • providing a dedicated employee support programme, staffed by people with specialist knowledge of probation work
Policies and processes	• reducing the burden from the volume of policies and paperwork • increasing the focus on processes being a learning rather than blaming experience

1. Introduction

The Government strategy for suicide prevention (Department for Health and Social Care, 2021) has identified people in the criminal justice system as a priority for several years and highlights the importance of providing training and support to those working with people who self-harm or carry out suicidal behaviours. This research responds to some of the challenges laid out in the strategy, presenting the findings from an exploratory study of probation staff experiences of working with people at risk of suicide and/or self-harm. The research involved interviews with 51 members of staff including Residential Workers, Probation Services Officers (PSOs), Probation Officers (POs), SPOs and people with strategic responsibility for policy in this area.

The rate of self-inflicted deaths amongst people on probation is higher than in the general population, and also higher than in prison custody. For example, Phillips et al. (2019) conducted new analysis of deaths of people on probation by examining data collected from Her Majesty's Prison and Probation Service (HMPPS). It was found that people on probation were 8.7 times more likely to die by suicide than people in the general population and 1.4 times more likely to die by suicide than people in prison. Similarly, in a systematic review of suicide among recently released prisoners in England and Wales (a meta-analysis of nine papers), Jones and Maynard (2013) found that the risk of suicide was 6.8 times that of the general population.

Women in particular appear to be at an elevated risk of dying whilst subject to probation supervision, with drug-related deaths and suicide featuring heavily (Phillips et al., 2019). While Ministry of Justice data suggests that people under post-sentence supervision and licences are also at an increased risk of dying from a self-inflicted death (Phillips et al., 2019), a meta-analysis found that while ex-prisoners have a high likelihood of suicide, this was not as high as it was for those serving community sentences (Skinner and Farrington, 2020). This was due to the fact that in prison, people are more likely to have received the necessary mental health treatment required, while those on community sentences with complex and challenging lifestyles may slip through the net of mental health services.

For ex-prisoners, analysis for the Equality and Human Rights Commission showed that the risk of dying from a non-natural cause is highest in the first two weeks after release (Phillips et al., 2016). This finding was also reflected in a study by Pratt et al., (2006) who found that just over a fifth of suicides occurred within 28 days of release, and just over half within the first four months. And in a Home Office study, Sattar (2001) explored rates and causes of death among male prisoners and those subject to community supervision in England and Wales from 1996 to 1997, with the author noting that deaths by any cause among supervised people tended to occur soon after being released from prison. Similar findings have been reported in both a Canadian (Daigle and Naud, 2012) and Australian (Katiminia et al., 2007) context.

Suicide is a complex phenomenon which has myriad underlying causes and explanations. There is not the space to go, in depth, into these causes but it is worth pointing to one recent influential model of suicide, the Integrated Motivational Volitional (IMV) model (O'Connor and Kirtley, 2018) which suggests that suicidal ideation and suicidal behaviour is the culmination of a complex and interrelated set of factors within a person's life. Importantly, many of these – such as feelings of thwarted belongingness, feelings of defeat and humiliation – are all likely to be highly prevalent amongst people on probation. The model also proposes that certain moderators, such as access to means, exposure to suicide,

and impulsivity, can lead to a person feeling that 'suicidal behaviour is seen as the salient solution to life circumstances' (O'Connor and Kirtley, 2018).

Probation can play a role in preventing suicide by ensuring that staff are aware of the stressors associated with elevated risk. The role which POs may play in preventing suicide has been explored in interviews with probation staff (Mackenzie et al., 2015). Staff were asked to see if they could retrospectively establish whether service users who later went on to self-harm or attempt/die by suicide had given any indication of suicidal intent during their supervision sessions, and if any learning could be obtained. Potential indicators or triggers of suicidal/self-harm behaviour highlighted by staff and specific to the probation process included missing appointments or awaiting a court sentence. Uncertainty or change, including a change to their sentences, or swapping GPs and psychiatrists, were also perceived as potential triggers due to the stress caused. Arguments with loved ones were another factor which could heighten risk, and additionally alcohol was viewed by staff as a contributing factor to suicidal feelings and behaviour. Similar findings were observed from the records of 28 people on probation who subsequently died by suicide (Borrill et al., 2017). In-depth exploration of the events and experience of these vulnerable service users provide further evidence that aspects associated with probation such as missed appointments, upcoming legal proceedings, changes in supervision, and failure to register risk may lead to a heightened likelihood of suicide. Research with people with experience of criminal justice (Mackenzie et al., 2018) suggests that people on probation linked a range of experiences such as bereavement and a loss of control over their suicidal feelings. Importantly, Mackenzie at al. (2018) found that people on probation have difficulties with trusting people in authority which acts as a barrier to disclosing suicidal feelings.

In addition to the recognition of risk, it is important that staff are aware of the factors which may act as a buffer to suicide and/or self-harm, with the evidence base showing that social support can be especially effective (De Motte and Thurston, 2022). Wu et al. (2011) found that family and friends were the favoured source of support for those in the community who engage in repetitive self-harm, although this should ideally be complimented with high-quality advice from medical professionals. Strategic recommendations for adult suicide prevention have highlighted the importance of explicitly emphasising social support networks when people experience challenging life events, as this can help protect them from self-harm and suicidal ideation (Tham et al., 2020).

As the self-inflicted death rate is high amongst people on probation, one would expect the number of staff members who have experience of working with people at risk of suicide also to be high, although little research has sought to examine this. Findings from interviews with 13 POs (Mackenzie et al., 2015) revealed that the majority believed they had a lack of training in this area. In addition, they expressed a lack of confidence in knowing the protocol if a person was to disclose suicidal feelings or self-injury. Despite the fact that training was available to all staff, participants' reasons for not attending included being overwhelmed with their current workloads and feeling under pressure to attend other training sessions. Those who had attended training said that it had helped them to feel better equipped to deal with suicidal service users as did those who had previous experience of suicidal incidents. Sirdifield et al. (2020) has argued that the lack of training for POs in either mental illness or substance misuse meant that mental health issues were often missed by probation practitioners.

Mackenzie et al. (2015) also identified the emotional impact which the death by suicide of someone under their supervision can have on staff, which research conducted beyond the field of probation has shown can be broad and enduring (Cassidy et al., 2004). Staff interviewed for this study (MacKenzie et al., 2015) did, however, feel that support was available when a person self-harmed or carried out suicide. In addition, nearly all

participants were aware of the support they could receive from a confidential counselling service working in partnership with probation. Participants also looked for support from senior colleagues; however, the availability and usefulness of this support depended both on manager attitudes and availability, as well as participants' willingness to seek out the support. The most frequent form of support came from discussions with co-workers and peers, and this was seen as the most accessible and valuable. It enabled staff to off-load their feelings immediately after an incident and to gain a range of perspectives on different situations. There is also reported evidence of underused formal post-incident support (Ludlow et al., 2015; Sweeney et al., 2018) and insufficient training provision (Ricciardelli et al., 2020).

A recent study (Sirdifield et al., 2022) explored the impact of the response to the pandemic on probation staff's ability to identify health related drivers of offending behaviour, the lived experience of accessing required health support, and partnership working and pathways into healthcare for those on probation. This included those at risk of suicide and broader mental health issues. The findings highlighted the challenges many of those under probation supervision faced in gaining access to health support during this time, with the impact on the health and welfare of supervised individuals being considered to be negative in the main. This was exacerbated for those with limited or no digital capacity and/or capability, and where staff were expected to bridge this gap, this could lead to burnout if they were not fully supported. Going forward, while face-to-face supervision was found to be key for identifying and monitoring changes in health status, the authors suggested that this could be combined with some degree of remote supervision, assuming the risks and needs of each individual were taken fully into account.

Self-harm and attempts at suicide should be seen as significant risk factors for later suicide and should not be dismissed by staff as manipulation or attention-seeking. The relationship between self-harm and suicide is often misunderstood. While self-harm can act as a coping mechanism for managing difficult thoughts and feelings and does not always mean someone is suicidal, self-harm is considered a high-risk factor for later suicide and needs to be factored into assessments. Due to the fact that there is a strong correlation between self-harm and suicide (Royal College of Psychiatrists, 2020), one would expect the rate of self-harm amongst people on probation to be high. Moreover, the link between mental ill health and self-harm and/or suicide is strongly correlated and people on probation have high levels of mental health needs (HM Inspectorate of Probation, 2021).

Wessely et al. (1996) found that nearly a third of clients in the West Yorkshire probation trust had a history of deliberate self-harm, whilst Pluck and Brooker (2014) found that between 25 and 40 per cent of randomly selected sample of probation clients (n=173) from one county in England had a lifetime history of self-harm. In the USA, Gunter et al (2011) found that 14 per cent of clients in a community corrections sample had self-harmed. Self-harm is high amongst people in prison and, almost without exception, everyone who spends time in prison ends up subject to probation supervision in the community. This has become a more acute issue during the Covid-19 pandemic, with government data suggesting that self-harm, especially amongst female prisoners, has increased significantly during the period of prison lockdown (Ministry of Justice, 2021). Despite this, little research has explored staff experiences of working with people on probation at risk of self-harm.

In interviews with probation staff about their understandings of suicide and self-harm (Mackenzie et al., 2015), it was revealed that staff often based their opinions of the motivation behind self-harm on prior knowledge which they had about the individual. So, for some it could be seen as related to their mental health issues, whilst for others, it was perceived as manipulative and under the person's control. The fact that some staff considered that self-harm could be manipulative or attention-seeking was considered to be

concerning by the authors, since previous research has demonstrated that even when offenders admitted an underlying manipulative purpose to their actions, they were no less vulnerable to suicide (Hills et al., 2000).

