SAMARITANS

PILOT OF POSTVENTION SUPPORT IN PRISONS – EVALUATION REPORT

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1. Executive summary

This report presents the findings of an evaluation of specialist post-suicide support, known as "postvention", piloted by Samaritans in 15 prisons in England and Wales and funded by Her Majesty's Prison and Probation Service (HMPPS). Postvention is defined as provision of support after a suicide in order to reduce the emotional impact of suicide and to support those affected by the death (Public Health England, 2016). This intervention included four elements: specialist training for Listeners to support prisoners after a suicide, guidance for prison staff provided by postvention advisors and via support booklets, as well as support booklets for prisoners with information on self-care. The evaluation was designed and delivered by Samaritans in collaboration with Nottingham Trent University. It used qualitative and quantitative methods to assess four aims:

- the operational feasibility of the Postvention Support service in prisons
- the impact of Postvention Support on staff and Listeners' subjective readiness to respond to a suicide in prison
- the impact of Postvention Support on prisoners' perceived ability to access support after a suicide
- to consider evidence of Postvention Support's impact on prisoners' suicide risk.

Findings

- The evaluation provided evidence of partial feasibility of Postvention Support in prisons. Postvention support was deployed following seven out of the eight suicides reported to Samaritans, and key elements of the intervention (Listener support and distribution of support booklets) were implemented effectively in each of these seven cases. This was however not accompanied by a substantial shift in approach to post-suicide support among senior leadership. In particular, postvention booklet for senior staff, which recommended limiting the use of written notices to communicate the news of the death to prisoners, and normalising expressions of grief among staff (via emphasis on 'opt-in' emotional support and forums of shared learning following a suicide), was not effective at achieving these aims.
- The intervention was overall effective at preparing Listeners for supporting their peers after a suicide. The Postvention Training Module for Listeners significantly improved their perceived knowledge, skills and confidence to provide post-suicide listening support.
- The intervention was partially effective at increasing prisoners' perceived ability to access the post-suicide support. Despite half of all surveyed prisoners who received Postvention Support reporting that they grieved for the person who died, proactive listening support was only taken up by 1 in 10 prisoners. We found that stigma around expressions of vulnerability continues to prevent many from accessing support.
- A small sample size made it challenging to examine evidence of Postvention Support's impact on prisoners' perceived resilience, suicidality and self-harm incidence. Most measures showed no effect as a result of Postvention Support, with two exceptions: the intervention provided tentative evidence of modest reductions in the use of more lethal self-harming methods and modest improvements in emotional coping (i.e. ability to manage emotions, including negative ones, in difficult situations).

The report concludes with recommendations for improvement of the Postvention Support for both Samaritans and HMPPS.

2. Background

2.1. Suicide in prisons and the 'contagion' effect

The prison population in England and Wales experiences high rates of self-inflicted deaths[2] compared to suicide rates in the general population (Ministry of Justice, 2019a; ONS, 2019). 95% of people in prison are male and the latest figures published by ONS show that male prisoners are nearly 4 times more likely to take their own lives compared to men in the community (ONS, 2019). In the 12 months to December 2019, 84 prisoners died 'as a result of their own actions' – a figure that is part of a trend showing a 44% increase in the rate of self-inflicted deaths since 2012 (Ministry of Justice, 2019a). There are many reasons people in prison are more likely to die by suicide than those in the community. For a summary, see Tomaszewska et al., 2019.

One outcome of the higher rate of suicide in prisons is an "exceptionally high" rate of exposure to suicide amongst both staff and residents (Slade et al., 2019). Research suggests that seeing or hearing about a suicide in prison can significantly increase prisoners' suicide risk (Keane & McKenzie, 2010). It may also trigger or exacerbate suicidal thoughts and feelings in already vulnerable individuals and may provide a model for imitative behaviour (Cheng et al., 2014). This phenomenon, known as contagion, affects not only those who were closely linked to the deceased (i.e. family, friends), but may also affect those in close geographic proximity (e.g. cell mates, other prisoners on the residential unit) and those who may identify with the deceased along markers of social identity such as ethnicity or religion (Public Health England, 2019). Suicide contagion is not unique to the prison environment and is also observed in the general population in different settings - often related to the effect of media reporting of suicide. However, closed environments such as prisons are particularly prone to contagion, partly due to the greater chance of prisoners identifying with the deceased (Niedzwiedz et al., 2014). Indeed, a contagion effect has been observed in approximately 6% of suicides in prison and 15% of self-harm incidents in prison (Keane & McKenzie, 2010; Niedzwiedz et al., 2014).

HMPPS recognises the potential for significant distress and trauma following a suicide (PSI 02/2018) and requires prisons to support prisoners and staff affected by a suspected suicide (PSI 64/2011). This includes support for former cell-mates and those on open ACCT plans, as well as support for involved staff offered via local Care Teams[3]. It is common practice for Listeners to offer emotional support to prisoners who need it. These actions demonstrate a systemic attempt to reduce suicide risk via contagion following a self-inflicted death. Yet, this response is largely confined only to those who were considered to pose a suicide risk before the incident and omits the more indirect geographical and social effects of suicide. In addition, staff time is required to deal with essential post-suicide processes like facilitating investigations and liaising with the family (PSI 64/2011). Inadvertently, this can reduce the time staff have to support prisoners, Listeners, or each other.

2.1.1. Developing Postvention Support in prisons

Samaritans has delivered emotional support services in prisons since 1991. This has included the Listener Scheme - an award-winning peer based emotional support service, which trains prisoners,

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[2] The Ministry of Justice definition of self-inflicted deaths includes all deaths where a prisoner apparently took their own life regardless of intent, which in some cases, not all, are suicides. Throughout this report, we define suicide as any act of intentional self-harm which results in death.

[3] Care Teams are selected uniformed and ununiformed staff members trained to provide post-incident peer support, information and signposting to their colleagues.

known as Listeners, to provide confidential emotional support to other prisoners with the aim of reducing feelings of distress which might lead to thoughts of self-harm and suicide. They are supported by local Samaritans volunteers[4], whose role is to select, train and regularly meet with the Listeners in their respective prisons. This service is supplemented by Samaritans' helpline, available to prisoners for free, 24/7.

In response to the problem of suicide contagion in prisons, Samaritans partnered with Nottingham Trent University to develop a "postvention" intervention for prisons to complement existing prison post-incident procedures. Samaritans has extensive expertise and experience in developing and delivering postvention interventions in other settings, such as the "Step by Step" service in schools. Postvention is defined as an intervention after a suicide to reduce the emotional impact of suicide and to support those affected by the death. Postvention interventions have proven successful in schools, workplaces and on the railway (Andriessen, 2009), however are not yet systematically provided in prisons in England and Wales.

In order to adapt and tailor Samaritans' existing postvention model to prison settings, we conducted a systematic review of the impact of exposure to suicidal behaviour in institutional settings (Slade et al., 2019). This found strong evidence of long-term and profound mental health and wellbeing effects on a proportion of those exposed to suicidal behaviour.

For residents, there was strong evidence of a relationship between their exposure to suicide and their own suicidal behaviour, although the direction of this relationship remains unclear. The review identified a cumulative impact of exposure and/or proximity to suicide over the longer term, which was often compounded by cultural expectations of not showing emotional vulnerability.

For prison staff, the review found a consistent presence of anxiety among staff in the short, medium and long term following a suicide. There was strong evidence amongst staff of ongoing intrusive memories over many months and years, although no causally confirmed relationship to PTSD. The review identified a 'crisis of professional confidence' along with 'anxious avoidant' responses that impacted on staff's professional behaviour, compounded by cultural expectations of not showing emotional vulnerability (Barry, 2017; Slade et al., 2019).

The systematic review concluded that exposure to suicide and the subsequent negative impact on prisoners' mental health and staff's professional confidence means both are high-priority groups for post-suicide intervention. It demonstrated there is "a need for a specific and ongoing intervention with clearly defined and evidence-based structures to minimise negative outcomes [following a suicide in institutional settings]." This project aimed to deliver an intervention meeting this need within male prisons in England and Wales. The intervention was informed by a number of recommendations that arose from the systematic review:

- Prioritise support for those with greatest proximity or cumulative exposure to the suicide
- Encourage appropriate grieving and emotional expression about the death over the following weeks
- Ensure appropriate and ongoing communications and transparency around the suicide to help resolve confusion and prevent blame
- Facilitate suicide postvention peer support within clear boundaries.

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[4] Each team usually has a Branch Prison Support Officer (BPSO) who acts as a lead volunteer for the team.

Additionally, the Postvention Support was developed collaboratively with those likely to benefit from the intervention (i.e. prisoners, Listeners, Safer Custody staff). Samaritans conducted focus groups with these groups in four establishments where suicides had occurred in the 12 months before the beginning of the pilot. These consultations aimed to ensure that the intervention meets the needs of prisoners and staff, and that the intervention design and its expected outcomes were feasible. The intervention was informed by a number of recommendations that arose from the focus groups, many of which mirrored findings from the systematic review. These were:

- Sensitive and clear communication about the death
- Empathetic and compassionate responses from staff, rather than a "business as usual" approach
- Visible support on the wing where the death occurred
- Additional skills-based and role play content in the training for listeners
- Support for staff with "breaking the news" and communicating difficult information.

These recommendations were translated directly into the development of the pilot postvention intervention within the current project. Further detail on the specific recommendations that informed the intervention is provided in Appendices 1 and 2.

2.2. The postvention intervention design

The postvention intervention comprised four main components:

1) **Postvention Training Module (PTM) for Listeners,** which aimed to provide them with specific skills to support other prisoners after a suicide in prison; delivered by local Samaritans prison support volunteers in all prisons which piloted the intervention (listed in section 2.3 below). It included recognising signs that someone may be struggling, and how Listeners can look after themselves and others to manage the impact on their emotional health. PTM built on the skills Listeners develop during Listener Initial Training (LIT), though it was adapted to equip them to be more proactive, as opposed to reactive, in relation to providing emotional support to prisoners following a suicide.

2) **'Support after a suicide' booklet for prisoners**, which encourages and provides guidance on help-seeking and mutual support, as well as signposting prisoners to key sources of emotional support, including Listeners and Samaritans' helpline.

