Commentary

Deliberate self harm and the Probation Service; an overlooked public health problem?

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Summary

Reducing the suicide rate is one of chief targets of Health of the nation, although considerable scepticism has been expressed about whether or not this can be achieved.1 We have reported that nearly a third of those supervised by the West Yorkshire Probation Service had a history of deliberate self harm (DSH). Comparing the known risk factors for DSH and suicide with the composition of those supervised by the Probation Service suggests this is a high-risk group that has not traditionally been well served by mental health services.

Keywords: deliberate self harm, probation, suicide prevention, parasuicide

Introduction

The current climate is becoming increasingly hostile towards offenders. This partly comes from an overdue recognition of the plight of victims, but also from disillusionment with social hypotheses of criminal behaviour, which are being displaced by increasing emphasis on moral responsibility, and even concepts of wickedness. However, the hostility shown by the community towards offenders is occasionally mirrored by the hostility they feel against themselves.

The last few years have witnessed an alarming increase in the number of people committing suicide in prison,2,3 and another alarming increase in 'accidental' deaths amongst opiate addicts in the month after prison discharge.4 One response has been the current emphasis on 'diversion from custody'5—official policy now emphasizes the need for mentally abnormal offenders to receive care from the Health Service rather than custody within the criminal justice system as far as possible.

The continuing rise in the prison population (51 243 on 16 March 1995, an all-time high) means that the problem of prison suicide will remain in the public eye, and efforts to ensure that the mentally ill do not make up too much of the prison population will continue. However, it is only a minority, albeit an increasing one, of offenders who receive custodial sentences. The majority (88 000 last year) are supervised by the Probation Service.

The prevalence of deliberate self harm amongst those on probation orders

Until now there have been no studies of deliberate self harm (DSH) or suicide in this population. We recently reported a pilot survey of the prevalence of deliberate self harm amongst offenders currently supervised by the Kirklees and Calderdale Divisions of the West Yorkshire Probation Service.6,7 In this paper we discuss our findings with particular emphasis on the public health implications.

Deliberate self harm (sometimes known as parasuicide) is a term that refers to any deliberate act of self harm with a non-fatal outcome. Of the 238 sampled in our study using reply paid questionnaires 71 (31 per cent) had a history of self harm. In the majority the respondent considered these were serious attempts to commit suicide. The frequency of self harm was similar whether

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self reported by questionnaire, or reported by the supervising probation officer, suggesting some reliability, but also the high level of awareness of the problem by probation staff. In the primary report we drew attention to the main limitation of the study, namely the low response rate (20 per cent), reflecting the inherent difficulties of working with this population. For that reason, the study should be seen more as highlighting the need for further work than providing any definitive answers. Nevertheless, given the nature of the population served by the Probation Service, we concluded that this is a group at high risk of suicidal behaviour.

Since then, another study has also looked at the prevalence of DSH in those on probation orders, although based solely on the views of probation officers alone. The results were very similar. Forty-eight per cent of those receiving a probation order with a condition of psychiatric treatment attached were viewed as being at risk of self injury. Even more surprising was that an almost identical proportion (46 per cent) of the far larger number of those with no psychiatric supervision condition were viewed to be similarly at risk.

There is no population-based or even primary care based study in this country to provide a valid comparison. However, evidence from elsewhere suggests that a 31 per cent prevalence of DSH amongst those on probation orders represents a substantial increase. Of those in US primary care, 2-6 per cent have experienced suicidal thoughts within the last year. A similar annual prevalence of DSH episodes coming to medical attention is reported by US high school students.

Common risk factors for DSH

Why should those on probation be so much at risk? The answers lie in the epidemiology of DSH, suicide and the risk of suicide after DSH. The known risk factors for DSH include unemployment, major depression, separation or divorce, previous child abuse (both physical and sexual), alcohol and drug abuse, and poor educational achievement. All of these factors are interlinked, but one theme that emerges for adolescent DSH is the absence or breakdown of parental support.

The major risk factors for suicide were recently outlined in a systematic review of the prevention of suicide. These include substance abuse, both alcohol and drugs, demographic factors (being divorced, single or separated), unemployment, mental illness and previous parasuicide.