These views were, however, found to be less common in those participants who had attended suicide prevention training or had more direct experience of suicidal behaviour. For these participants, suicidal behaviours were perceived as having an internal purpose such as a 'cry for help', or self-harm as a 'release from frustration'. Regarding the perceived seriousness of suicidal behaviours, those who disclosed their feelings as well as repeat self-harmers or those with previous suicide attempts were often regarded by staff as being less serious and those individuals being less likely to eventually complete suicide. This again contradicts other research findings (Hawton et al., 2014; Joiner, 2005). Again, attitudes changed when staff had experience of dealing with suicidal service users, some of whom they had at the time considered to not be at high risk due to previous self-harming behaviours.

2. Findings

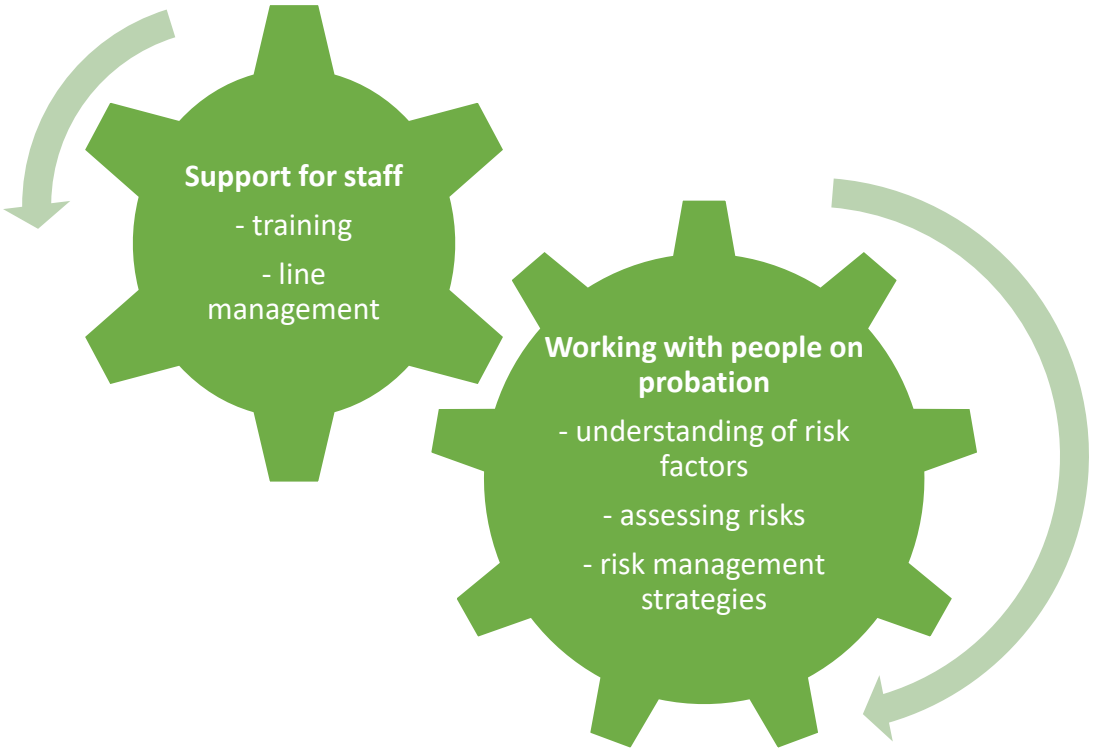
In light of the current literature, this research addressed the following questions:

- What do probation staff know about the prevalence and nature of suicide and self-harm amongst people on probation?
- How is the risk of suicide and self-harm assessed, what barriers exist in this area and are there examples of good practice?
- How do probation staff support people on probation in managing any risk of suicide and/or self-harm?
- What training do people working in probation receive and how confident do they feel in working with this group of people?
- What is the impact of working with people at risk of suicide and/or self-harm on staff?

The findings presented are based upon interviews with 51 members of probation staff. We interviewed and conducted focus groups with frontline practitioners in APs (n=19) and community teams in the Probation Service (n=17). We also interviewed frontline probation practitioners (n=5) and managers (n=1) in Community Rehabilitation Companies (CRCs) prior to unification.[2] These interviews with staff were focused on how confident they felt around working with people at risk of suicide and/or self-harm, what training they had undertaken, how they assessed and managed peoples' risks and what challenges they faced in doing so. Finally, we discussed what support they received from the organisation and explored experiences of post-death investigations. We also interviewed SPOs in APs (n=7) and people who had strategic responsibility for this area of work (n=2). We asked SPOs about how they worked with staff and residents to reduce the risk of suicide and self-harm, and how they supported staff with this aspect of their work. We asked our strategic leaders about overarching policies and practices which are in place to respond to the high risk of suicide and self-harm faced by people on probation.

The themes set out in the following sections were generated through a process of reflexive thematic analysis (Braun and Clarke, 2021) by the research team (see Annex A for further details on the methodology), encompassing the work in individual cases and the wider support in place for practitioners.

[2] Prior to the unification of probation services in June 2021, the public sector National Probation Service (NPS) advised courts on sentencing, and supervised those individuals who presented a high or very high risk of serious harm or who were managed under MAPPA. Private sector CRCs supervised most other individuals presenting a low or medium risk of serious harm.



2.1 Prevalence and risk factors

We started our interviews by asking people about their perceptions of the prevalence of suicide and risk factors associated with suicide and self-harm amongst people on probation. Most of our participants agreed that this was higher than the general population:

> "*It is quite a prevalent thing that we deal with when we're working with people*." (PO2, Community)[3]

> "*I would say that 80 per cent of my caseload suffer with some form of mental health and/or self-harm*." (PO3, Community)

We also asked participants why they thought the prevalence of suicide and self-harm amongst people on probation is high, which tended to lead on to a broader discussion about the risks that this group of people face. Two groups of risk factors were identified:

- those which are present in the wider population
- those linked to being within the criminal justice system and on probation.

First, the factors that are associated with self-harm and suicide amongst the broader population, but which were either more prevalent or exacerbated by the fact of being on probation. For example, participants identified high rates of mental ill health and substance use amongst the caseload, both factors which are highly correlated with self-harm and suicide in the broader population (Brådvik, 2018). Isolation was a theme which also

[3] Participant codes are used to protect participants' identities and maintain anonymity. PO denotes Probation Officer; PSO denotes Probation Services Officer; SPO denotes Senior Probation Officer and RW denote Residential Worker. AP means the participant works in approved premises and Community shows they work in a community setting.

occurred frequently in our discussions and participants suggested that being on probation could – for some people – make feelings of isolation even more acute. Sometimes this was seen to be a product of someone's offending (people convicted of sexual offences are seen to be particularly vulnerable to being isolated) or the result of having been isolated by a period of imprisonment and struggling to resettle in the community:

> "*Some people have absolutely nothing and really don't want to be in the hostel, find it very stressful*." (PSO2, AP)

> "*Some of the guys come out now worried about being exposed for their offence"*. (RW3, AP)

Participants also identified relationship breakdowns, restricted access to children and family members, homelessness, and military backgrounds as factors which they considered relevant to an increased risk of suicide and/or self-harm.

Trauma and complexity featured highly in discussions. Participants recognised that people on probation were likely to have experienced trauma in their lives. In turn, this made them more vulnerable to self-harming and suicidal behaviours, and made supporting them more difficult:

> "*Because they've had extraordinary traumatic lives, all sorts of things have happened to them and they've had to develop coping mechanisms to deal with things that are very difficult*." (PO4, Community)

> "*You've got lots of people with very complex needs*." (PSO, Focus Group 1, Community)

The second group of risk factors were more closely associated with probation supervision, reflecting the findings in Borrill et al. (2016). Here, participants talked about the risks associated with transitions within and through the criminal justice system and how they could increase the risk of someone self-harming or feeling suicidal:

> "*Well, there is the whole stress of going through the court process. It is very stressful. I mean I've only ever had to appear at court as a witness in a breach hearing and it terrified me and I hadn't done anything wrong. I was just there as a witness, so I dread to think how stressful that whole situation is. If someone has an underlying issue with anxiety or depression that additional stress can make it completely overwhelming. It's the whole court process, it's the whole going into prison, coming out of prison and that's one that people forget about a lot*." (PSO3, Community)

Whilst the transition into custody has been well documented and prisons have sought to mitigate these difficulties, our participants were keen to highlight the difficulties of transitioning from custody into the community:

> "*I think systemically, some of the risk involved in that is that transition from a highly structured prison environment, which has highly structured sets of rules and regulations and twenty-four hour healthcare and support services and things in place … they're two completely separate systems in the sense of the different computer systems and the different forms and the different policies and there isn't a single, coherent set of policies that transcends that pre-release through to AP through to community setting. So, it feels like things can happen in the gaps. There are a lot of gaps that can open up for people in those systems through healthcare, drug treatment, which we are well aware of in terms of the access to*

services, access to prescriptions, access to wider support that comes from some of those moves". (Strategic2)

Those moving from custody into an AP could be particularly at-risk as they are more likely to present with complex needs and fewer assets which could act as protective factors:

"*People who are going to APs, because they're high and very high-risk individuals, all highly complex individuals, which is why they gain an AP placement, they, by definition, have more complexity, they've often spent a lot longer in prison, they're under much tighter licence conditions, they don't have the protective factors that might come from being able to go home to a family or community. In my mind the risks are really that they probably have more risks and less protective elements*." (Strategic1)