3) **Two support booklets for staff**: **'After a suspected suicide' booklet** for all prison staff and '**A Best Practice Guide'** targeted at senior prison leadership. These booklets provide practical best-practice guidance on talking about suicide, identifying those struggling to cope after a suicide (prisoners or prison staff) and tips on how to signpost to emotional support such as the Samaritans helpline or Listener scheme. Both booklets included a foreword from Deputy Director of the Safety Group at the HMPPS.
The Best Practice Guide additionally provides detailed advice on planning a suicide response. This includes:

- the importance of timely and compassionate communication about suicide, particularly its role in preventing rumours and managing confusion. To this end, the Best Practice Guide recommended that news of suicide is shared with prisoners in-person, and that the use of written notices is limited, where possible.
- the importance of visible leadership for setting the tone of the post-suicide response (e.g. by offering reassurance to staff who may feel a loss of professional confidence, normalising expressions of grief among both prisoners and staff, diffusing a tense atmosphere which may be present among prisoners).
- guidance on leading the emotional support response for prisoners (by facilitating Postvention Support from Listeners) and staff (by reminding staff of available support services including Samaritans helpline, focusing on staff who are supporting others – Family Liaison Officers, Care Team members, Heads of Safety).

4) **Bespoke postvention advice** and practical support on implementing the postvention response was offered to pilot prisons in the aftermath of a suicide, delivered by specialist members of Samaritans' Prisons Team. They were contactable 24/7 via an emergency phone line, as well as being available to attend prisons in person.

2.3. Introduction and deployment of the intervention

In order to design and implement the intervention, the Project Working Group was established in August 2018. The group met fortnightly throughout the project (to March 2020) to discuss and advise on the intervention development and design, and to monitor its implementation. It comprised of Samaritans Project Manager and Prisons Programme Manager, members of HMPPS Safety Team, two HMPPS Group Safety Leads, an Academic Advisor based at Nottingham Trent University and the Lead Researcher. The process of relationship building with prisons selected to pilot Postvention Support (as outlined below) was additionally supported by an HMPPS Implementation Manager.

The intervention was piloted in 15 prisons in the South East of England (see Table 1 for list of pilot prisons). These prisons deployed Postvention Support in the event of a suicide within the pilot period (7 months; September 2019 – March 2020). Within each pilot prison, the Samaritans Postvention Team worked with a Single Point of Contact (SPOC) appointed by each No.1 Governor to facilitate the project. The implementation of the intervention was restricted to male establishments. In doing so, we recognised the different impact of suicide on female prisoners (Fazel & Benning, 2009), as well as a considerably lower number of suicides in the female estate (Ministry of Justice, 2019b).

Table 1: Pilot Prisons that received the Postvention Support intervention after a suicide

Prison	Prison Type	Security Category
HMP Belmarsh	Local	A/High Security
HMP Woodhill	Local	A/High Security
HMP Swaleside	Training	B
HMP Elmley	Local	B/C
HMP Pentonville	Local	B
HMP Lewes	Local	B
HMP High Down	Local	B
HMP Isis	Training	C
HMP Wormwood Scrubs	Local	B
HMP Wandsworth	Local	B
HMP Brixton	Local	B
HMP Rochester	Training	C
HMP Coldingley	Training	C
HMP Standford Hill	Resettlement	D
HMP Ford	Resettlement	D

This pilot group of 15 prisons included all prisons within two Prison Groups (regions) – Kent Surrey and Sussex and London, as well as three high security and long-term group prisons. The sample size of 15 prisons was selected to strike the right balance between the time needed to introduce and embed Postvention Support to each participating prison and the need to maximise the chance of the intervention being deployed enough times to enable evaluation of its feasibility and effectiveness. Working with two prison groups also allowed Samaritans to engage with Prison Group Safety Leads who helped secure the buy-in of key staff in the participating establishments, including Heads of Safety.

The Postvention Support offer was introduced to all pilot prisons in the following ways:

1) Introductory project visits with SPOCs by Samaritans Postvention Project Manager between June and August 2019 to explain the project aims and structure and to familiarise the SPOC with elements of Postvention Support and their role in their deployment after a suicide;
2) Support booklets for staff and prisoners were posted to all pilot prisons ahead of the pilot period (September 2019)
3) 2 -hour Postvention Training Module (PTM) sessions were delivered by local Samaritans volunteer teams in all pilot prisons ahead of the pilot period. The training sessions were however not compulsory, so it is important to note that not all the active Listeners took part in the training[5].
4) Samaritans Postvention Advisors visited all pilot prisons again during the pilot period and met with SPOCs, Heads of Safety and Senior Leaders to introduce 'the Best Practice Guide' in more detail.
5) Support and Shared Learning Event was organised in October 2019, which facilitated knowledge and experience exchange between Safer Custody Teams from all pilot prisons on key elements of the postvention response (communicating the news of suicide, leadership after a suicide, supporting prisoners and staff). Staff from nine of the 15 pilot prisons attended the event.

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[5] Feedback data gathered following PTM sessions in 7 pilot prisons indicates that on average 65% of the then active Listeners took part in the postvention training.

The intervention was purposely flexible to enable prisons to deploy Postvention Support in ways which were most beneficial to their prison populations and most practicable to their regime and security arrangements. Postvention Support needs were agreed between the pilot prison SPOCs and Samaritans Postvention Team, but with decisions on deployment ultimately taken by Senior Leadership in pilot prisons. At a minimum, the Postvention Support was intended to comprise the following actions:

- The Postvention Team is notified within 24 hours of a suicide taking place and advises the prison on the deployment of Postvention Support in fitting with their contingency plan
- Listeners proactively offer support to other prisoners in line with PTM training on the residential unit where the suicide took place
- Listeners meet with Samaritans volunteers and support each other prior to supporting other prisoners
- The 'Support after a suicide' booklets are distributed to prisoners and the 'After a suspected suicide' booklets are distributed to prison staff
- Prison managers inform prisoners of the suicide and support prisoners and other staff members in line with postvention advice.

2.3.1. Postvention Support delivered within the pilot

Within the pilot period, Samaritans were notified of 8 apparent self-inflicted deaths across 5 pilot prisons, and Postvention Support was subsequently deployed in response to 7 of those incidents (more detail on this is contained in section 5).

Table 2: Number of suicides Samaritans was notified about within the pilot period

Prison	Number of suicides
HMP Belmarsh	2
HMP Elmley	1
HMP High Down	1
HMP Pentonville	3
HMP Wandsworth	1
Total	8

3. Evaluation aims and research questions

While there is some evidence to show postvention can help reduce suicide risk in institutional settings (Andriessen, 2009), the intervention described above is the first of its kind provided in prison settings. Therefore, building evaluation into the pilot was essential to assess whether the support meets the needs of those affected by suicide. This report provides the first evaluation of whether such support is feasible in the prison settings, whether it can help prison staff support prisoners at the time when they are likely to experience a 'crisis of confidence' and, perhaps most importantly, whether it can help reduce the risk of contagion after a suicide takes place. As such it adds to a small but needed evidence base on what can be done to reduce suicide risk in custody, especially when that risk is heightened through exposure to suicide.

In order to achieve the aims, four research questions were set out:

1) Can the Postvention Support be sufficiently effectively deployed for this service to be feasible?
2) To what extent is the intervention effective at preparing Listeners and staff to support prisoners following a suicide in prison?
3) To what extent is Postvention Support effective at improving prisoners' ability to access support after a suicide?
4) What evidence is there of the postvention intervention's impact on prisoners' future suicide risk (compared to post-suicide support as usual)?

The evaluation adopted a responsive design whereby data were collected after Postvention Support was deployed in response to a suicide.

Data were collected, analysed and written up by a Samaritans Researcher who was independent of but worked closely with the Postvention Project Team which designed the intervention and advised prisons on its implementation.

4. Evaluation design and methodology

4.1. Evaluation design

In order to meet the evaluation aims and to answer corresponding research questions, a mixed-method research design was adopted, collecting and analysing a range of primary and secondary data (as detailed in Table 4).

In order to understand whether Postvention Support was more or less effective than post-suicide support as usual at reducing prisoners' suicide risk (as described in section 2.1.), 9 comparator prisons were included in the study (see Table 3 below). These prisons did not receive the Postvention Support following a suicide, however some comparable primary data related to prisoners' suicide risk were collected after a suicide occurred by way of comparison. Samaritans were notified of three suicides in the comparator group (two at HMP Leicester and HMP Liverpool) during the pilot period where data were collected.

Table 3: Comparator prisons included in the evaluation

Prison	Prison Type	Security Category
HMP Manchester	Local	A
HMP Liverpool	Local	B
HMP Leicester	Local	B
HMP Nottingham	Local	B
HMP Lincoln	Local	B
HMP Gartree	Training	B
HMP Hewell	Local	B, C, D
HMP Featherstone	Training/resettlement	C
HMP Onley	Training	C

4.2. Methods

Table 4 provides an overview of the data, sample, and analyses used to answer the research questions. More information about evaluation methods is included in Appendices 3 and 4.

Table 4: Research questions and corresponding data collection methods

Research question	Data collected and samples
Can Postvention Support be sufficiently effectively deployed for this service to be feasible?	**Data collected:** descriptive monitoring data on: 1) types of incidents reported to Samaritans by pilot prisons 2) which elements of the intervention were delivered in response to each reported suicide. **From whom?** SPOCs in five prisons where Postvention Support was initiated **How does it help to address the research question?** These data provided insight into whether Postvention Team were notified of suicides in time, and whether information booklets for prisoners and staff were distributed, in line with feasibility criteria. **Data collected:** survey-based Branch Prison Support Officer (BPSO) feedback

	From whom? 5 BPSOs who supported their prisons in the implementation of Postvention Support following a suicide. **How does it help to address the research question?** These data allowed for an understanding of the extent to which Listener support was deployed, in line with feasibility criteria. **Data collected:** survey-based feedback from prisoners **From whom?** 138 prisoners in 2 prisons, housed on residential units where Postvention Support was deployed **How does it help address the research question?** These data allowed for an understanding how news of the suicide was shared with prisoners and whether this was in line with postvention advice.
To what extent was postvention advice and training effective at preparing Listeners and staff to support prisoners following a suicide in prison?	**Data collected:** survey-based PTM training feedback **From whom?** 94 Listeners who took part in PTM training in seven out of 15 pilot prisons **How does it help address the research question?** These data allowed for an understanding of the impact of PTM on Listeners' perceived knowledge, skills and confidence in supporting prisoners after a suicide. **Data collected:** qualitative data, via 3 focus groups **From whom?** Listeners in 2 prisons which implemented Postvention Support **How does it help address the research question?** These data provided insight into Listeners experience of putting knowledge and skills from the PTM into practice and gather their suggestions on how PTM can be improved. **Data collected:** qualitative data, via 3 focus groups and 4 1:1 interviews **From whom?** Prison staff in 2 prisons which implemented Postvention Support, including: Heads of Safety, Custodial Managers and officers in Safer Custody teams **How does it help address the research question?** These data provided insight into the impact of postvention advice (delivered via Best Practice Guide, postvention advisor and the 'After Suspected suicide' booklet) on staff's readiness to support prisoners and each other after a suicide.
To what extent is Postvention Support effective at improving prisoners' ability to access support after a suicide?	**Data collected:** prisoner feedback, via survey **From whom?** 138 prisoners in 2 prisons, housed on residential units where Postvention Support was deployed; and 99 prisoners 2 comparator prisons where Postvention Support was not available **How does it help address the research question?** These data provided insight into whether prisoners grieved and felt affected by the suicide, and whether they felt able to ask for support from a variety of sources, including Listeners, chaplains, prison officers. Comparison of results from pilot and comparator prisons determined whether Postvention Support affected help-seeking. **Data collected:** qualitative data, via 3 focus groups **From whom?** Prisoners in two pilot prisons, housed on residential units where Postvention Support was deployed following a suicide