What factors are associated with an increased risk of suicide in those with a previous history of DSH? Completed suicide is associated with substance abuse, unemployment, low social class, antisocial personality, prior criminal record and previous in-patient psychiatric treatment. The five-year all-cause mortality of DSH is 11 per cent, deaths by suicide accounting for 6 per cent, with young men once again being the most at risk. Overall between 10 and 14 per cent of people involved in DSH eventually take their own life, a risk over 100 times that of the general population.

It is clear that there is a substantial overlap between the risk factors for DSH and suicide, and those likely to be common in offender populations. A survey of 215 Probation Service clients in Dorset showed that 46 per cent of offenders supervised on statutory orders had alcohol problems, 45 per cent had prison records, 35 per cent had drug-related problems and 33 per cent had been in care as children. The West Yorkshire study of 238 offenders supervised by the Probation Service gave slightly lower rates of alcohol and substance misuse difficulties, but the proportion with a history of either being in care or custodial sentences was similar. Fifty-seven per cent were currently unemployed. Of the known risk factors for suicide only physical illness and belonging to certain professions such as farming or medicine seem to be under-represented in probation samples.

Two areas require special mention. The first is the changing age and gender pattern of suicide. In general, suicide increases with age. However, during the last two decades in this country the rate of suicide among young men has increased alarmingly to an all-time high.

A similar phenomenon has been noted elsewhere in Europe and the United States – there has been a four- and six-fold increase in suicide rates for adolescents in the United States in the last 30 years. Similar rises have been noted for DSH up to the mid-1980s, although the rates have now started to fall in many countries. Whereas the increase in DSH affected both sexes, that for suicide is restricted to males. The relevance of this to the Probation Service is clear – nearly all those receiving Supervision Orders are males under 30.

The second area is the role of antisocial behaviour. Prisoners have an estimated five-fold increase in relative risk of suicide. In our probation survey we noted that one-third of those reporting previous DSH indicated that their first episode of self harm occurred when in custody. The Swedish Conscripts Study, a record linkage study of over 50,000 young men, showed that early predictors of antisocial personality disorder, such as contact with child welfare offices or the police, were strongly associated with suicide, more so than such ‘classic’ mental disorders as depression or schizophrenia. Antisocial and criminal behaviour are also risk factors for subsequent suicide after DSH.
Why these rises have occurred is controversial. Time trend studies link the rise in youth suicide and DSH to several factors, of which the associated rise in the prevalence of drug misuse has attracted most attention. Alcohol misuse was identified in 24 per cent and drug misuse in 23 per cent of a recent ‘psychological autopsy’ study on young male suicides in Canada. Fewer than 30 per cent had been in contact with psychiatric services during the year before death. The links between drug misuse and suicidal behaviour are themselves complex – both could reflect a joint psychopathology, the availability of drugs could be linked to ease of access to methods for self harm, or substance abuse could cause psychiatric disorder. These have been discussed in greater detail elsewhere.

We also emphasize that although the United Kingdom has a rich tradition of research into DSH, without exception all studies have been based on those who attend hospital casualty departments. Research from other countries suggests that a substantial proportion, perhaps as much as 75 per cent, of DSH does not result in attendance at a casualty department. If these findings are replicated in this country it would suggest that official, hospital-based statistics significantly underestimate the size of the problem, and that much DSH is ‘hidden’ in populations such as those on probation.

Management implications

What are the implications as regards management? First, although those on probation are very likely to represent a high-risk population for DSH, it remains true that the overwhelming majority of those at risk for DSH are not on probation. Assuming a similar rate of DSH amongst the population in this country to that recorded in the United States allows one to calculate the population attributable risk fraction for DSH amongst the clients of the Probation Service – the figure is 3 per cent.

Notwithstanding the above, any steps to reduce self harm even in small populations would be welcome. The Department of Health is, as a matter of policy, committed to encouraging links between the Health Service and criminal justice system. Despite the high-risk population covered by the Probation Service, formal links between the Probation and Health Services are few – less than 2 per cent of those on probation orders have conditions of treatment attached. This may not be such a serious omission, however, as all probation officers must possess a social work qualification, something which those in the Department of Health who have the task of implementing the Health of the nation targets may find reassuring. But for how much longer? The Home Secretary has recently indicated his intention to change the nature of the Probation Service, and a social work background will no longer be obligatory. Perhaps multi-agency working has yet to penetrate Whitehall.

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References