Another factor which was seen to increase the risk of self-harm or suicide was new legal proceedings, potential breach, or licence revocation. One participant suggested that stringent controls over some peoples' lives may be counterproductive. This participant's account of a person on probation who had experienced suicidal ideation in the past noted that his upcoming release – which would be under 'normal' licence conditions – would be less harmful for him:

"*I actually think that this man might do better because he won't be under quite so many rules*." (PO4, Community)

2.2 Assessing risk of suicide and self-harm

2.2.1 Obtaining information ahead of assessment

Participants described how they assess and identify people who are deemed to be at risk of suicide or self-harm. Most people who reside in APs arrive following release from prison and so the prison was seen by those we interviewed as an important source of information in relation to identifying people at risk. Ideally this identification would be done as part of the resettlement process, prior to release. However, where people are released from prison at short notice or allocated to an AP at late notice, this was, understandably, more difficult. Although some participants said that getting relevant information from the prison was easy, the majority described experiencing real difficulties. There was particular concern around difficulties in accessing information from ACCT documentation which is used to manage suicide and self-harm in prisons. Some said they would find out whether someone was on an ACCT but not the content of the ACCT, whilst others said they got much more detail. In most cases getting information required tenacity and perseverance from staff as well as good relations with the prisons:

"*It is really difficult to be able to get the information from the prisons that they have relating to [suicide and self-harm] - it's getting easier as time goes on, the relationships are getting better with the prisons but it's not where it should be yet.*" (PSO, Focus Group 3, AP)

There was some evidence that the newly implemented Offender Management in Custody (OMiC) policy had improved matters because the Prison Offender Manager (POM) is better connected to probation, probation technology and the Community Offender Manager (COM). But this was by no means a universal view. Participants said that getting information from other departments in the prison was even harder than getting ACCT information or information from the POM, with healthcare being particularly difficult. Although recognising the important issues around patient confidentiality, participants tended to believe that due to their remit to keep people safe, they should have easier access to healthcare information

when people are released from prison. Current prison guidance[4] is that medical information can be shared but this should normally take place with the consent of the individual.[5]

Whilst participants from APs tended to look to prisons for information, those from CRCs generally sought information from the police and courts. Participants spoke about seeking background information from paperwork received from the police and Crown Prosecution Service, pre-sentence reports, as well as existing OASys[6] and nDelius[7] entries. However, they also reported feeling unable to rely on such information, both because of concerns about the accuracy of the record and because it was difficult to obtain, with one interviewee describing access to these sources of information as a 'Brucie Bonus'[8] (PSO2, CRC). In contrast, a court-based participant reported being provided with information, but not having the time to use it:

> "*….but we haven't got the time to be looking deeply into these people's pasts and histories. We do get updates from mental health teams, safeguarding, etc., but all we can do is really put that into the report.*" (PO, Focus Group 3, Community)

2.2.2 Initial assessment

There are two main tools that are used to assess and manage risk of suicide or self-harm once someone has arrived at the AP, both of which have been introduced in the last 18 months. Firstly, the Support and Safety Plan (SaSP) – which was introduced as part of the new Collaborative Approach to Risk and Emotion (CARE) approach – is undertaken with all people who arrive at the AP. This booklet is supposed to be completed by the resident with their keyworker within one day of arriving. In general, participants spoke highly of the SaSP. The fact its completion is led by the resident was seen as empowering and meant that the SaSP would be tailored to each individual's needs.

Good practice example: Being client-led

The Support and Safety Plan (SaSP) aims to provide individualised information and encompasses:

- *an opportunity to assess the types of risks, triggers and needs for residents*
- *how staff can help to prevent issues*
- *providing residents with a support structure including how to support themselves in the event of distress.*

Staff in APs were generally positive about the SaSP, identifying that its main strength was that it was led by the person on probation. They found that giving residents the opportunity to define their own risks and triggers was an effective way of assessing risk, and that this approach was empowering to the individual. One AP staff member reflected

[4] See PSI 64/2011 – Management of prisoners at risk of harm to self, to others and from others (Safer Custody): Managing prisoner safety in custody: PSI 64/2011 - GOV.UK (www.gov.uk)

[5] Disclosure without an individual's consent can also be made if it is considered necessary to protect the individual or anyone else from risk of death or serious harm.

[6] The main probation assessment tool currently in use in England and Wales is the Offender Assessment System (OASys), which was initially developed in 2001, building upon the existing 'What Works' evidence base. OASys provides a standardised assessment of the needs and risks of service users which, once identified, can be used to develop and deliver sentence plans.

[7] nDelis is the probation case management system.

[8] This refers to a gameshow hosted by Sir Bruce Forsyth in which players could win a bonus prize by winning a game.

that it "makes staff feel that they're working alongside the resident, supporting them. And I think the resident feels listened to, heard".

Giving both AP residents and people on probation more widely the power to identify and define ways in which probation can support them is one approach to facilitating greater autonomy over how people are 'managed' and lead their lives. Moreover, participants suggested that the SaSP can be used as a way of developing trusting relationships with residents, which can lead to more openness in future work.

In the CRCs, staff were required to go through an induction pack, leading to the completion of an OASys and a Kessler 6, the latter being a screening tool for psychological distress, with a high score prompting staff to refer the person for additional support. Participants were divided about the utility of the Kessler 6, with some feeling that the questions are too generic and cover too recent a timeframe, whilst others reported finding the tool a helpful prompt to start a conversation.

AP participants said it was helpful to discuss triggers and signs of deterioration in advance with residents so that they could keep a look out as the residents settled in. However, there was some concern, especially amongst PSOs, that asking people about suicide and self-harm upon arrival was expecting too much of people going through the difficult transition from custody to the community:

> *"I just think it's more detailed than what we do now, and I've got some concerns around that because it's asking lots and lots of questions. It's a very early stage in people's stay when you know that all they want to do is get out of that interview room and go and speak to their family or speak to somebody and I'm not sure you get the best out of people when you're bombarding them with things*." (PSO2, AP)

This view was mirrored in the responses from community PSOs, who felt that the initial meeting was a difficult time to raise such issues:

> "*When the case comes to us after sentencing it normally has a flag to say suicide/self-harm risk but even if it doesn't have that it still is something that we ask in our induction process… it's normally the first time you speak to someone and asking them questions of that nature on your first meeting is not always the best*." (PSO2, CRC)

For community PSOs, but not those based in APs, the initial assessment process had been further complicated by the move towards telephone interviews during the pandemic:

> "*The physical distance has been difficult and also wanting to get off the phone because I don't like being on the phone whereas in a face-to-face interview there's somebody I might push a few buttons and ask a few more questions, with Covid I just wanted to finish the conversation and move on to my next task, so I don't think I've successfully assessed those risks in the way I used to do*." (PSO2, CRC)

2.2.3 Importance of building a relationship

Time was considered an important factor by participants from both APs and the community, with participants from CRCs citing caseload size and a lack of time as impediments to building a rapport and assessing risk. AP participants suggested that they need more time to create a working relationship before tackling the difficult and 'intrusive' questions that are

required in the SaSP, although one staff member noted that a possible solution was asking informal questions which facilitated the creation of a constructive relationship, with the potential to encourage more openness in future encounters:

> "*So I don't really like asking very directly of, well, have you had any self-harm incidents or have you done this and that or thought about any of this because we do have that, again, when they come in to the AP, during the induction we do have a form which we have to complete so the same thing, you have to ask very, very personal questions, very deep questions but because they are so used to those questions they just go through it and there's no emotions that they can put in and really talk to you about so instead of going through that I would just talk to them, say how was their day, how they were doing or if they've done anything special, have they met friends, have they got people around that they can talk to?*" (RW2, AP)

There is scope for some flexibility, although there is clearly a balance between assessing risk in a timely way so that risks are not missed, and doing so in a sensitive way that does not jeopardise the working relationship between resident and keyworker. Indeed, AP participants highlighted that the period following arrival is risky, and that they do not yet know the individual or what is going on for them:

> "*I find for myself in my working practice the sooner I can start the relationship with the person who's going to be coming to us, the better. If they have got concerns, whether it be suicide, self-harm or anything else the sooner you get in contact with them you have the more time to be able to build their trust and you will get more information out of them over time*." (PSO, Focus Group 3, AP)

Participants from the community argued that people on probation may not disclose risk issues before a relationship is built:

> "*People won't tell you these things and you won't know if people are at risk of self-harm or suicide or struggling if they don't trust you. They need to trust you to open up and your skills and who you are and how you get to that point, that's very much an individual thing and some of that can't be taught either. You're seeing a lot as well that a lot of service users are being moved around, you've got PQiPs, they come in, they do their training for 18 months, they take someone on a sentence for 18 months and then off they go. I've got someone on my caseload that went through six officers in a year, so they've got no continuity and then when they are struggling we're not picking them up on these things because things are getting missed in handovers and they've got no relationship and they don't trust us*." (PSO1, Community)

What is clear is that risk assessment tools on their own are inadequate when it comes to accurate and comprehensive assessment of risk. Time and relational skills are critical underpinning components which enable staff to work more effectively.