	How does it help address the research question? These data provided insight into prisoners' views on the suitability of Postvention Support and reasons for accessing or not accessing it.
What evidence is there of the postvention intervention's impact on prisoners' future suicide risk (compared to post-suicide support as usual)?	**Data collected:** psychometric data on suicidality and coping appraisals, via survey **From whom?** 138 prisoners in two pilot prisons where Postvention Support was deployed following a suicide[6]. 99 prisoners in two comparator prisons where Postvention Support was not available. The questionnaires in both prison types targeted prisoners who were housed on the same wing as the deceased prisoner at the time of death. **How does it help address the research question?** These questionnaires assessed prisoners' suicidality (suicidal thoughts/plans) and perceived ability to cope after a suicide. Questionnaires were administered at two timepoints: 1) within seven days of each suicide and 2) within 4 – 6 weeks of the respective suicide, in both prison types, to assess whether the intervention affected suicidality and perceived ability to cope, over time. **Data collected:** secondary data on self-harming incidents and methods obtained from C-NOMIS **From whom?** 138 prisoners in two pilot prisons where Postvention Support was deployed following a suicide. 99 prisoners in two comparator prisons where Postvention Support was not available. Data in both prison types were collected in relation to prisoners who were housed on the same wing as the deceased prisoner at the time of death, and were collected at the same two time points as the psychometric data. In addition, descriptive statistical data were obtained on the number of self-harm incidents and self-harming methods at both timepoints within the above four prisons. **How does it help address the research question?** This assessed the differences in self-harming incidence and methods between both prison types over time, allowing to see if the intervention can reduce the frequency of self-harm and lethality of methods used to self-harm.

Thematic analyses of focus group and interview data and *descriptive analyses* of survey and monitoring data provided insight into feasibility of Postvention Support and its effect on 1) subjective preparedness to provide post-suicide support among Listeners and prison staff, and 2) perceived ability of prisoners to access support.

Longitudinal analyses of prisoner survey data allowed for the exploration of the effect of Postvention Support on suicide risk over time, compared to post-suicide support as usual. Where data were insufficient for analysis, descriptive statistics are also provided. More detail on data analysis methods can be found in Appendix 4.

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[6] Psychometric questionnaires and prisoner attitudes surveys were administered together as one survey package within both pilot and comparator prisons. On average, nearly a third of prisoners housed in residential units where these data were collected returned valid surveys.

4.2.1. Limitations

There were two chief methodological limitations related to this evaluation, which impacted the results and the conclusions:

1) The feasibility of Postvention Support was evaluated in local establishments only, most of which were Category B prisons (see Table 2), as suicides only occurred in these prisons during the pilot period. This means that findings on the feasibility of the pilot may not be directly generalisable to establishments of other types and security categories.

2) Data on the effect of the intervention on suicide risk, prisoners' perceived ability to access support and staff readiness to provide support were only collected following 3 out of 7 suicides where Postvention Support was deployed. This was due to the time-intensive nature of data collection, which was carried out by one researcher. It should also be noted that the abovementioned 3 suicides occurred within 2 pilot establishments. This means generalisability of findings based on these is limited. This limitation is noted, where applicable, throughout the discussion of findings below.

5. Findings and discussion

This section provides a discussion of the findings in relation to the key research questions outlined in section 3, to provide insight into the feasibility and effectiveness of the Postvention Support.

5.1. Research Question 1: Can the Postvention Support be sufficiently effectively deployed for this service to be feasible?

5.1.1. Was the postvention team notified of suicides within 24 hours?

The Postvention Team was only notified of a suicide within 24 hours in one out of the eight cases. Notification took place within 48 hours in five out of the eight cases, and in two further cases within 72 hours of the suicide. The 24 hour target was therefore not met in the majority of cases, and monitoring data indicates that reasons for this were largely operational (e.g. absence of Single Points of Contact, staff shortages). Part of the emotional impact of suicide is likely to occur immediately after exposure (Public Health England, 2016), so swift notification from the pilot establishments is essential. Timely notification and good communication is also essential to ensure timely implementation of Postvention Support.

Following the notification process, Postvention Support was initiated in response to seven out of eight suicides of which Samaritans Postvention Team were notified during the pilot period. In one case, Postvention Support was not deployed at all as the Postvention Team were unable to contact the Single Point of Contact and the Safer Custody team. In the future, the intervention would benefit from including the notification process as a fixed part of prisons' death in custody contingency plans.

5.1.2. Did Listeners provide proactive support to other prisoners? Were they supported by local Samaritans volunteer teams in doing so?

Listener support was a key part of the postvention response and it was deployed following all seven suicides where Postvention Support was made available. BPSO feedback confirmed that Listeners provided support on all residential units where the suicide took place within 48 hours. In two cases Listener support was provided within 24 hours. Similarly, BPSOs were able to visit their prison and meet with Listeners before listening support was offered on every occasion – in all cases this took place within 48 hours of each suicide. This means that Listener support was successfully deployed, in line with Samaritans postvention guidance.

The postvention guidance states that support should be prioritised for those who have likely known and lived alongside the prisoner who passed away. However, some affected prisoners may live in other parts of the prison. Listener support was much less readily available throughout the rest of the prison, with two-thirds (65%) of the BPSOs reporting that the Listeners were not able to offer Postvention Support on other residential units. Where provided, this support usually took place more than 48 hours after the death, but within a week. Future developments to Postvention Support should consider widening out access to Listener Support to residents who were socially close to the deceased prisoner or may have closely identified with them, but are housed in other parts of the prison.

5.1.3. Were "Support after a suicide" booklets distributed to prisoners?

'Support after a suicide' booklets were distributed in all 7 instances where Postvention Support was deployed. In 6 of those cases booklets were handed out to prisoners on the residential unit where the suicide took place, in line with project feasibility criteria set out in section 2.3.

This was however not the case in one instance, where the suicide took place in a healthcare unit. This was due to concerns prison staff had about the appropriateness of the booklets for prisoners with significant mental health vulnerabilities, with one-to-one support offered by Healthcare staff deemed more appropriate. 'Support after a suicide' booklets were instead handed out to prisoners on an alternative residential unit, selected by the Safer Custody Custodial Manager, where prisoners who were socially close to the deceased prisoner resided.

While the monitoring data demonstrates the deployment of postvention booklets as overwhelmingly feasible, cases such as this raise questions about the suitability of postvention resources for prisoners considered vulnerable (e.g. those with serious mental health conditions, especially when housed in healthcare units; and prisoners with serious learning disabilities such as those housed on a Therapeutic Community+ unit at HMP Gartree).

In another case, the suicide took place following a period of hospitalisation in excess of 10 days. The postvention response was deployed after the death was officially confirmed to prisoners, by this point prisoners had heard about the event through rumours. As a result, one officer stated, "*it ['Support after a suicide' booklet] was thrown back in our face*" and considered as given "*too late*". This incident challenged the premise of "immediate" support. While Postvention Support was technically provided on time and in line with the pilot's expectations, this did not reflect the reality of prisoners' need for support before this point. Prison staff recognised that prisoners' wellbeing was potentially affected before the point of death, yet were hesitant to offer prisoners, at this point in time, support resources which explicitly referenced suicide.

Latest MoJ data for 2019 shows that self-harm in prison is at record levels, and that 5.6% (3,214) of self-harm incidents in 2018 were serious enough to require hospitalisation (Ministry of Justice, 2019b). It is important that future postvention resources include clear guidance to staff on how to respond after incidents of serious and potentially fatal or life-changing self-harm.

5.1.4. Did staff inform prisoners about the suicide safely and sensitively?

The Postvention Support did not lead to staff in pilot prisons communicating news of a suicide in a more sensitive way. In fact, prisoners in comparator prisons reported they were almost twice as likely to be informed of a suicide in-person compared to those where Postvention Support was available (22% vs 12%). Written notices were the most common form of communication in both pilot and comparator prisons, with over half (55%) of prisoners in pilot prisons being told in this way.

It is important to note however that this data was only collected from prisoners following 5 suicides (3 in pilot prisons and 2 in comparator prisons), so this finding may reflect communication cultures in individual prisons more than the impact of postvention advice. Nonetheless, future Postvention Support should include more in-depth work with Senior Leadership Teams to explore approaches to limiting the use of written notices as a standard way of informing prisoners of a self-inflicted death.

5.1.5 Were "After a suspected suicide" booklets distributed to staff?

The 'After a suspected suicide' information booklet for staff was distributed following all 7 suicides where Postvention Support was deployed. This was done both by handing the booklets directly to staff members, as well as making them available in key strategic areas frequently attended by prison staff (e.g. wing offices, staff locker rooms). In two out of the seven cases, the booklets were handed out within 24 hours of the suicide and in four cases within 48 hours. In one case the booklets were made available more than 72 hours after the death and this was due to absence of the Single Point of Contact. This case further stresses the importance of making the deployment of Postvention Support less dependent on particular staff members and more a clear element of prisons' death in custody action plan, as highlighted in section 5.1.1.

5.2. Research Question 2: Did postvention advice and training prepare staff and Listeners to support prisoners and themselves following a suicide?

5.2.1. Staff

Does the 'Best practice guide' prepare prison managers to respond to a suicide?[7]

All interviewed managers described the Best Practice Guide as a useful source of guidance on supporting prisoners after a suicide. In particular, they reported that it deepened their appreciation of the role of listening support in reducing emotional distress after a suicide and made them more likely to deploy Listener support as a result. It was also clear however, that this was linked to a reliance on the BPSOs to coordinate this support:

> "The main thing from it [the Best Practice Guide] was how important the Listeners are and we've been in touch with Barry[8] (BPSO) and you know, making sure they can get out and about and offer support".