2.2.4 Observing changes in behaviour

Building relationships with people on probation was also identified as important in enabling staff to learn an individual's normal presentation, and thereby recognise when this changes, as well as allowing staff to identify the triggers which might cause someone's mental health to deteriorate. For people in APs, these triggers were often related to residents' personal circumstances:

"*A change of circumstances or fall out with relatives or split up with partner, can't see children...*" (PSO, Focus Group 1, AP)

Observing changes in a person's behaviour was identified as an important part of on-going risk assessment. Participants described the ways in which they look out for any changes in behaviour that might indicate an increase in risk. Such 'signs' included withdrawal from daily life/activities and (if in an AP) staying in rooms more than usual, a change in behaviour when interacting with staff or other AP residents (where applicable), or increased drug or alcohol use:

"*Once you do know someone you know how they normally would answer the phone or how they would normally present when you see them face-to-face and I think you can pick up when there's a difference in that presentation so even the way someone says 'hello' you can tell if it's a happy hello or a sad hello and I'll say, oh, wow, you don't sound yourself today, is there something you'd like to talk about or something like that.*" (PO, Focus Group 3, Community)

Although, as the quote above indicates, it could at times be possible to pick up cues that someone is struggling through their presentation on the phone, participants working in the community generally reported that the move towards telephone interviews during the pandemic had impacted negatively on their ability to recognise these signs:

"*It's really hard to sort of assess their presentation on the phone. It's easier for them to cover things up and it's easier to miss the subtle signs when you're asking the questions, what's their sort of shift in their body language which can make it difficult to choose what question you're going to ask next.*" (PSO, Focus Group 1, Community)

2.3 Managing risk

There was a range of responses about how probation practitioners worked with and supported people who they knew were at risk of suicide and/or self-harm. Due to the difference in contact levels and responsibilities, as well as marked differences in the degrees of confidence staff felt talking about managing risk – with APs staff seeming more confident than those in the community – risk management is discussed separately for APs and community staff. That said, across both the community and AP settings, an overarching theme is one of difficulty in implementing risk management plans effectively:

"*I find that people get quite easily assessed actually, that's probably the easiest bit but then it's what follows on from it.*" (PSO, Focus Group 1, Community)

2.3.1 Risk management in approved premises

APs have a much clearer duty of care to protect residents than community probation supervision and all deaths that occur in an AP are investigated by the Prisons and Probation Ombudsman (PPO). APs manage risks in different ways depending on the level of risk that the resident poses; how this operates depends on the risks and whether someone is being managed according to their SaSP or a CARE plan. If an act of self-harm or attempted suicide has taken place, or a member of staff assesses the individual to be at risk of suicide or serious self-harm, they must initiate the CARE approach. If someone arrives in the AP from prison on an open ACCT, the CARE must also be opened. In this sense, CARE is akin to an ACCT and was specifically designed to operate in a similar way. In essence, CARE requires the AP manager or designated person to detail the strategies which are being put in place to manage someone's risk of self-harm or suicide. Such strategies include regular monitoring of people in their room, and the use of techniques such as distraction boxes. A key plank of the

CARE approach is engaging residents in meaningful conversations about their risks and situations.

Good practice example: Meaningful conversations

Staff in APs talked in depth about the recently introduced policy of having meaningful conversations with residents, a core component of the CARE approach. CARE guidance states that meaningful conversations are more supportive and helpful to a person at risk than observations. During these conversations, the use of open questions is recommended to encourage dialogue with an individual. The number of conversations will vary depending on the degree of risk, and residents with a raised or high level of suicide are likely to require higher frequency conversations, alongside observations.

Meaningful conversations were seen as a good way of creating and nurturing relationships with residents as they demonstrated to people on probation that staff had a genuine interest in their lives. They can also provide opportunities for staff to learn about a person's risks and triggers and identify when they may be struggling, but in a more informal and less intrusive way than through formal assessments and interviews.

Staff did however note that in order for these conversations to be genuinely meaningful, it was necessary for them to have the right skills and experience. Otherwise, they were in danger of being little more than a 'charade', with risk of self-harm and/or suicide being managed in the more standard way, through frequent observations.

Meaningful conversations have the potential to be a useful and effective way of supporting people on probation, and there is scope for extending the use of these beyond APs. For this to be effective, however, the Probation Service needs to ensure that staff have the time and resources to be able to practice in this way to avoid defaulting to welfare checks.

SPO participants had most to say about CARE as they are responsible for opening and overseeing this approach. On the whole, they were supportive in principle and certainly pleased that there is now a document that was specifically designed for APs that focuses on managing the risk of suicide and self-harm. However, the overwhelming feeling was that these good intentions are undermined by an overly prescriptive, process driven approach. Several SPOs mentioned the fact that it is very lengthy and onerous:

> "*I think that we're told it's not a process. Well, it is a process. There is lots of forms and it's been very difficult, I found, sort of rolling it out and trying to make sense of it. It feels like let's have another meeting, another review, and lots of people need to be there and all of that, so it seems quite complex, and I think that if I was the recipient of this, I would find it quite overwhelming as well. It's very review, review, review.*" (SPO7, AP)

Moreover, once implemented a CARE plan requires constant work and monitoring, summed up by the following quote from a SPO:

> "*Well, so once I open a CARE plan, I have to then schedule an immediate meeting with the resident and assess them and there's a lengthy interview that I have to go through. Then I have to draw up a further immediate plan. Then I have to schedule a multiagency meeting involving possibly their parents, their family members, their Offender Manager, their police office, their CPN [Community Psychiatric Nurse]. I have to do that within a set timeframe and then I have to write a care plan on the back of that meeting and then I have to*

implement that care plan. This is on one resident. I've got 25 residents, all with other needs to manage, all while I'm supposed to be delivering a positive regime of purposeful activities, careful risk management. It's a lot to ask." (SPO4, AP)

There are two main types of risk management strategy which are used in APs. The first focuses on monitoring and making sure that people do not have access to the means with which to harm themselves. This can involve regular checks and monitoring while people are in their rooms, removing sharp objects or items which someone could use to kill themselves. Several participants mentioned distraction boxes which have been recognised as useful in terms of preventing self-harming behaviour. Such techniques were recognised by participants as relatively short-term in nature.

Longer-term approaches were summed up by participants by referencing the need to have 'meaningful conversations' with residents (see good practice example above). Both longer- and shorter-term term risk management strategies depend on good communication between staff and residents but also between staff members themselves. In the APs, staff were positive about the daily handover meetings, seeing them as a good way of ensuring that all staff within an AP are aware of residents' risks and current situations.

One barrier to longer-term support for AP residents is the fact that people are in APs, on average, for around eight weeks, which is a short time in which to develop relationships, assess risks and make referrals where relevant. More fundamentally, however, is that longer-term work requires the involvement of specialist mental health provision from outside the AP. It is worth noting that several participants stressed that they are not specialists, with one saying, *"It feels like there's a lot of pressure on staff to open wounds of mental health with a resident"* (RW1, AP).

Thus, APs need to make use of community mental health provision and participants described a range of services which they draw on to support residents including CPNs, Community Mental Health Teams (CMHTs), GPs and, in emergency cases, A&E and acute psychiatric care. Here, the real difficulty was a lack of capacity in community-based mental health services and, as found in other research, a silo approach to community provision which can make accessing services more difficult (Dominey and Gelsthorpe, 2020). Many participants described long waiting lists and difficulties in making referrals. This not only results in a poor service for residents but also takes its toll on staff:

"*The mental health at the hospital and outside in National Health, it's minimal. It's nothing. If it's an emergency ring 999. Or ring the hospital crisis team and leave a message. You'd be very lucky to get through to a crisis team person and it's the person who has got to then speak to their GP to be referred to [talking therapy service], they then have to go through [talking therapy service] which can take weeks and at the time they're going through crisis and all they've got there to be honest is staff, staff to talk to and whilst staff are doing our normal jobs*." (RW1, AP)

Overall, it seems that the extent to which APs work closely with community and in-patient mental health services occurs on an *ad hoc* basis which, in turn, is contingent on individual staff members' networks and experience. Moreover, even where APs have good working relationships with mental health services, they struggle to access them in a timely manner for their residents. Thus, while APs appear to be relatively well-equipped to implement short-term risk management strategies, they are hampered when it comes to supporting people to receive the longer-term treatment, they need to reduce their risk of suicide and self-harm.

2.3.2 Risk management in community settings

Participants working in the community were less confident about how to manage and support people who faced a risk of suicide and/or self-harm. In most cases, participants discussed risk management in terms of referring people to other services. These might include NHS mental health services but also charitable organisations, some of which had contracts with the Probation Service and some of which were available to all. On the whole, staff were able to identify at least one service in their local area which worked with people at risk of suicide and/or self-harm. Several participants mentioned the potential for providing counselling to people on probation but also that the Probation Service does not currently have the staff or contracts in place.