While a closer working relationship with the BPSOs can have benefits for the quality and the reach of the Postvention Support for prisoners, this can place a disproportionate burden on Samaritans volunteers. While Samaritans branches support prisons the best they can, there may be instances where volunteer time is limited and overreliance on BPSOs may limit the effectiveness of the postvention response. It is important that future postvention guidance for senior staff stresses the role of prison staff working alongside the BPSOs to facilitate Listener support after a suicide.

The Best Practice Guide also improved the preparedness of senior staff to support their staff after a suicide. They reported that advice from the guide made them more aware of the emotional burden staff experience while responding to a suicide, however also admitted that identifying staff who may be struggling, beyond those obviously distressed, remained a challenge. Many linked this to a culture of bravado present among uniformed prison staff, which can stigmatise expressions of emotional vulnerability while on duty (Barry, 2017). Senior staff saw the guide as a useful reminder to signpost their staff to sources of emotional support beyond the Care Team, such as Samaritans' helpline. While 3 out of 5 interviewed senior staff members reported signposting their staff to Samaritans shortly after the suicides, they agreed that there was a need to promote it further in a systematic and sensitive way.

> "I mean, I've been doing this for, what, 16 years, and I've always been led to believe that it's [Samaritans] for prisoners only, same as IMB [Independent Monitoring Board]. I was really pleasantly surprised when I found out that there was the option of staff using the Samaritans. I think maybe there's some work we can do about raising staff awareness of what the Samaritans do, who you are, the fact that you're volunteers and the fact that you're there for anyone at any time whether you're at work, whether you're at home and you want to pick up the phone."

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[7] These findings are reflective of the impact of postvention advice in two of the pilot prisons where staff focus group data were collected. The findings therefore may not necessarily be generalisable to the other three prisons which deployed Postvention Support after a suicide within the pilot period.
[8] All names in this report have been changed.

At the same time however, evidence of impact of the postvention guidance on managers' readiness to support staff via visible leadership was mixed. The interviewed managers agreed that the Best Practice Guide was instrumental in raising their awareness about the negative impact of suicide on staff's professional confidence. Immediately after the apparent self-inflicted deaths, they described making themselves visible to Safer Custody staff, made sure that staff debriefs were held, and took an active role in ensuring that emotional support for staff was available on an opt-in basis (e.g. through the Care Team, counselling via PAM Assist). This however, did not go hand in hand with deeper systematic actions to normalise expressions of grief or to challenge the culture of bravado, which they described as deterring many staff from seeking support. This could be most clearly seen in continued emphasis on the 'opt-in' nature of support provided to staff, including those who are involved in supporting others (Family Liaison Officers, Care Team members), and limited effort to boost professional confidence among staff to respond to future suicides, e.g. via forums which facilitate collective learning from past responses to suicide.

> "We have the Care Team and they can obviously access PAM Assist. But you know, it's true, I don't think generally we're very good at that emotional intelligence… in other professions people are better at recognising actually, I'm getting really stressed and I can't cope with this. Whereas we just keep banging on and banging on and banging on until it's too late. You know there is the hot and cold debrief after a death in custody, but clearly there is much more we could do. We have been thinking about, you know, having like a staff wellbeing day, it actually makes sense. I think the group sessions on training days, they'd help to make Postvention Support not so out of the blue, so that support and those conversations about, you know, educating yourself emotionally, are more ongoing, not only when someone does die."

The managers cited time and staffing constraints as the main reasons why the above reflections were not implemented in response to the recent suicides. It is also worth noting that visits from the Postvention Project Team, which aimed to advise senior leadership on implementation of the best practice guidance within their own establishments, did not take place until after the deaths occurred in both prisons where senior staff were interviewed. Experiences of managers in both prisons underline that best practice guidance is unlikely to be fully effective if delivered in isolation from meetings with the Postvention Project Manager/Postvention Advisors. It is vital that such meetings continue, and that wellbeing support for staff after a suicide as well as encouraging help-seeking behaviour become key topics of these meetings. It is also important that any subsequent changes to practice are reflected in the local contingency planning, to ensure that all learning is operationalised in the event of future suicides.

Does the 'After a suspected suicide' booklet prepare prison staff to respond to a suicide?

Postvention advice was least effective when distributed via 'After a suspected suicide' booklets. Despite the booklet being widely available, most interviewed staff reported that they did not read it. This form of postvention advice therefore had little effect on staff preparedness to seek or offer Postvention Support.

> *"Visits got theirs [booklets], Reception got theirs, so it literally went everywhere. The management, managers got theirs, that all went really smoothly and really fast but that's because it's all fresh in our minds isn't it?*
>
> Facilitator*: "But did you use it yourself?"*
>
> *"I didn't really go through the booklets as such."*
>
> *"I've not read, no, we did flick through it."*

Future developments of Postvention Support should explore alternative approaches to providing staff with information immediately following a suicide. When asked why the booklet was not used, the interviewed staff overwhelmingly pointed to the importance of practicality. One staff member mentioned for example: *"They probably could have been smaller, something you can carry with you, sort of thing".* Postvention Project Team developed pocket-size versions of this booklet during the pilot period in response to staff feedback, but the late development meant they were not evaluated. Future versions of the Postvention Support should incorporate these adapted booklets and test whether they are more effective at preparing staff.

Are prison staff able to engage with the postvention advisor?

Bespoke postvention advice provided to managers throughout the pilot period was one of the key elements of the Postvention Support. Our data show that this advice was used by both senior and junior Safer Custody staff, mostly in the days following a suicide. Among 4 interviewed staff members who spoke to the postvention advisor, they reported a significant positive impact on their sense of preparedness to support prisoners and themselves. The advice appeared to serve 2 key purposes:

- A source of practical information on the implementation of different elements of Postvention Support, especially where its deployment was delegated to a Safer Custody staff member less familiar with the project and where it was not included in the prison's contingency plan.

> *"I don't think it would have been as smooth… Because we had spoken to Natalie[9] [the Postvention Advisor], we knew what to do, when to do it, who needed it, it was organised, we had everything here, didn't we?"*

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[9] All names in this report have been changed.

> *"It was brilliant, you know, that it's there if you need it. If not for that I really wouldn't have known what I was doing with the Listeners and everything else. So in terms of making you feel prepared, great."*

- An empathetic space to discuss stresses related to implementation of the death in custody contingency plan and the emotional burden of a wider post-suicide response in prison.

> *"They seemed interested in how things were… how you're coping and so on… and you know you can never be ready for something like that and every one [death] is different, but you still have to tell the family, get all the paperwork together. You don't think [about] how you're coping with it all, so it's nice when someone actually asks."*

This demonstrates the benefit of direct emotional support to prison staff, even for those who do not actively seek it. In the context of persistent stigma around emotional expression, this finding highlights the vital role postvention advice can play as a source of both emotional support and practical advice, in a way that was not achieved via postvention booklets. However, emotional support was not originally envisaged as a core part of the postvention adviser's role. It is therefore important that proactive telephone emotional support to affected staff becomes a more prominent element of future Postvention Support offer.

5.2.2. Listeners

Has the Postvention Training Module increased Listeners' knowledge of how to support prisoners after a suicide?

The Postvention Training Module was highly effective at increasing Listeners' knowledge of how to provide Postvention Support after a suicide. Overall, 88% of trained Listeners agreed or strongly agreed that during the training sessions they have learnt things they did not know about supporting prisoners after a suicide. The effectiveness of PTM at increasing Listeners' knowledge was measured across 4 areas, each presented below:

- 98% agreed or strongly agreed that the training provided them with understanding of different feelings people may experience after a suicide;
- 97% agreed or strongly agreed that "I understand how I can help myself after a suicide in prison"
- 93% agreed or strongly agreed that "I understand how I can support others as a Listener after a suicide in prison"
- 93% agreed or strongly agreed that the training helped them develop awareness of the processes prisons go through after a suicide.

The effectiveness of the training module was reflected in findings from 2 focus groups with Listeners (from HMP Pentonville and HMP Belmarsh) who delivered Postvention Support. Most agreed that the training's content about different emotional reactions after a suicide had enabled them to quickly identify and offer support to prisoners who may be affected, particularly prioritising former cell mates and those who were close to the deceased:

> *"Remember, there was one that was really struggling. And we had to calm him down. We didn't even calm him down, we let him vent it."*

> *"Knowing that people react in different ways really helped because the guy he shared the cell with… you'd never know by his reaction."*

There were however 7% (8) of respondents, most of whom served as Listeners for 3 years or longer, who did not feel the training had taught them things they did not already know about supporting prisoners after a suicide. This may reflect the high level of practical experience and confidence in their skills Listeners develop over time, which means they are more likely to have already supported prisoners in a variety of circumstances, including after a suicide. One Listener remarked:

> *"Having been a listener for nearly 5 years and having experienced a death in custody, I didn't learn anything I didn't already know".*

The trained Listeners comprised a relatively inexperienced cohort - 65% of them had served as a Listener less than a year, and 19% had 3 or more years of listening experience. Future training sessions should take account of the varying service length and levels of listening experience Listeners may have. In particular, there is an opportunity to make the training material more relevant to the long-term serving Listeners, drawing on their experience while developing new skills and knowledge. This may for example involve more advanced role play scenarios which require nuanced judgments about caller wellbeing and confidentiality.

Has the Postvention Training Module increased Listeners' confidence to support prisoners after a suicide?

Nearly 70% reported that they have never provided emotional support after a suicide, and feedback provided by Listeners shows that postvention training was highly effective at increasing their confidence in supporting themselves and others following a suicide. This effectiveness was measured across 2 areas, each presented below:

- 98% of postvention trained Listeners reported they felt clear about their role as a Listener following a suicide after the training;
- 93% agreed or strongly agreed that "This training session has prepared me to be a Listener after a suicide in prison".

Similar findings were reflected in the focus group data from HMPs Pentonville and Belmarsh.

More frequent and timely delivery of the Postvention Training Module would have improved Listener confidence further. Listener focus group data revealed that number of postvention-trained Listeners had reduced after the postvention training was completed, mainly because of prison transfers. While postvention training was provided to new Listeners during the next six-monthly Listener Initial Training (LIT) course, the interviewed Listeners worried that at times there may not be a sufficient number of postvention-trained Listeners in between postvention training sessions to provide adequate listening support in the event of a suicide. It is therefore important that the Postvention Training Module becomes a fixed element of the LIT, and that frequency and timing of future training sessions reflect the pace of Listener turnover. This is particularly important in local prisons, where prisoner churn is high, as is suicide risk (Tomaszewska et al., 2019).

5.3. Research Question 3: Did Postvention Support improve prisoners' awareness of the available support and perceived ability to access it?

5.3.1. Were prisoners aware of the available support and how to access it?

The majority of interviewed prisoners reported frequently seeing Listeners on their wing after the suicide and being aware of Postvention Support. The Postvention Support also appeared to increase prisoners' awareness and familiarity with existing emotional support services, notably Samaritans' helpline. Many prisoners found the "Support after a suicide" booklet a useful way of signposting and explaining these services. Within the prisoner attitudes survey, 62% respondents reported reading the booklet and the majority (57%) found it helpful.

> *"Yeah, like, in that way it's good. Even if you don't speak to someone there and then, if you read the leaflet it does say, if you need help go and ask for it."*

These data suggest that Postvention Support had a noticeable effect in raising prisoners' awareness of how to access support, if needed. However, some prisoners still expressed uncertainty about how to access Samaritans' helpline – *"apparently there's a number that works on everyone's PIN, but I don't know what that number is"* – so there is an opportunity to improve signposting further.

5.3.2 How likely were prisoners to access support after a suicide?

Prisoners in pilot and comparator prisons were equally as likely to be affected by the suicide and as many as half of the surveyed prisoners in both regions reported that they grieved for the person who died. Despite high levels of reported grief and high awareness of support among prisoners, the intervention did not increase prisoners' likelihood to access or ask for support after a suicide. While the number of prisoners who wanted support after the recent death was similar in both pilot and comparator prisons, prisoners in pilot prisons were on average half as likely to report that they asked for any support after the suicide (see Appendix 6 for full data).

Prisoners in both regions were most likely to ask for support from healthcare (pilot 16%; comparator 33%), Chaplain (pilot 14%; comparator 25%) and an officer (pilot 12%; comparator 15%)[10]. The 'take up' of the proactive offers of Listener support was low, with less than 5% of prisoners in both regions reporting having done so after the recent suicide. There was a strong sense that '*you don't talk to other prisoners about your problems*', even when prisoners acknowledged the impact the suicide had on their mental health and the benefits that peer support might have had in terms of helping reduce distress and confusion following the suicide. This meant that many would not take up the support offered by Listeners, especially in the presence of other prisoners.

> *"People have problems, like, problems like this. Everyone in here can have problems, they just, kind of, that gets pushed to the back and forget about it. Why is this any different after someone kills themselves?"*

> *"I've got an issue, I'm stressed, this has happened. Outside, I just, I would turn to someone that I talk to. I don't have anyone here, I still wouldn't go to a Listener. I'll just keep it inside."*

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[10] More detailed data on types of support offered to and requested by prisoners is included in Appendix 6.

Among those who spoke to a Listener, taking up a direct offer of peer support was often about getting "*out of the cell and having a chat*" with someone who could empathise with the pains of an extended lockdown and the confusion felt on the landings. It is in this context that proactive listening support was considered most useful:

> *"I'm not going to lie, they've [Listeners] helped me before. I've been in my cell, I just-, literally the difference between getting out of my way and not going out of my way gives half an hour out of my cell. And it's good to talk, even about, you know, what's going on"*

Framing the support in these terms appeared to be more acceptable to prisoners, rather than in times of crisis or struggling to cope. Previous research on the effectiveness of the Listener Scheme highlights that lack of intention to access support from the Listeners is higher among those who have never accessed the Listener Scheme, while prisoners who have spoken to the Listeners before are more likely to speak to them again in the future (Scowcroft et al., 2018). For Postvention Support to be effective at improving prisoners' access to support after a suicide, greater consideration needs to be given to the effect of stigma and 'non-user' perceptions of the Listener Scheme.

5.4. Research Question 4: What was the impact of Postvention Support on suicide risk and ability to cope?

5.4.1. Were prisoners' appraisals of their ability to cope improved as a result of Postvention Support?

Prisoners' appraisals of their ability to cope were measured using three psychometric subscales: Social Support (e.g. feeling that they have friends or family they could turn to for support), Emotional Coping (e.g. ability to control or manage negative emotions) and Situational Coping (e.g. problem-solving). Responses in each scale were rated on a 5-point scale from 'strongly disagree' (1) to 'strongly agree' (5).

Table 5: Resilience Appraisals Scale (Johnson, Gooding, Wood, & Tarrier, 2010)

Emotional coping	Social support	Situational coping
• *In difficult situations, I can manage my emotions* • *I can put up with my negative emotions* • *I can control my emotions* • *I can handle my emotions*	• *If I were to have problems, I have people I could turn to* • *My family or friends are very supportive of me* • *If I were in trouble, I know of others who would be able to help me* • *I could find family of friends who listen to me if I needed them to*	• *When faced with a problem I can usually find a solution* • *I can generally solve problems that I face* • *I can usually find a way of overcoming problems* • *If faced with a set-back, I could probably find a way round the problem*

In order to assess the impact of Postvention Support on prisoners' appraisals of their ability to cope, changes in answering patterns to questions in the above subscales over time among prisoners who received Postvention Support were compared to changes in answering patterns among prisoners who did not receive it.

Emotional coping

The results suggest a positive, if weak, impact of Postvention Support on emotional coping. Prisoners in both pilot and comparator prisons appraised their emotional coping more positively when asked about it a month after a suicide compared to when they were asked about it within 7 days of the suicide. However, this increase was more pronounced in prisons where Postvention Support was available, with the mean increasing by around 0.1 in comparator prisons but by 0.2 (out of 5) in prisons which received Postvention Support. Prisoners in pilot prisons demonstrated odds of 40.18 (95% credible interval: 0.18 - 28051.75)[11] that they would report improved emotional coping

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[11] Odds ratios are a measure of association between the predictor variable (prison location) and the outcome variable (in this case social support). We would expect an odds ratio of 1 if the location of the prison does not have a meaningful effect on the outcome variable. Therefore, if the credible interval contains the odds ratio of 1 we could conclude that there is insufficient evidence of a difference between locations. The small sample size means we would expect wide credible intervals in the results.

post-intervention and a probability of 87.4%[12] that this was linked to availability of Postvention Support. This probability was the highest of all coping appraisal measures and, although still below the conventional 95% benchmark for concluding evidence for an effect, suggests a *possible* link between the availability of Postvention Support and improved self-reported ability to control and manage emotions.

Social support

There was, at best, weak evidence to suggest that the Postvention Support had a positive impact on prisoners' ability to cope after a suicide by feeling they had friends or family they could turn to for support. Prisoners' ability to cope after a suicide by drawing on social support was similar in pilot and comparator prisons, with mean scores increasing by around 0.2 (out of 5) in both groups. Prisoners in pilot prisons had odds of 13.4 (95% credible interval: 0.05 - 7178.01) that they would report greater social support-related resilience.

This means that prisoners in prisons which piloted Postvention Support were more likely to positively appraise their ability to cope by drawing on social support in comparison to prisoners who did not receive Postvention Support. Analysis also showed a 77.3% chance that this can be attributed to presence of Postvention Support (the lowest of all included resilience appraisal measures). This is below the 95% benchmark, and as such there is insufficient evidence to conclude that the Postvention Support contributed to prisoners' improved social coping.

Situational coping

As with prisoners' appraisal of social support, there is, at best, weak evidence to suggest that the Postvention Support improved prisoners' situational coping. Prisoners in pilot prisons had odds of 11.12 (95% credible interval: 0.11 - 1613.67) that they would report improved situational coping in comparison to prisoners in comparator prisons, with a probability of 81.9% that the Postvention Support increased scores. This suggests that prisoners where Postvention Support was deployed were more likely to positively appraise their ability to cope through problem-solving, compared to prisoners who did not receive Postvention Support. However, probability of 81.9% is below the 95% benchmark, so there is insufficient evidence to conclude that the Postvention Support contributed to prisoners' improved situational coping.

Coping appraisals summary

Overall, there was insufficient evidence to confirm the Postvention Support improved overall resilience and coping among those prisoners who received it. Our findings do not suggest any substantial change in social support or situational coping, but indicate that Postvention Support had a slight positive impact on emotional coping – prisoners' self-reported ability to control and manage their emotions. This is not unexpected as social support and situational coping are not direct aims of

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[12] This percentage compares the probability that the intervention has a positive effect to the probability that it has a negative effect. If there were no evidence for a positive intervention there would therefore be a 50% chance that it had a positive effect while percentages over 90% can be considered moderate evidence and over 95% strong evidence for a positive effect.

the Postvention Support or the Listener Scheme. Conversely, supporting prisoners' emotional management was one of the intervention's aims and the evidence suggests this is where the strongest impact may be found.

5.4.2. Was prisoner's self-reported suicide risk reduced as a result of Postvention Support?

The impact of Postvention Support on prisoners' suicide risk was assessed using two psychometric subscales: cognitive suicide indicator (which focuses on the personal beliefs around suicide that an individual may hold) and current ideation indicator (which focuses on current thoughts to harm oneself or take one's life). The below table presents questions included in both subscales:

Table 6: Current Suicidal Indicator and Cognitive Suicidal Indicator subscales (Mills & Kroner, 2003)

Cognitive suicide indicator (attitude towards suicide)	Current ideation indicator (current suicidality)
• *'Suicide is an option for me'* • *'If circumstances get too bad, suicide is always an option for me'*	• *'I have recently had thoughts of hurting myself'* • *'Life is not worth living'* • *'I have a plan to hurt myself'.*

In order to assess the impact of Postvention Support on suicidality, changes in answering patterns to the above questions over time among prisoners who received Postvention Support were compared to changes in answering patterns among prisoners who did not receive it.

Attitude towards suicide

Our results show that within 7 days of a suicide taking place, 21% of prisoners surveyed in pilot prisons answered 'true' to at least one cognitive suicide indicator question, compared to 28% in comparator prisons. One month after the suicides, reported cognitive suicidality decreased by 2% in both pilot and comparator prisons. This suggests that prisoners are less likely to consider suicide an option as time passes since the suicide, regardless whether they have received Postvention Support or not.

Prisoners who received the Postvention Support had 0.06 odds (95% credible interval: 0 - 34.6) of responding 'true' to the cognitive suicide indicator questions, compared to prisoners in comparator prisons. This means that prisoners who received Postvention Support were less likely to consider suicide as an option, compared to prisoners who did not receive Postvention Support. Evidence also showed a 79.9% probability that Postvention Support reduced the likelihood of prisoners considering suicide as an option. However, this is below the 95% benchmark, so there is insufficient evidence to conclude that Postvention Support reduced cognitive suicidality.