The main conclusion is that there is a real lack of resources and services that staff can draw on to help them support people. There was a consensus that probation staff do not have the skills or training to work, in depth, with people at risk of suicide and/or self-harm. This means that staff are, by and large, reliant on other services when it comes to supporting people at risk. There is thus a need for investment in services both within and outside of the Probation Service. Participants were keen to stress that being in the community made it difficult to work with people in these high-risk groups:

> "*….in the community you're on your own really*". (PO, Focus Group 2, Community)

Several of our interviewees discussed the nature of working with people in crisis and it seems that the situation varied across the research sites. Some participants suggested that crisis intervention was reasonably good:

> "*Every time I've rang them for somebody, I think they've been really positive to be honest, that's not something I've experienced myself but I'm not undermining other people's experiences of it, but it is down to funding.*" (PO, Focus Group 3, Community)

Others raised serious concerns about where a duty of care lies and the difficulties in getting people into appropriate crisis care:

> "*I've been at an appointment, things have been going on outside the room and we've been told to stay in because somebody is threatening to kill themselves and demanding that somebody comes and sees them, they've tried to access mental health and so obviously we ring the police, the police come, the paramedics come. This new schedule that the paramedics are supposed to deal with them as opposed to the police so there's always this argument for about an hour and they usually go off to A&E and then we find 20 minutes later they've been released from hospital with no bed or treatment, so we then often end up with people back in probation because they don't know where else to go so they're at their wit's end and demanding to get help, be seen. It's frustrating for them, obviously very difficult for us".* (PSO2, CRC)

Participants also discussed techniques for supporting people in the immediacy through (similarly to APs) meaningful conversations or, as in the following extract, harm minimisation strategies that clients can use:

> "*I've got one now that's actually talking to me about his self-harm, and we've discussed, how can I put this? Less invasive, less harming behaviours. We've talked about the elastic band. We've talked about using ice. We've talked about what he's actually getting from the self-harm. Is it a case of he wants to – is it like a punishment? Is it because – because some people are very different and*

they actually like to see the blood? Some people like to feel the pain and for him it was he liked to feel the pain not specifically the blood, that's why we were talking about the elastic band twanging because it's like that instant sort of sharp shock isn't it. So, yeah, we've had very open conversations about that sort of thing and where he can get help. I'm constantly reminding him of where he can get help." (PSO, Focus Group 4, Community)

It was apparent that most of the participants who felt confident were either experienced members of staff and so had come across and supported lots of people with mental ill health or had personal experience of mental ill health, self-harm or suicide. These people were able to bring their own knowledge and experience to their work with people on probation.

In relation to people who are not in crisis, participants complained of inadequate services, long waiting lists, and complicated referral processes which are not feasible for people on probation:

"*Well, 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, they'd have to be suitable for the Personality Disorder Pathway to get access to that or you tell them to self-refer to talking therapies via their GP because you can't do that referral for them. If they're a drug user and they're engaged with services, they can sometimes get counselling through that, but they've got to speak to them and there's a waiting list. What else do we do? Some charities*." (PSO1, Community)

"*So, you know, we just have to Google mental health services in the borough that someone lives in, then we have to try and contact the GP, can you refer them on? They go 'it's going to take months', yes, but start that process. So, for something that you think could be relatively easy just to refer someone that is really, really struggling, it's really hard. It's nigh on impossible*." (SPO1, CRC)

"*I've found it can be quite difficult if you're writing a risk management plan and you're saying, you know, you're going to have substance misuse agencies and mental health agencies and it all feels a bit tokenistic at the end of the day when you know that there's an 18 month waiting referral to be assessed or to then get some sort of IAPT [Improving Access to Psychological Therapies] or CMHT involved, and you know they're not even likely to get to that stage*." (PSO, Focus Group 1, Community)

The issue of accessing GPs was highlighted frequently, with participants saying that people on probation are more likely to face barriers due to high levels of homelessness and a wider disengagement from primary care (Brooker et al., 2020):

"*With the guy that I've got who's a rough sleeper; I've tried to refer him to a local mental health service, but it's been pushed back because they didn't have a contact number or an address for him so it's the sort of barriers to them engaging with the right services*." (PO2, Community)

Even if the person on probation does contact their GP and they are able to get an appointment, a further challenge is in ensuring that the person actually attends:

"*You've crawled over hot stones, you've got an appointment, all they've got to do is turn up and speak to somebody. They get waylaid. They can't go. They can't*

face it. They don't want to. Something else happens, they're going to go a different day, they've overslept." (PSO, Focus Group 2, Community)

Moreover, participants highlighted a significant problem around local health services being unable to deal with complex needs. For example, some participants talked about people who were both using substances and had mental ill health who were unable to access a dedicated service for either issue:

"*And people feel passed around a lot don't they and often if there's drug or alcohol misuse mixed with their mental health it's so hard to get them in to services because mental health won't touch them because of their drug and alcohol use so that's a big challenge for people not fitting with either service. Dual diagnosis stuff does seem to be a big issue*." (PSO, Focus Group 1, Community)

Despite the prevalence of dual diagnosis, probation staff struggle to find services willing to work with the issues together. This is exacerbated by the relatively high prevalence of neurodiversity amongst people on probation.

Another issue was the problem of thresholds. Participants suggested that one of the easiest ways to support people was through the Offender Personality Disorder Pathway. However, some felt that the threshold for this was too high, and others were reluctant to have to identify people with a personality disorder in order for them to be able to access mental health services. It would seem that in-house services are restricted to those with acute problems so that those with less immediate needs are neglected.

Partnership working is critical to good practice, but this was reported, in many cases, to be lacking. Participants talked about the inconsistent nature of working relationships between services. Worryingly, good relationships between service providers seemed to depend more on strong relations between individuals than on a framework for information sharing and partnership working:

"*I've had a good relationship with our secondary care service because of my old job so they'll let me refer directly into them and this, that and the other and I can ring them up and chat to them*." (PO1, Community)

Where there was adequate support, it was largely ad hoc and certainly patchy. Brooker et al. (2017) have argued that healthcare in probation is commissioned on a 'wing and a prayer' and our participants' responses would suggest that this is certainly occurring in the context of services for people at risk of suicide and/or self-harm.

Good practice example: Partnership working (mental health services)

Partnership working was seen to be key in relation to providing appropriate support and treatment to those at risk of self-harm and/or suicide, and having good relationships with mental health providers was viewed to be of crucial importance. Staff in some APs spoke about how mental health professionals, such as community psychiatric nurses, would regularly visit the hostel. This was considered to be a benefit as not only could they speak to residents who were in crisis, but they were able to put the required services in place much more swiftly.

Where the AP was an accredited Psychologically Informed Planned Environment (PIPE), due to their joint management by probation and the NHS, a clinical psychologist would visit once a week, to allow staff to talk through cases and for support the be provided.

Similarly, in one CRC, due to strong partnership links, staff had been able to refer people on probation to a local mental health service for support and treatment. These dedicated arrangements were seen positively as they can:

- *allow for quick access to information, support and advice for probation*
- *provide opportunities for residents to see a mental health professional in an informal and ad hoc manner*
- *make it easier for probation staff to know where to find help when they need it.*

While these stakeholder partnerships work well where they are in place, they appear to be local in nature and depend heavily on individuals developing and then nurturing the relationships. There are clear benefits from formal links between the Probation Service and mental health services, and a more fundamental embedding of mental health provision into probation would help staff and people on probation receive the support they need.

2.4 Training and confidence

Levels of confidence amongst participants varied from very confident when working with people at risk of suicide and/or self-harm (despite the difficulties in supporting them as set out above) to very lacking in confidence. A clear pattern emerged in that – perhaps unsurprisingly – people with more professional experience felt more confident working in this area. However, other participants who felt confident were those who had some personal experience of suicide and/or self-harm.

All participants expressed a desire for more training. Some of our participants were able to describe exactly what training they had received, whilst others were more vague. The Probation Service does provide a two-day training package to staff although this has not been delivered during the pandemic and it has been replaced by a short online course. Participants who had undertaken this training package were – on the whole – positive. Participants who had only undertaken the online course were less positive. However, staff were more likely to talk about other training that they had undertaken which they then used to support their work in probation. For example, one practitioner spoke very highly of optional training they had undertaken with the Psychologically Informed Consultation and Training (PICT)[9] Service:

> "*It was delivered by trained psychologists who work in PICT and obviously they work with people on probation who have mental health problems, so they have a lot of experience not only of how people who are disclosing suicide or self-harm behaviours, you know, experience things but have specifically helped people on probation, people who have come out of prison, people on community orders*." (PO2, Community)

Other participants highlighted the importance of external training provision in helping them feel confident:

> "*I did further training through Lancaster University when I was on the team. If I hadn't had that I wouldn't have the knowledge I have now*." (PO, Focus Group 3, Community)

[9] Psychologically Informed Consultation and Training (PICT) is a model of consultation, training and joint working that supports the wider system to work more effectively with people presenting with personality disorders and other complex mental health presentations and challenging behaviours.

> "*I think the only training I've done on self-harm and suicide is when I worked with a charity, but they had quite a good training package on if I'm honest, like there was training I would never ordinarily thought of that they put on*." (PO, Focus Group 3, Community)

Participants wanted more training on suicide and/or self-harm. Moreover, they argued that this training needs to be specific to probation work which is, generally, poorly understood by mainstream services. Training should – in the view of our participants – cover risk factors around suicide and self-harm, but should also cover how to have meaningful conversations and talk to people about suicide and self-harm, and be aligned to the broader probation values of working with individuals:

> "*I think I just have main recommendations which it needs to be actual, not online training, it needs to be a proper face-to-face training, we need to take an individualised approach to our service users, there needs to be clean, clear person-centred processes for these things centred around the service user. There needs to be a clear understanding between active and passive suicidal ideation because otherwise you've got people phoning an ambulance for someone that's passive and it's making things worse*." (PSO1, Community)

We also heard about the potential value of having training delivered by people with lived experience:

> "*I think it needs to bring somebody in who has had those experiences to talk to us about how they were feeling at the time and to tell us what would have helped them or what did help them. People are scared to talk about suicide*." (PSO2, CRC)

While there appears to be a considerable need and appetite for more training, time is also needed. As we noted above, practitioners' difficulties in assessing and managing risk stem, in large part, from structural and organisational problems such as high workloads and insufficient services. Training, therefore, should not be seen as a panacea for the issues raised in this report:

> "*In training you're told this is so important, you know, relationships, you need to spend time, you need to spend time doing a risk assessment, the reality is you've got an hour to do that OASys, you haven't got time to – so the two things are at odds straightaway. It's impossible to do both with the caseloads that we've got and the high-risk caseloads*." (TPO1, Community)

2.5 Impact on staff and organisational support

We asked participants about their experiences of, and views on, support for staff who work with people at risk of suicide and/or self-harm. We explored with frontline staff their experiences of support from direct managers and sought their views on what constituted good and helpful support. Our interviews with managers included their approaches to supporting staff, as well as how supported they felt both by their managers and at an organisational level.