Current suicidality

Similar results were found regarding current suicidality. Within 7 days of a suicide taking place, 15% of prisoners surveyed in pilot prisons reported current thoughts of suicide or self-harm, compared to 10% in comparator prisons. These levels of reported current suicidality decreased by 2% in both pilot and comparator prisons, when prisoners were surveyed one month later. This indicates that prisoners are less likely to have suicidal thoughts as time passes since the suicide, irrespective of whether they have received Postvention Support or not.

However, prisoners who received Postvention Support were less likely to report current suicidality than prisoners who did not receive it, as they had 0.04 (95% credible interval: 0 - 10.59) odds of responding to the current suicidality questions with 'true' compared to prisoners in the comparator prisons. Evidence also showed a 84% probability that Postvention Support contributed to this. Although below the conventional benchmark of 95%, this suggests a *possible* link between the reduction in current suicidality in pilot prisons and the availability of Postvention Support.

Suicide risk summary

Overall, the above evidence is insufficient to confirm that Postvention Support reduced suicide risk among prisoners who received it. Our findings do not show any significant change in prisoners' attitude towards suicide (whether they consider suicide as an option). However, our findings also indicate the Postvention Support helped reduce current suicidality among prisoners who received it, although this effect is modest.

5.4.3. Was likelihood of self-harm reduced as a result of Postvention Support?

We assessed whether postvention support had any effect on self-harming behaviour on the wing where Postvention Support was deployed by comparing self-harm behaviour in the 4 weeks before the suicide (pre-suicide) and the 4 weeks following (post-suicide). There were a total of 26 self-harm episodes in the pre-suicide period and 16 in the post-suicide period among prisoners who resided on the same wing as the deceased prisoner across both prison types. Data collected from C-NOMIS suggests that, regardless of availability of Postvention Support, prisoners were less likely to self-harm 4 weeks after the suicide compared to 4 weeks before suicide.

On the wing where the suicide occurred, self-harm incidents in pilot prisons reduced by 1 incident from pre- to post-suicide (from 6 to 5 incidents by 2 individuals). In comparator prisons the self-harm incidents reduced by 9 incidents from pre- to post- suicide (from 20 incidents (by 4 individuals) to 11 incidents (with a slight rise to 5 individuals)[13]. As presented in the Table 5 below, this reduction was reflective of a broader decrease in self-harm incidence in both prison types as a whole. There was an average fall of 28% in the number of self-harm incidents from pre- to post-suicide periods across both pilot and comparator prisons. However, the overall number of individual self-harm incidents

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[13] It should be noted that the figures in the comparison group figures are dominated by one individual with a high number (8) of aggravating wound incidents in the pre-suicide period but with zero in the post-suicide period.

was too small to undertake detailed analysis. This means there was insufficient evidence to conclude whether Postvention Support helped reduce the number of self-harm incidents in pilot prisons.

Table 7: Changes in self-harm incidents over time in pilot and comparator prisons

	Postvention			Comparator		
	Pre suicide	*Post suicide*		*Pre suicide*	*Post suicide*	
Individuals	65	60	-8%	34	34	0%
Incidents	160	116	-28%	106	71	-33%
Incidents / Individual	2.46	1.93	-21%	3.12	2.09	-33%

Some small differences were noted between pilot and comparator prisons in the pattern of self-harm method. Where Postvention Support was deployed, there was a slight reduction in ligature use (from 1 to zero) and a concurrent rise in use of ligatures in the comparator sample (from 1 to 3). This suggests that Postvention Support may have a positive effect on self-harming behaviour by reducing the use of methods which are most likely to result in a completed suicide (ligature), but given the small sample of self-harm incidents available, these results cannot be generalised. Further research with a larger, more robust sample is needed to confirm this novel hypothesis that Postvention Support may decrease lethality of self-harming behaviour.

6. Conclusion

This postvention pilot aimed to support HMPPS efforts to reduce suicide risk following a suicide in custody by introducing timely and targeted Postvention Support to three key groups: 1) prisoners, by offering proactive support and signposting to support services, 2) Listeners, by providing specialist training on Postvention Support, and 3) prison staff and prison managers by offering targeted advice and guidance.

Immediately following a suicide, distribution of support booklets and proactive Listener support were effectively deployed in seven out of eight cases of suicide reported to Samaritans Postvention Project Team. This support can be deployed fairly swiftly (within 48 hours of a suicide taking place), but that timeliness remained dependent on availability and cooperation of Single Points of Contact. Key prison staff absence was the main factor underpinning delays in notifying the Postvention Advisors and subsequent deployment of Postvention Support.

However, this was not accompanied by a shift in approach among prison managers, particularly when dealing with prisoners themselves. We found that written notices remained the most common form of communication and prisoners in comparator prisons were almost twice as likely to be informed of a suicide face-to-face compared to those where Postvention Support was available. Overall, postvention advice made prison managers more sensitive to the impact of suicide on staff and more likely to signpost staff to existing channels of emotional support. However, key guidance from the Best Practice Guide, which aimed to normalise emotional expression among staff, was not operationalised.

Similarly, perceived ability to access support among junior prison staff was not improved via 'After a suspected suicide' information booklets. While findings show that these booklets were made widely available immediately following a suicide, many staff did not read them. Instead, telephone advice provided by Postvention Advisors was used by some staff as a source of emotional support, despite having been originally designed primarily for the purpose of practical support on the implementation of Postvention Support.

The Postvention Training Module effectively improved Listeners' perceived knowledge, skills and confidence to support other prisoners and themselves after a suicide. In particular, increased awareness of different emotions people experience after a suicide gained during the training enabled Listeners to implement Postvention Support effectively, by identifying and offering support to those directly exposed to suicide (i.e. cell mates) and those likely to be particularly distressed by it (friends).

However, our findings suggest that the intervention was less effective at increasing prisoners' subjective ability to access support after a suicide. Despite similar numbers across pilot and comparator prisons reporting grieving for the person who died, prisoners who received Postvention Support were no more likely to ask for support and there was limited take up of the proactive support offered by Listeners. Stigma which inhibits expressions of emotional vulnerability between prisoners will need to be addressed within future Postvention Support, if Postvention Support is to be effective in increasing prisoners' access to support.

Although there is insufficient evidence to suggest a definite effect of Postvention Support, our data suggest that it did, on balance of probabilities, have a positive effect on emotional coping and current suicidality. Across all prisons, a reduction in suicidality and improvement in perceived coping occurs naturally in the weeks following a suicide in prison. Our data suggest that Postvention Support, although its impact on suicide risk is modest, has the potential to support and accelerate this process. Interestingly, a lack of an increase in the use of ligature in pilot prisons, which did occur among prisoners who did not receive Postvention Support, suggests that Postvention Support may have an impact on self-harming behaviour. However, these findings need to be evaluated at a larger scale to provide conclusive results which can be generalised to the wider prison population.

Taken together, the above findings provide evidence of feasibility and effectiveness of some key elements of Postvention Support. However, further changes to the design of the intervention are needed to ensure that the support can be rolled out throughout the prison system in a way that effectively reduces the emotional impact of suicide and supports those affected by the death. Importantly, findings of this evaluation highlight that in order to be fully effective, this support must be delivered in conjunction with a broader effort to: 1) improve wellbeing of staff and prisoners generally, especially via normalising help-seeking behaviour; 2) equip senior leadership with confidence to lead the post-suicide response in a safe way, one which takes account of the barriers which prevent staff and prisoners from seeking support. Given the strong evidence of the negative impact of suicide, on staff and prisoners alike, demonstrated in our systematic literature review (Slade et al., 2019), it is essential that Postvention Support is developed and integrated with prisons' suicide response and wider efforts to achieve culture change in prisons.

Recommendations

HMPPS should consider how Postvention Support can be integrated into the broader package of existing support available to both staff and prisoners. Postvention Support has the potential to effectively support prisoners and staff following a death in custody. To achieve this, HMPPS should examine how the Postvention Support package could be improved and rolled out across the prison estate. The below recommendations set out how Samaritans and HMPPS should work together to achieve this.

HMPPS and Samaritans

Postvention Support should be embedded into prisons' death in custody contingency plans. This is paramount to ensure swift deployment of Postvention Support in the event of a suicide, in a way that does not rely solely on Single Points of Contact. Key elements of Postvention Support should be introduced more widely to Safer Custody teams (e.g. via staff training events, death in custody action packs).

Develop additional practical advice for senior leadership teams (in a way which takes account of time and staffing constraints in individual establishments) on:

1) how to challenge elements of staff culture which may deter some staff from seeking support,

2) putting in place measures which help mitigate the negative impact of suicide on staff's professional confidence,

3) embedding personalised, face-to-face approaches to sharing news of a death with prisoners, as a standard practice following a self-inflicted death.

Samaritans

The 'Best Practice Guide' for senior staff should be updated to include guidance on:

1) responding to self-inflicted deaths on residential units for vulnerable prisoners (especially those with serious learning disabilities and/or mental health conditions)

2) responding to incidents of serious or life-changing self-harm;

    3)   the role of Samaritans volunteer teams in supporting the deployment of Listener support.

Postvention Training Module (PTM) should become a fixed element of Listener Initial Training (LIT). This would minimise the risk of there being too few postvention-trained Listeners in the event of a suicide.

The Postvention Training Module for Listeners should include discussion of the impact of stigma around help-seeking on the take up of pro-active listening support. The training should include tips on how to offer support to prisoners in a way that is sensitive to this stigma. These tips should be developed in consultation with both the Listeners and prisoners.

HMPPS

Promote external support channels among prison staff which offer anonymity and confidentiality, including Samaritans' helpline. This can include increased use of the pocket-size versions of "After a suspected suicide" booklet and/or signposting within POELT training and death in custody debriefs. For staff directly involved in supporting others after a suicide (e.g. Family Liaison Officers, Care Team members), proactive telephone or face to face support should also be considered.

Specialist bereavement services should be delivered alongside Postvention Support. This would help support prisoners, many of whom reported high levels of grief. The design and delivery of such support should be informed by the findings of the trial of a tiered bereavement service by Cruse Bereavement Care, funded via the 2020-22 HMPPS Innovation Grant.

7. Appendices

Appendix 1: NRC summary of findings from the postvention user consultation

User consultation to inform development of Samaritans pilot project: Postvention in prisons- advice and guidance after suicide.

Introduction

The Samaritans recently conducted research titled; *User consultation to inform development of Samaritans pilot project: Postvention in prisons- advice and guidance after suicide.* Postvention refers to activities carried out following a suicide, to mitigate the impact on those exposed to it and reduce the risk of further suicide or serious self-ham.