2.5.1 Frontline staff perspectives on support

Support received by frontline staff from direct managers was reported to be variable. Some praised their managers' efforts to support them and their colleagues, particularly in the aftermath of self-harm incidents and the deaths of people on probation. Many others, however, felt that support from managers was lacking or perfunctory, and believed that

questions about wellbeing and signposting to organisational or external resources was 'box ticking' by their managers:

> "*At the minute if somebody does die while they're on probation our manager has to do a prescriptive 'how do you feel about that?' It just feels very fake, very forced and it's ticked a box then and they go on the system and literally physically tick a box to say, yes, I've spoken to that member of staff, they're fine. I don't think that's particularly useful*." (PSO2, CRC)

> "*When it happened with that lad obviously my boss asked me if I was okay and then I got an email from one of the head of services about three weeks later and it was just to check in and say do I want a Teams chat and I just sort of said I'm fine. I don't know the woman. I felt that is very much ticking a box*." (PO3, Community)

> "*PAM Assist has everything and I'm saying that sarcastically because that is a generic response that our line managers will give us … Then if I say I'm stressed, 'go to PAM Assist.' And then I tell you that I'm worried about supervising a resident with suicide, then you tell me PAM Assist. To me you're watering down what they offer because no one is going to have the answer so I feel that there should be a direct line for us to deal with suicide or self-harm for residents, that would be the ideal way of dealing with it for me because then I feel, okay then, these people are trained to deal with this*." (PSO, Focus Group 2, AP)

Some of those with lengthier careers in probation said that they believed the quality of support from direct managers had deteriorated over time. These participants identified workload intensification across probation as problematic, believing that their managers did not have enough time to offer meaningful support, and themselves less time to access any support provision. Similarly, more recent entrants to probation reported that increasing workloads left them feeling unsupported to work with people at risk of suicide and/or self-harm.

Those who positively rated their managers and the support they provided often focused on their manager's experience and operational knowledge, which from participants' perspectives translated into understanding and recognising their work with those at risk of suicide and/or self-harm:

> "*I think she is very much on the ball because she's been through it before, and it is a shame to say that but when we had the death in the AP, she was on out of hours anyway and when she realised that two members of staff had had to issue CPR, she was in that AP at five past midnight. She was there, she was sitting with them*". (RW, Focus Group 2, AP)

> "*My manager, she's very supportive and when I was training and when I had these experiences, like when I had the guy who threatened to kill himself because he was going to the AP, I went straight to her and she was very supportive in making sure that I did the right things and that we did the right things for him as well… as a manager she's a really supportive manager and she acknowledges the impact that certain cases can have on people based on their history*". (PO2, Community)

> "*[My manager] is very open, she's very accessible, she's very knowledgeable. She's been in the job for 14 plus years. She's a fountain of knowledge and she's always encouraging you to go and talk to her if you're struggling or if there's*

something, if there's questions you want to ask, if you want to reflect on how you've approached a problem or how you've dealt with an issue, she's very open and encourages you to come and talk to her and supportive." (RW5, AP)

Despite different views on the quality of support they received from their direct managers, a common issue raised by frontline participants related to the lack of ongoing and long-term support for staff. For these staff, managers were seen as failing to appreciate the emotional impact on frontline staff who encounter self-harm and self-inflicted deaths:

"*I think what isn't given to Probation Officers is the ongoing support that you need because it's not just about dealing with acute incidences, it's a chronic problem, so self-harming behaviour can be really chronic and over a period of eight weeks of supervising someone who is constantly talking about suicidal thoughts and is actively self-harming, that as an emotional wellbeing for a Probation Officer is an incredible thing to hold and I think that there is zero support with that*." (PO4, Community)

"*It was more about getting the forms filled in and making sure we'd done everything right and making sure everything – it wasn't really about how you felt about what had just happened which, you know, I think it's quite – it is sad. It's people isn't it. It's lives, regardless*." (TPO1, Community)

As these quotations illustrate, inadequate or absent support translated into some participants feeling a lack of care and recognition from management following incidents of self-harm and deaths by suicide. Managers checking in with their staff about their wellbeing was raised by some as an important feature of meaningful longer-term support for frontline staff. These accounts indicated that this was a more informal practice, dependant on the approach of individual managers. Some suggested that managers should be more attentive:

"*So, I believe the immediate support is very good but then after a while it comes down to the individual to ask for support. I think the management oversight can slip and they say they're fine, they're back to work, they're working. … I think unless an individual member of staff actually six months down the line asks for support they shouldn't be having to ask, they should be approached, how are you doing? It's six months down the line, you've got all this stress coming, how are you feeling? You shouldn't rely solely on them to ask for support*." (PSO, Focus Group 3, AP)

Participants also identified several organisational-level inadequacies in the support provided. Some pointed to a lack of clear processes for accessing support following a death by suicide. Several AP participants suggested that current support provision did not appropriately recognise the residential setting of APs and the increased potential to encounter suicide and self-harm risk. PAM Assist was mostly rated negatively in terms of its ability to provide the specialist knowledge, understanding and support required for people working in this role, with one participant stating that "*PAM Assist are as useful as a chocolate teapot*" (PSO1, Community). It is important to note that a small number of participants expressed some positive views on PAM Assist, while others felt that their support provision was too generalised or unsuitable for those who experience serious distress related to working with people at risk of suicide and/or self-harm.

One aspect of support which was seen as beneficial was clinical supervision.

Good practice example: Clinical supervision

Some participants in this study had experience of receiving clinical supervision, either in the context of probation work or in other settings. Those who had undergone clinical supervision spoke highly of it as a way of improving their wellbeing in general, as well as helping them deal with the emotional aspects of the work which is inherent in probation practice.

Clinical supervision can help staff deal with the trauma which can occur when someone on their caseload dies, and can help with their feelings of grief, which are often pushed to one side given the bureaucratic nature of the processes to be undertaken after a suicide. Reflecting on their experience, one staff member stated that clinical supervision helped them to appreciate that the emotions they were experiencing at the suicide of a long-term client were completely understandable, something which was a great source of relief to them.

However, we found that most participants who mentioned clinical supervision discussed it in terms of wanting to access it but being unable to do so. As such, this research suggests this the Probation Service should make clinical supervision more widely available to staff.

Gaps in formal support were often filled by informal support from colleagues. For some, the closeness and understanding they felt with and from their colleagues meant that this support could be more meaningful than formal workplace support:

> "*I think probably rely on colleagues for the support, yeah. I would say managers are more like has everything been done that should have been done but, yeah, I think you probably rely more on colleagues to have discussions for support afterwards*." (PSO, Focus Group 1, Community)

> "*Within my team there's people who have experienced it within personal life, within family members, whatever it might be and that pulls a lot in to it as well, you know who you can talk to, who you can gain further information from and we're not really shy within my team, we're all quite open with each other which is a really good thing to have, so if some of us have struggled or had mental health issues we're quite open about it so there's a good base there within the hostel*." (PSO, Focus Group 1, AP)

> "*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, Focus Group 2, AP)

Collegial support following self-harm incidents or deaths by suicide often focused on colleagues affirming each other's actions and decisions. One participant, describing a recent experience of being on a telephone call with a resident who disclosed that they were feeling suicidal, spoke about how he felt "*bucked up*" after receiving praise from a colleague who was nearby during the call:

> "*If we're specifically talking about suicide and self-harm, it's definitely more support and reflection. It's like saying, 'this just happened, and I did it like this, do you think that was good?' And he's like, 'yeah, yeah, yeah, yeah, no, that was good, that was a good way of handling it', you know, it's more just bucking each other up, 'you handled that well mate.' The other day I was on with [a colleague]*

when I was on the phone to one resident for five hours talking about suicide and he was just like, 'Ah, well done for that mate, you've done really well today, that must have been tough. I tip my hat to you,' and all that. Yeah, we buck each other up." (RW5, AP)

Suggestions for improving support mainly focused on the need for increased awareness among managers about the emotional impact of this work on frontline staff, alongside more practical suggestions, such as time off for those who experience a death of someone under their supervision.