The aim of this research was to inform the development of a suicide postvention intervention in prisons, by conducting a user consultation with people living and working in prison who have experienced a self-inflicted death in custody (SIDC). NRC approval for the user consultation was sought due to the sensitive nature of the topic.

The development of this pilot intervention has been funded through the HMPPS Innovation Grants for Improving Safer Custody. Reducing the incidence of self-harm and suicide in custody is a business priority for HMPPS, and the project seeks to mitigate the impact of serious self-harm and self-inflicted deaths in custody and reduce the likelihood of further incidents.

Research methods

This research used qualitative methods only with focus groups and interviews being the only form of data collection. The research involved consulting with three different sets of stakeholders who would benefit from the suicide postvention intervention: prison residents, Listeners, and prison staff. Focus groups were held in four of the prisons where the intervention will be piloted; HMP Lewes, HMP Elmley, HMP Swaleside and HMP Pentonville during the time between 05/02/2019 and 24/04/2019. The number of participants in each group are displayed below:

Prison:	Residents:	Listeners:	Staff:
HMP Lewes	5	12	11
HMP Elmley	5	8	6
HMP Swaleside	2		4
HMP Pentonville		13	
Total:	**12**	**33**	**22**

These groups were supplemented by 1:1 interviews with key staff in 2 prisons, including a Managing Chaplain, Head of Healthcare, Head of Safer Custody, and Safety Hub Manager. This data was collected by the Postvention project team. These sample groups were chosen as the research being collected was going to be directly informing the resource.

As a result of the specific nature of the participant group convenience sampling was used, with a target size of between 5 and 8 participants in each group.

There were limitations when conducting this research which are important to note. They are listed below:

- Participants were selected and self-selected due to an interest in the topic and therefore it is not a representative sample, thus at risk of biased towards those who have been adversely impacted by a SIDC.
- The timeframe of this research was extended due to operational challenges.
- The sample size of some groups were small due to operational challenges.
- The pilot project and therefore the user consultation will be focussing solely on adult male prisons, due to the higher risk of SIDC in these establishments.
- The consultations require participants to have good spoken English, meaning some prisoners may have been excluded from taking part.

The focus groups and interviews were guided by five research questions;

1. What were the key areas of need in the days, weeks, months, following SIDC?
2. What information and support do prisoners need following a SIDC?
3. What training would help listeners provide better support following a SIDC?
4. What resources do staff need to better support prisoners after a SIDC?
5. Do the proposed materials being developed meet the needs identified above?

Results

1. <u>What were the key areas of need in the days, weeks, months, following a SIDC?</u>

Research explored 3 key areas of need in the days, weeks, months following a SIDC were highlighted;

Communicating the news

> *'A bad first day experience sets you on a bad course' (Resident HMP, Swaleside)*

Residents and Listeners expressed that being told through a note on the wing, or through other residents was insensitive and confusing as this could be up to three or four days after an incident. Residents acknowledged the difficulty of staff speaking to people one to one, however found there needed to be a more sensitive approach than what is currently happening.

Understanding and support from Staff

'One bit of help could be the difference' (Resident, HMP Elmley)

Residents and Listeners reported that the lack of willingness from staff to share information highlighted a lack of understanding of the impact of a suicide in prison.. All stakeholders also identified that support from senior staff was a key area of need, to have their understanding and compassion and not to adopt a *business as usual* attitude one day after an incident. Staff also identified that peer support was invaluable following a SIDC. Staff discussed the traumatising nature of witnessing or finding a body, the care team is there at the time yet there needs to be an extension of this, as opposed to a one off meeting.

Supplying support on the wing

Residents felt deploying either Listeners, healthcare or the chaplain to the house blocks would show a more consistent offering of support though being physically present in this time after a SIDC.

2. What information and support do prisoners need following a SIDC?

Residents and listeners agreed that clear and concise information from prison staff would reduce speculation amongst the community and provide assurance. Residents need the opportunity and awareness of how to pay respects to the individual, one resident identifying when there was a memorial it was over subscribed, therefore he could not pay his respects. Residents reported they need immediate information on how to get support, and to be reminded of this further down the line as they may be affected at any point. Listeners felt as though there was a delay between the incident taking place and them being informed. Listeners claimed this lead to more confusion and distress throughout the prison as they could not support other people on the wing.

3. What training would help listeners provide better support following a SIDC?

The provision of further training for Listeners who had not experienced a suicide before was raised. This, according Listeners, is essential in being able to manage difficult conversations. The research found that some elements of the training needed further explanation to help the Listeners engage, for example adding context for the role-play, skills practice scenario involving providing emotional support to another Listener. Another key finding of the specific Listener training focus group was the need for small language changes to reflect that used by men in prison.

4. What resources do staff need to better support prisoners after a SIDC?

Staff expressed that any kind of support resources would make a difference during this difficult time. Guidance on how to break the news and how to communicate difficult information was particularly needed. This was a particular concern amongst young or new officers with little experience of challenging conversations- in the current training for new staff what to do after suicide is not included. Senior management reported they need resources to educate them on the lasting effects of suicide, not just on the immediate feelings. Staff identified they need a resource with clear guidelines on how to support one another in order to be able to support prisoners. Staff stressed the importance of a concise resource, clearly signposting support networks for both staff and residents following PTSD and stress.

Implications for HMPPS

Due to the small convenience sample used for this research, the results of these user consultations were not designed to be generalised.

The findings have been used to inform the development of the suicide postvention intervention, which will be piloted and evaluated during 2019-20 before consideration of any future use by HMPPS. The following resources were directly informed through the user consultations;

- Listener training
- Postvention Guide and staff handbook
- 'Support After A Suicide', prisoner leaflet

Appendix 2: Amendments to intervention design from findings of the systematic review of literature

Table 8: Amendments to intervention design from findings of the systematic review of literature

Finding	Impact on intervention
Initial responses (by staff and prisoners) to a self-inflicted death in custody mirror those for suicide bereavement	• Included information on 'normal' responses to bereavement by suicide in all resources • Drew on and adapted existing suicide bereavement resources e.g. Help is at Hand booklet
Prisoners report an initial response of 'confusion' around the death and reasons for suicide More transparent and compassionate communication about the death is needed	• How, and what, information about the death is communicated to prisoners is key – this should be a focus for guidance in prison toolkit & in-person advice o Balance between avoiding unnecessary detail and providing (limited) accurate information to reduce rumour/unhelpful speculation. Discuss with media & schools teams • Include information to support understanding of suicide in resource for prisoners
Staff may experience a 'crisis of confidence' in their professional abilities, linked to fear they will be blamed for the death Prison staff are less likely (compared to inpatient staff) to see a death by suicide as opportunity for learning or improving professional practice	• Include guidance in prison toolkit on prison-wide/leadership responses which support learning and reaffirm staff professionally e.g. through debriefing processes • Encourage governors/staff to take ownership of learning and development (through toolkit & in-person advice) • Consider role of, and support for, non-HMPPS staff (e.g. healthcare) in staff toolkit
Prison staff and prisoners reported wanting more support but feel unable or unwilling to ask for/accept it voluntarily Prisoners are more likely (compared to secure inpatients) to draw on peer networks for support than on staff	• Focus intervention on developing proactive support offer for prisoners and staff • Include signposting for further support, and encouragement to seek help if needed, in all resources • Include guidance in resource for prisoners on supporting other prisoners e.g. how to start conversations • Include guidance and encouragement on speaking to prisoners about how they are, in staff toolkit and Listener training

Prison culture makes it difficult for people to express emotions, which can hinder recovery	• Consider including guidance in staff resources on how to bring prisoners together for group support • Discuss any options to mandate support from staff workstream (Guy) and/or pilot prisons during user consultation – incorporate these into prison toolkit • Signpost/link guidance to other staff support initiatives e.g. hot debrief learning bulletin, TRiM
'Intensity of exposure' to death by suicide (either through proximity or repeated experiences) may increase the risk of negative long-term outcomes for staff and prisoners	• Include information/guidance on identifying people at risk in prison toolkit (and Listener training) e.g. identifying which prisoners were on the wing at time of previous SIDCs o Ask PHE if any evidence from community settings re. direct/secondary/vicarious & repeated exposure and any difference in impact or potential different responses
Lifetime exposure to suicide is linked to own self-harm/suicidal behaviour for prisoners, but it is not known whether this is pre-existing or a causal relationship Limited evidence of mechanism for contagion or clustering of self-inflicted deaths in prison Possible mechanisms include suggestion from indirect exposure (Werther effect), or imitation of method, although this impact appears to be small Environmental impact and changes may be having greater impact on future suicidal behaviour than individual factors	• Include advice on sharing news about the death in prison toolkit – balance between sharing accurate information and limiting detail to reduce potential for imitation; language use; including messages of hope… • Discuss during staff consultation the questions prisoners ask, confidence in responding, and what guidance may be needed • Include advice on timing and tone of communications and follow-up e.g. after conclusion of inquest • Intervention will include addressing wider environmental impacts e.g. by increasing staff confidence in looking after themselves and supporting prisoners • Ensure prison toolkit and postvention advice consider postvention from perspective of prison community as a whole

Appendix 3: Psychometric scales used to evaluate impact of Postvention Support on suicidality and resilience

Current Suicidal Indicator and Cognitive Suicidal Indicator subscales (Mills & Kroner, 2003)

Two sub-scales were used to measure suicidality in this evaluation: Current Suicidal Indicator (3 item scale) to measure current suicidal ideation and Historical Suicidal Indicator (3 item scale) to provide a baseline for suicide risk in the samples. Both are part of the Depression Hopelessness Scale (DHS), which is a questionnaire that has been specifically developed with prisoners and widely used in the Canadian Correctional Service to measure depression and hopelessness, including a critical item checklist for suicide risk factors.

This was used to assess the impact of the intervention on levels of self-reported suicidality (ideation, plans, attempts).

Resilience Appraisals Scale (RAS) (Johnson, Gooding, Wood, & Tarrier, 2010)

RAS is a 12 item scale which measures positive forms of self-appraisal, which can act as a protective factor against suicidal ideation in the face of stress (Johnson et al., 2010). The scale contains three subscales: coping related to social support (4 items), coping related to emotional regulation abilities (4 items) and coping related to situational problem solving (4 items). Responses are rated on a 5-point scale from 'strongly disagree' (1) to 'strongly agree' (5).

This was used to assess the impact of the intervention on prisoners' perceived ability to cope after a death by suicide.