2.5.2 Managers' perspectives on supporting staff and feeling supported

SPOs' reflections on how supported they felt at an organisational level to support their staff revealed similar variability in experiences and access to services. Most SPO participants told us that they believed that managers needed more support, particularly at the organisational level:

"*I certainly feel an awful lot, a huge sense of responsibility and I think at times certainly after dealing with a succession of fatalities, you know, the ability to switch off or not switch off and constantly check or check that things are okay when you're not actually at work, yeah. I mean certainly for me I think that's been an issue which, you know, I've had to work through and recognise that the team and the skills of the team, it's all still there and to have confidence about that. I think certainly as part of the support for teams I think the support for managers could be better*." (SPO2, AP)

Several participants spoke about changes in staff support services over their time working in probation, but their perspectives varied. One suggested that recent improvements in support for probation staff could be in part driven by learning from the Prison Service's policies for critical incident support for prison staff, which may have been facilitated by probation and prison being linked as two organisations under Her Majesty's Prison and Probation Service (HMPPS). Another explained the need to take account of workloads, otherwise staff could not realistically access newly introduced supports:

"*They send emails about wellbeing and stuff, wellbeing this, wellbeing grids, can we have a wellbeing representative? Can we have a meeting for this? Can we have a meeting for this? You know. Wouldn't it be lovely if staff came together across the grades to have a coffee on a Tuesday at 10 o'clock? Well yeah, but, you know, are you going to take some workloads off them? No. They won't do anything that, you know. I am increasingly – I'm sure individual managers care, I'm sure my manager cares about my wellbeing, I have a good relationship with her and she's supportive and stuff but the idea that the organisation cares about my wellbeing is complete nonsense. Complete nonsense because the organisation asks me to drive and absorb constant change and the two are not compatible.*" (SPO4, AP)

In addition to the need to acknowledge how workloads affect staff accessing the support in place, some managers echoed frontline staff concerns about the need for longer-term support beyond the immediate aftermath of deaths by suicide and self-harm incidents:

"*I've certainly been involved in conversations with senior management who really didn't, I can't say everybody doesn't but certainly some of the senior managers had no understanding at all of things, for example of post-traumatic stress and, you know, in dealing with, in trying to support staff. … It's getting better, but I think there is work to be done and certainly work around the long-term and then*

the cumulative impact of dealing with, not even serious incidents. … So, I think there's work to be done there about long-term support, understanding the cumulative impact on people's wellbeing." (SPO2, AP)

2.5.3 The impact of Covid-19 adjustments on staff support

The arrival of Covid-19 and the move to working from home for the majority of probation staff impacted their access to both formal and informal support. For frontline staff, prior to Covid-19, the physical presence of managers and more experienced staff was an important aspect of feeling supported. Many of those working from home recalled feelings of uncertainty and loneliness in the early stages of the pandemic, with significantly reduced opportunities to speak with and to seek advice from managers and colleagues about working with people at risk of suicide and/or self-harm. Most participants who had to work from home earlier in the pandemic had started to work back in their offices again at the time they were interviewed. Many spoke positively about experiencing increased collegiality and peer support following their return to the office:

"*We were talking today as a team actually and saying if it wasn't for each other and obviously now that we're back in the office that's feeling a little bit better and we can actually, you know, if you've had a bad session with somebody or somebody's worried about somebody you can have that discussion without having to try and see who's online or what they're doing and that is so important to have that, offload that concern about somebody*." (TPO1, Community)

The impact of Covid-19 adjustments on support from managers was most strongly felt by frontline staff in APs, as early in the pandemic managers and keyworkers worked from home to support social distancing, while Residential Workers remained on site. Both Residential Worker and PSO participants acknowledged the negative impact of these measures on the quality of support for Residential Workers:

"*Due to Covid-19 everybody has been told that they need to reduce the footfall, so nobody has to come in that is not – well, everyone's a frontline worker to be honest but some people have been told they don't have to come in. That leaves pressure I would say on the Residential Workers who do have to come in to do everything so where management is required and needed, even though they are available over Skype or telephone it is not the same as having them in the building when you've got self-harm and drinking, people who are alcoholics, people who are drug users. It is very stressful*." (RW, Focus Group 2, AP)

"*I also think [Covid-19 has] been very stressful for staff due to the lack of support. There's only been two RWs in the house at any one point, now you're used to having two keyworkers in the house, you're used to having the manager in the house and as you were saying, if you're working at near full capacity and also the residents have just come from prison where they've been banged up for 23 hours a day so they're only used to being out for an hour so they were looking to come and enjoy, come out to a bit of freedom and, again, we're restricting them. So, there was a bit of backlash from that I would say but particularly I will mention for staff, staff at our place were feeling burnt out and really stressed because of the apparent lack of support. Yes, your manager's working from home, your keyworkers are working from home but they're not physically present and if you need assistance there's not physically a body there to come and help you*." (PSO, Focus Group 3, AP)

2.6 Experience of post-death investigations

A small number of participants reported experience of post-death investigations. These mainly related to Coroners' inquests, either being interviewed prior to an inquest or attending an inquest to give oral evidence. Some AP staff also had experience of PPO investigations following the death of a resident.

For participants who had given evidence at a Coroner's Court, the experience was described as stressful. One PSO who had been through several inquests explained that answering questions in the presence of bereaved families could be difficult:

> *"[Inquests are] not nice. They're not nice at all. They're very stressful. The major thing is seeing members of the family. They have people there in front of you grieving, really grieving and you're having to ask technical questions. When were they last seen? What was your action? What did they do? What state of mind were they in? That also brings into question sometimes their actions and how they presented to their son. Yeah. It's not nice*." (PSO, Focus Group 3, AP)

Many of those who had not attended inquests told us that they were aware of how these investigations worked, often learning about the processes from colleagues' stories of giving evidence in Coroners' Courts. Some of these participants reported similar concerns about the prospect of having to answer questions at an inquest:

> "*I think what they felt was that somebody's looking to blame somebody. So, a lot of anxiety leading up to the inquest and then I think the whole thing is traumatic, isn't it? It brings it all back to you. You do think, 'Could he have done this? Could he have done that?' It's such an intense process as well and you're being quizzed on things that you just do automatically that you probably don't always give a lot of thought to, so I suppose you're worried about are you going be asked something that you just can't answer, that kind of thing*." (PSO2, AP)

> "*I mean this guy I was telling you about who went to jump off a bridge, I was mortified after that situation because I was like if he goes and kills himself now, the Coroner's Court, the ombudsman, they're going to come here and they're going to grill me because I was the last person to talk to him and I was just like what will I be able to say? You know, it's like, oh, I said this to him, I said this to him. I felt like I didn't know whether these were the right things to say. I might have made it worse for all I knew, you know, because we are not trained in that side of that, the psychotherapy side of it. I don't know how else to describe it*." (RW5, AP)

Several participants told us that they were or would be concerned that the outcome of an investigation into a death would be that they or their colleagues would be held directly responsible or blamed for what happened. For some, these concerns could lead to "*second-guessing*" (PO, Focus Group 3, Community) their decisions and worrying about paperwork:

> "*The first time I had to go [to the Coroner's Court] I was like oh my god, oh my god, even though I'd done everything right and as long as you've done everything right then it shouldn't be a scary experience. But I think, yeah, as soon as I knew that this person passed away, I went back through everything. I'm like oh my god, did I miss anything, what did I do? Because you do, don't you? I was like was everything up to date? Had I put all those notes and have I logged all the emails? So, I did a little bit of like, oh, yeah, I have. Obviously, I didn't change anything but you just sort of do a little bit of looking over yourself,*

but I felt confident that I had as well and I've had support and things, but I think, yeah, it's natural if someone dies in that way." (PO1, Community)

Increases in the volume of policies and paperwork were often mentioned by frontline staff when discussing fears about being blamed. In particular, increasing numbers of policies and paperwork associated with the management of suicide and self-harm risk resulted in heightened awareness of the potential to be blamed, possibly leading to the internalisation of responsibility:

"*They've brought these processes out, they've brought this paperwork out, they've brought these procedures out and if we miss a T to cross or an I to dot and someone goes out and does something silly, hurts themselves, it's because you never did a meaningful conversation with him that day. It's because you never checked on him that time*." (RW1, AP)

"*I mean I'll be honest, the forms that you get to fill in make you feel like you've missed something. You fill them and it's like was there anything else you could do? Every question it was almost like what else could you have done for this not to happen? I actually said that to my manager at the time, this form that you have to fill in it makes it look like you're guilty about something that you haven't been a part of, but you do feel guilty even filling it in like you've missed something*." (TPO1, Community)

"*This is what I was telling you about the CARE plan and why I don't like it, you know, 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, AP)

Some participants linked staff concerns about being blamed for a person's suicide to a wider 'culture of accountability' within probation, which created substantial fear among staff of being blamed and left them feeling that good practices or evidence of learning went unrecognised:

"*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? That is a horrible way to – You can understand they need to do these things but it's so punitive to staff and actually staff probably go through quite a lot of distress ourselves and it feels that there's little recognition for the good stuff we do but a lot of blame if we miss something*." (RW, Focus Group 1, AP)

"*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 … it's not*

necessarily supporting people if you're just hitting them with a stick all the time. You're not going to get the best out of your practitioners if you're just hitting them with the accountability stick all the time. You're not." (SPO4, AP)

Most of those who had participated in an investigation or had attended an inquest following a death told us that they did not know what to expect from the investigation. Lack of familiarity with the investigative processes of the Coroner's Court or PPO prompted feelings of apprehension and nervousness prior to and during an interview or inquest. As one participant explained, they were unaware that the family could ask questions at an inquest until they were at the court:

"*I didn't realise that you could be questioned by the family and then his mum stood up, her face was all red and everything and she just said I have no questions, I want to thank you because we gave up on him years ago and at the hostel he seemed his happiest. But I didn't realise they could do that because I thought when they said Mrs so and so have you got any questions, I was like what's going on? No one said to me 'this is going to happen, that's going to happen, this is why we're doing it'. I was just called like you are in court and you just go through it don't you so, yeah*." (SPO1, CRC)

Delays between deaths and investigations were also highlighted as a source of stress. Several participants spoke about lengthy delays for inquests, which could be for several months or years, depending on the coronial area. Protracted investigative processes could mean that memories or emotions associated with the death and the deceased may be brought back to participants' minds as they receive updates about or confirmation of the investigation:

"*It's all right until you get that email from the probation solicitor telling you that it's going to happen and then it kind of drags it all up again and there was quite a few of us not involved but were there on shift so we kind of like – we debrief with each other*." (PSO, Focus Group 1, AP)

Managers were aware of the impact of these delays on their staff. In addition to causing worry and stress for staff, significant delays could mean that staff giving evidence may struggle to recall the death, their actions and the actions of others:

"*I mean I know that one of my team at the moment, my PSO, she's involved in an inquest, this was a death that happened at [approved premises] about four years ago now. [...] This inquest has been postponed and postponed and postponed and she was on, she came on duty that morning when the body was found and this morning I've seen the email from her, the inquest is now happening [soon] and I know that [Name] will be already worried about that. She knows, she's been to Coroner's Court a few times, and that was something that happened four years ago, four and a half years ago and she's expected to have recall of that. [...] staff have been involved in this inquest for about four, four and a half years and it's still with them. So, I think it would be helpful if coroner's courts could deal with things a bit quicker.*" (SPO1, AP)

Prolonged delays between deaths and investigations meant that staff remained connected in some way to the death and the deceased for months or years afterwards, and may need support during this time. Perspectives on support were mixed among the cohort. Managers felt that there had been recent improvements to how the aftermath of deaths were handled:

"*Again, it's getting better but my experience of the first two inquests, the first two fatalities, yeah, the support was almost non-existent. Whereas my*

experience on the most recent incident, even though the resident was not living at our AP at the time of the incident we were included, our staff group were included, I was and still am included in the support that was offered to everybody, it was recognised that our involvement with that individual had been significant because he'd been resident at the AP for quite some time and that was good, that has been good." (SPO2, AP)

Others felt that prolonged delays between deaths and investigations could impact the quality of support that staff received from managers. One PSO described feeling 'forgotten' by their managers and advocated for a more proactive approach to supporting staff who were awaiting investigations:

"*I think that because time has passed it might be up to 18 months from the actual death so you get to Coroner's Court and the inquest or the ombudsman comes wanting statements, the management can seem to forget, well, that's done and dusted, it's six months ago.*" (PSO, Focus group 3, AP)

3. Conclusion

This research builds on and confirms much previous research area in this area. The size and breadth of our sample – which includes staff from across AP and community settings as well as managers and leaders – substantiates some of the findings from other studies. A need for more training and better communication between different practice settings has been identified elsewhere (Mackenzie et al., 2015; Phillips et al., 2019) and to see that these issues persist is concerning. Participants suggested that self-harm, suicidal ideation, attempted suicide and suicide are highly prevalent amongst people on the probation caseload, and that they are more likely to present with issues that are known to be highly correlated with elevated risks of suicide and/or self-harm. They also suggested that the state of being supervised could exacerbate existing and create additional risks, thus adding to what we know about the pains of penal supervision (Durnescu, 2011; Hayes, 2018; McNeill, 2019). Such factors included: transitions to and from custody, new legal proceedings, and relationship breakdowns/separation from family members as a result of criminal proceedings.

Participants had a number of techniques for assessing risks, ranging from using formal risk assessment tools to gathering information from differing sources and speaking to people on probation themselves. There appears to be – for many – serious issues around accessing information from prisons in preparation for release. In particular, accessing information from an ACCT was highlighted as a key concern for staff in APs. Where these arrangements worked well, it was through good working relations between individual people and/or prisons and probation providers rather than the result of a systematic approach to information sharing.

Risk management in APs appeared to be more robust than in community settings, with participants having a good knowledge of what they could do to help people. These techniques included short-term and long-term interventions. In the community, participants mainly relied on external services such as NHS mental health services and charities. However, participants raised many barriers to using these services, including long waiting lists, insufficient services, difficulties for people leading challenging lives in accessing mainstream services, and a tendency for such services to be ill-equipped to respond to the complex needs with which many people on probation present.

Across the board, staff would like more training although they also stressed that they were not and should not become mental health practitioners. Participants preferred face-to-face training and suggested training around suicide and self-harm should be regular and ongoing rather than one off. There is more training around suicide than self-harm, leaving a real gap in knowledge and training around self-harm.

The death of someone on probation has a real impact on staff. Some support is available to staff after someone dies but for many this felt more procedural than supportive. Managers feel the responsibility to support staff keenly but do not always believe that they are able to do so sufficiently. Participants also suggested that support is needed after a self-harm incident or attempted suicide. Overall, staff were negative about PAM assist, believing that this more generic support service was not suited to addressing the specific difficulties they faced in their role. Participants felt that the increased volume of paperwork adds to the pressure they feel when working with someone at risk of suicide and/or self-harm. In some cases, the paperwork required after a death appeared to take precedence over the emotional support being provided. The recently published new policy framework for the reporting and reviewing of deaths under probation supervision (Ministry of Justice and HM

Prison and Probation Service, 2022) explicitly recognises the emotional impact that a death may have, and it is good to see that there is now a process for supporting staff. We also welcome an explicit statement on how learning from deaths will be used to improve the service provided.

A small number of our participants had experience of attending inquests. They felt unprepared for them and experienced these as stressful events which were more about apportioning blame than learning from the circumstances of a death.

In light of these conclusions, we make the following recommendations:

- There needs to be improved processes for information sharing about the risks that people face, especially for people leaving prison on an open ACCT. Some participants said that – through personal contacts – they were able to get this information and it enabled them to plan more effectively.
- Improved risk assessment needs to be accompanied by more training and lower caseloads. There needs to be a recognition that good risk assessment relies on strong working relationships and so staff need to be provided with the time to develop and nurture such relationships with people on probation to support them effectively.
- There needs to be improved services in the community for people on probation who are at risk of suicide and/or self-harm. The Probation Service has very little control over NHS services but there is evidence that creating strong links between community provision, such as engaging community psychiatric nurses in APs, can be helpful. The Probation Service does have control over services that are provided, for example, through the Dynamic Purchasing Framework, and we would suggest that some provision for counselling is made available to people on probation.
- Participants prefer face-to-face, practical and applied training, and value hearing from people with lived experience. The pandemic has, understandably, led to more online training but face-to-face provision needs to be prioritised as Covid-19 restrictions are lifted. There is a clear need for more training around self-harm.
- Some participants felt very supported when working in this area; others less so. It would appear that this largely depends on relationships between practitioners and SPOs. There is scope for a more consistent approach to supporting staff. PAM assist was largely experienced negatively, partly because staff working for PAM Assist have little knowledge of probation. We would suggest that a dedicated employee support programme is established which is staffed by people who have specialist knowledge of probation work and what it entails.
- The volume of policies and paperwork adds to staff burdens and hinders the quality work that they want to undertake with people on probation, as well as increasing feelings of being blamed after an incident. There should be a focus upon reducing the burden placed on staff and processes being experienced as a learning rather than blaming exercise.
- There is little research undertaken with people under probation supervision who have experienced self-harm and/or suicidal ideation. As such, work which further explores the user experience and perspective could prove very fruitful in terms of identifying how probation can support those at risk.

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Annex A: Methodology

Research design and theoretical underpinning

The findings presented in this bulletin are derived from semi-structured interviews conducted with a range of staff across the Probation Service and CRCs (before they were disbanded). Semi-structured interviews and focus groups were chosen as they provide a flexible but rigorous method of collecting data across different participants who have different job roles. Both interviews and focus groups were designed to respond directly to the research questions posed in the findings section of this report (section 2). Staff were given a choice as to whether they took part in an interview or a focus group as we were conscious that some of the content may prove distressing, especially for people who had direct experience (either professionally or personally) of suicide and self-harm.

Sampling and recruitment

Having received ethical approval from Sheffield Hallam University and the National Research Committee at HMPPS, we approached several NPS divisions and CRCs to request access. As probation was undergoing unification, this process took some time. Once we had approval, an email was sent on our behalf by a relevant person in the division/region/CRC. In some cases, this was sent out as an entry in a region-wide comms email; in others, it was sent as a standalone request for participants. Staff were given a brief overview of the research and invited to contact us for more information. Volunteers were then provided with an information sheet, including details about confidentiality and data protection. Fully informed consent was obtained before interviews took place.

We sought to sample a diverse range of participants, focusing primarily on staff grade as well as gender. It proved difficult to recruit SPOs in community teams, but otherwise our sample includes people from a range of roles including frontline practitioners in APs (n=19) and community teams in the Probation Service (n=17). We also interviewed frontline probation practitioners (n=5) and managers (n=1) in CRCs prior to unification. We interviewed SPOs in APs (n=7) and people who had strategic responsibility for this area of work (n=2).

Data collection

In total we spoke to 51 people across CRCs, APs and the Probation Service. We undertook the following data collection exercises:

- 10 focus groups with frontline practitioners, including residential workers, PSOs and POs
- 27 interviews with frontline practitioners (residential workers, PSOs and POs), SPOs and people with strategic responsibility in the area.

The interviews and focus groups lasted, on average, 56 minutes with the shortest being 30 minutes and the longest 96. We interviewed AP staff from across England and Wales and our community-based staff were drawn from four different probation regions. This meant we spoke to people working in large urban areas as well as more rural settings. Data collection in APs took place between July and August 2021 and interviews with community-based staff were undertaken between September 2021 and January 2022. All interviews and focus groups were carried out online using MS Teams to limit the spread of Covid-19 as well as to provide participants with maximum flexibility and convenience. The recordings were professionally transcribed ready for analysis.

Analysis

In order to make sense of our data and generate key themes, we used Reflexive Thematic Analysis (Braun and Clarke, 2021). Three members of the team led on analysis with each taking a sensitising concept[10] to generate the key findings. These sensitising concepts were developed from other research as well as our own knowledge of both research, policy and practice in the field. This analytic process resulted in the themes presented in this report.

[10] Sensitising concepts are constructs that are derived from the research participant's perspective, using their language, or expressions, and that sensitise the researcher to possible lines of enquiry.