Appendix 4: Analysis methods used to assess impact of the intervention on suicidality, coping appraisals and self-harming behaviour

To address assess the effect of the intervention of suicidality, resilience and self-harming behaviour, data from NOMIS and the questionnaires described above were analysed using Bayesian mixed effects models. These estimated 1) whether suicidality, resilience and self-harming behaviour changed between T1 and T2 depending on whether Postvention Support had been received. These analyses allowed to assess the effect of the intervention across time and to check if any change in these data is attributable to the Postvention Support. In cases of substantial attrition at Time 2, multiple imputation was used to handle missing data.

In the Bayesian approach, one output of the model is the *posterior distribution* which contains the estimates of the variable being modelled. The posterior can be inspected and used to determine the most likely true population value of the estimate. In this report provide the mean value of the posterior distribution was provided and also the 95% credible interval (CrI). This interval captures uncertainty around the mean and allows us to say that the true population value has a 95% probability of falling within the given range.

All model estimates were reported as *odds ratios*, put simply, odds ratios are a measure of association between the predictor variable (in this case prison location) and the outcome variable (response on the Suicidality and Resilience measures). An odds ratio of 1 is expected if the predictor does not have a meaningful effect on the outcome. In this case, it would mean that the location of the prison does not affect the response a prisoner gave on the measure. Therefore, if the credible interval contains the odds ratio of 1 we could conclude that there is insufficient evidence to suggest answering patterns are different between locations.

As odds ratios can be difficult to interpret we also include a more direct assessment of the evidence that there is an effect of the intervention. This is the posterior probability that the estimate is greater than or less than zero. For example, if there was no evidence that the intervention had a positive effect the posterior probability would be 50% - as there would be equal chance of a positive or negative effect. A posterior probability of an effect greater than zero of 95% or more is generally considered strong evidence for an intervention.

Appendix 5: Further information on prisoners who completed psychometric questionnaires

354 questionnaires were returned across the two time points, 237 at Time 1, and 117 at Time 2. A breakdown of the numbers of returned questionnaire numbers across time points and condition can be seen below.

Table 9: Responses to psychometric questionnaires

Time Point	Postvention	Comparator	Total
1	138	99	**237**
2	73	44	**117**
Total	**211**	**143**	**354**

Across both prisons, participants had a mean **age** of 36.5 years (with a standard deviation of 12.1 years). The number of questionnaires returned at Time 1 and the percentage of these returned at Time 2 for each age category across prison types is detailed below.

Table 10: Prisoners who completed psychometric questionnaires – breakdown by age

Age Category	Postvention T1	Postvention T2 %	Comparator T1	Comparator T2 %	Total T1
18-20	10	50%	1	0%	**11**
21-24	18	50%	2	48%	**20**
25-29	29	62%	14	20%	**43**
30-39	50	54%	35	32%	**85**
40-49	21	48%	17	48%	**38**
50-59	6	17%	5	100%	**11**
60 and over	3	100%	10	100%	**13**
Total	**137**	**-**	**84**	**-**	**221**

The number of questionnaires returned at Time 1 and the percentage of these returned at Time 2 for **each ethnic group** across prison types is detailed below. Due to small numbers in most groups, these have been collapsed into two groups of White and BAME participants.

Table 11: Prisoners who completed psychometric questionnaires – breakdown by ethnicity

Ethnicity	Postvention T1	Postvention T2 %	Comparison T1	Comparison T2 %	Total T1
White	64	53%	74	48%	**138**
BAME	74	53%	25	32%	**99**
Total	**138**	**-**	**99**	**-**	**237**

The number of questionnaires returned at Time 1 and the percentage of these returned at Time 2 for each **legal status group** across prison types is detailed below.

Table 12: Prisoners who completed psychometric questionnaires – breakdown by legal status

Legal Status	Postvention T1	Postvention T2 %	Comparison T1	Comparison T2 %	Total
Indeterminate/Life	8	38%	5	80%	**13**
Determinate sentence	91	54%	51	52%	**142**
Remand or untried	39	54%	43	32%	**82**
Total	**138**	-	**99**	-	**237**

Men in prison who are of White ethnic group, in the age group of 30 - 39 years and have the current legal status of remand or untried are considered to be higher risk of suicide whilst in prison. The following details outline the number and percentage within the Time 1 and Time 2 samples in pilot and comparator prisons.

At Time 1 there were:

- 138 (60.55%) White prisoners, 64 (46.4%) in postvention prisons and 74 (74.7%) in comparison prisons.

- 85 (39.1 %) prisoners between the ages of 30 - 39 years, 50 (36.5%) in the postvention prisons and 35 (41.7%) in the comparison prisons.

- 82 (35.85 %) prisoners had the legal status of remand or untried, 39 (28.3%) in the postvention prisons and 43 (43.4%) in the comparison prisons.

- 14 (6.2%) prisoners who were in all three higher-risk groups. This broke down as 6 (4.3%) in postvention prisons and 8 (8.1%) in the comparison prisons.

At Time 2 there were:

- 70 (64.2%) White prisoners, 34 (46.6%) in postvention prisons and 36 (81.8%) in comparison prisons.

- 38 (32.95 %) prisoners between the ages of 30 - 39 years, 27 (37%) in the postvention prisons and 11 (28.9%) in the comparison prisons.

- 35 (30.3 %) prisoners had the legal status of remand, 21 (28.8%) in the postvention prisons and 14 (31.8%) in the comparison prisons.

- 5 (4.75%) prisoners who were in all three higher-risk groups, 2 (2.7%) in postvention prisons and 3 (6.8%) in the comparison prisons.

The number of ACCTs opened before and after the suicide are shown below. Note that the numbers recorded below only represent ACCTs that were opened *during* the study period and does not include ACCTs that were already opened prior to the study commencing. Due to the current circumstances, researchers cannot go to prisons to confirm numbers or collect additional data.

Table 13: Number of ACCT documents opened before and after suicides

	Postvention	Comparison	Total
Prior	4	11	**15**
Post	8	23	**31**
Total	**12**	**34**	**46**

Prisoners who answered "true" to items 5, 6 and 7 on the Depression and Hopelessness Scale were considered to be a higher risk of suicide. At Time 1 there were 61 (22.59%), 30 (19.74%) prisoners in the postvention prisons and 31 (26.27%) prisoners in the comparison prisons who answered "true" to all three items.

Appendix 6: Results of prisoner feedback survey

Table 14: Methods used to communicate news of death

How were you told about death?	Postvention n	Postvention %	Comparison n	Comparison %
Staff member	16	11.8	20	21.5
A notice	75	55.1	30	32.3
Another prisoner	27	19.9	23	24.7
I witnessed it	9	6.6	8	8.6
Other	6	4.4	6	6.5

Table 15: Time after the death when news of death was communicated

How soon after were you told?	Postvention n	Postvention %	Comparison n	Comparison %
Same day	60	44.1	43	47.8
The next day	34	25.0	40	44.4
More than one day after	41	30.1	6	6.7

The number and percentage of prisoners across time points and location who said that they had grieved for the individual who died is shown below.

Table 16: Number of prisoners who reported grieving after the death

Time	Postvention n	Postvention %	Comparison n	Comparison %
1	61	50%	50	50%
2	37	50%	26	60%

The following questions asked about the support the prisoner received since the death. The number (and percentage) of prisoners who responded to each option for each support type is detailed below. Note that the numbers of prisoners who responded to each item below varied.

Table 17: Support sought by and offered to prisoners after the suicide

Officer

Support	Response	n Postvention	Percentage Postvention	n Comparison	Percentage Comparison
Officer	I couldn't or wouldn't ask	37	61%	17	**50%**
Officer	I was offered support	17	28%	12	**35%**
Officer	I asked but did not get support	3	5%	5	**15%**
Officer	I asked and got support	4	7%	0	**0%**
Total	-	**61**	-	**34**	-

Healthcare

Support	Response	n Postvention	Percentage Postvention	n Comparison	Percentage Comparison
Healthcare	I couldn't or wouldn't ask	40	71%	15	**50%**
Healthcare	I was offered support	7	12%	5	**17%**
Healthcare	I asked and got support	5	9%	6	**20%**
Healthcare	I asked but did not get support	4	7%	4	**13%**
Total	-	**56**	-	**30**	-

Custodial Manager

Support	Response	n Postvention	Percentage Postvention	n Comparison	Percentage Comparison
CM	I couldn't or wouldn't ask	43	77%	20	**67%**
CM	I was offered support	7	12%	5	**17%**
CM	I asked and got support	4	7%	1	**3%**
CM	I asked but did not get support	2	4%	4	**13%**
Total	-	**56**	-	**30**	-

Keyworker

Support	Response	n Postvention	Percentage Postvention	n Comparison	Percentage Comparison
Keyworker	I couldn't or wouldn't ask	45	85%	18	**60%**
Keyworker	I was offered support	6	11%	5	**17%**
Keyworker	I asked and got support	1	2%	4	**13%**
Keyworker	I asked but did not get support	1	2%	3	**10%**
Total	-	**53**	-	**30**	-

Chaplain

Support	Response	n Postvention	Percentage Postvention	n Comparison	Percentage Comparison
Chaplain	I couldn't or wouldn't ask	38	67%	14	**44%**
Chaplain	I was offered support	14	25%	10	**31%**
Chaplain	I asked and got support	3	10%	6	**19%**
Chaplain	I asked but did not get support	2	4%	2	**6%**
Total	-	**57**	-	**32**	-

Listener

Support	Response	n Postvention	Percentage Postvention	n Comparison	Percentage Comparison
Listener	I couldn't or wouldn't ask	37	71%	19	**61%**
Listener	I was offered support	13	25%	10	**32%**
Listener	I asked and got support	1	2%	1	**3%**
Listener	I asked but did not get support	1	2%	1	**3%**
Total	-	**52**	-	**31**	-

Samaritans helpline

Support	Response	n Postvention	Percentage Postvention	n Comparison	Percentage Comparison
Samaritans_helpline	I couldn't or wouldn't ask	41	79%	21	**72%**
Samaritans_helpline	I was offered support	6	12%	4	**14%**
Samaritans_helpline	I asked and got support	3	6%	3	**10%**
Samaritans_helpline	I asked but did not get support	2	4%	1	**3%**
Total	-	**52**	-	**29**	-

Table 18: Number/percentage of prisoners who received the 'Support after suicide' leaflet

After the death, do you remember getting the 'Support after Suicide' leaflet?	n	Percentage
Yes	73	56.6
No	56	43.4

Table 19: Number/percentage of prisoners who read the 'Support after suicide' leaflet

Did you read this leaflet?	n	Percentage
Yes	81	61.4
No	50	37.9

Appendix 7: Members of the Postvention Project Working Group

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