Making the Conversation a Little Easier for Probation and Parole Officers: Using Motivational Interviewing to Discuss Client Suicidal Ideation and Attempts[1]

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APPROXIMATELY 4,357,000 ADULTS are under community supervision in the United States, with the majority (3,492,900) under county probation systems (Oudekerk & Kaeble, 2021). Studies in the United States as well as other countries have found that adults on probation are at three to eight times greater risk for suicide ideation, attempts, or death by suicide, depending on the outcome studied, than those in the general population (Clark et al., 2013; Gunter et al., 2011; Sirdifield, Brooker, & Marples, 2020; Yu & Sung, 2015). For example, Philips and colleagues (2015) found an annual death by suicide rate of 118 per 100,000 of those under community supervision as compared to 13.6 per 100,000 in the general population, aged 30-49, and the rate was even higher for females under probation supervision at 146 per 100,000 in the same age category.

Current criminal justice reform efforts present probation and parole officers (POs) in community corrections with expanding responsibilities. These reforms include an increased focus on a working alliance with clients and the use of evidence-based practices as alternatives to more traditional surveillance and custody strategies (Bogue, 2020; Bonta & Andrews, 2017; Clark, 2021; Gunter et al., 2011). POs are in a position to identify clients who may be at risk for suicide and make appropriate referrals, if needed, both in the assessment process and beyond, during routine supervision (Borrill, Cook, & Beck, 2017; Mackenzie et al., 2018). Discussion of suicide, however, is often uncomfortable for both clients and POs. Clients themselves may be reluctant to disclose their suicidal thoughts or behaviors because of stigma, the possibility of an unsupportive reaction, or unwanted treatment (Hom, Stanley, Podlogar, & Joiner, 2017; Mayer et al., 2020; Sheehan et al., 2019). Like other helping professionals, POs may avoid discussion of suicide due to fear of increasing the likelihood that suicide might happen, anxiety about how to handle a situation where a client discloses suicide ideation or attempts, a sense of operating outside the person's scope of expertise, or lack of skill in knowing how to guide the discussion (Freedenthal, 2018; McCabe, Sterno, Priebe, Barnes, & Byng, 2017).

This article explores suicide ideation and suicide attempts in probation and parole clients and discusses the potential benefit of using motivational interviewing (MI) as a communication method to provide a framework for helping POs move past avoidance of the topic, particularly if it emerges in routine visits. We are mindful that it is beyond the scope of practice of POs to treat clients who are struggling with these issues. Given the high rate of suicide behavior and ideation in clients, however, a PO may perhaps be the first person to recognize that someone is considering suicide and can intervene in a way to get that person to the appropriate treatment provider. To illustrate how MI might fit into this process, a sample vignette and dialogue are presented.

Suicide in Probationers/Parolees

It is helpful to begin with definitions of suicide, suicide attempts, suicidal ideation, and suicide preparation. Death by suicide is a death caused by self-injury with the intent to die. Suicide attempts are those acts to injure oneself that may or not be severe enough to cause death, if no intervention is given.

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Suicidal ideation are thoughts about death or wanting to die that may be fleeting or longer lasting but do not involve any steps towards preparation. Suicide preparation involves determining or securing a method for death by suicide (O'Connor et al., 2013).

In the U.S., suicide is the tenth leading cause of death and the second leading cause of death for people in the age range of 10 to 34 years old (Stone, Jones, & Mack, 2021). Men are 3.5 times more likely to take their own lives than women, and firearms account for more than half of all suicide deaths in the U.S. (Silverman et al., 2020). There is a myriad of risk factors for death by suicide: previous suicide attempts, mood disorders, serious mental illness, alcohol misuse, opioid use, family history of suicide, problems in intimate relationships, grief and loss, poor physical health, employment problems, financial problems, or having access to lethal means (Clark, et al., 2013; Conner & Bagge, 2019; NIMH, 2021; Schmutte, Costa, Hammer, & Davidson, 2021; Silverman et al., 2020; Wilcox, Conner, & Caine, 2004). Suicide rates are higher in males than females, and are highest among American Indian/Alaskan Native persons and among males aged 25-34 (Stone et al., 2021).

Only recently has the issue of suicide with probationers received attention (Gunter et al., 2011; Sirdifield, Brooker, & Marples, 2020). An early study found increased suicide risk and mental health issues in both recently released prisoners and probationers (Gunter et al., 2011; Kariminia et al., 2007; Pratt et al., 2010). In a sample of 2,077 probationers in Texas, 13 percent scored as high risk for suicide. While mental health is not necessarily related to death by suicide, suicide attempts, or suicide ideation, in this study those who screened positive for a mental health disorder were two to eight times more likely to screen positive for suicide risk. Women were twice as likely to screen positive for high suicide risk (Cardarelli et al., 2015).

In a large retrospective study of 18,260 probationers, multivariate analyses found prior history of suicide to be the second largest independent predictor of overall mortality after taking into account age, race, gender, and substance dependence. White race, older age, and a hospitalization for a physical condition also related to shorter length of time to mortality (Clark et al., 2013). A large study of parolees found increased risk of suicidal ideation in comparison to the general population (8.6 percent versus 3.7 percent, Yu et al., 2014). Similarly, an evaluation of 3,014 male and 1,306 female probationers found an average annual suicidal ideation prevalence rate of 9.7 percent among probationers in comparison to 3.6 percent in non-probationers (Yu & Sung, 2015). Sociodemographic variables were largely similar between male and female probationers with one exception: race within the group of female probationers. Black female probationers were twice as likely to experience suicidal ideation (Yu & Sung, 2015).

While risk factors and pathways to suicide specific to probationers and parolees have been examined less, a qualitative study of seven probationers who had made near-fatal suicide attempts while under community supervision revealed that experiencing bereavement, a sense of losing control over their lives, or important legal events such as upcoming court dates preceded suicide attempts. While a general lack of trust in the criminal justice system created a barrier to disclosing feelings of suicidality to probation officers, when a strong relationship was established, this served as a protective factor (Mackenzie, Cartwright, & Borrill, 2018).

Content analysis of the records of 28 probationers who completed suicide while under supervision identified missed appointments, warnings from the court or breach of terms, and changes in probation officer or supervision routine (e.g., meeting times, location of services) as risk factors associated with suicide (Borrill, Cook, & Beck, 2017). The need for suicide prevention training, close collaborative relationships with mental health professionals, and use of a process for uniformly noting suicide risk in shared case management records for comprehensive communication were suggested as needed changes to prevent suicide during the probation supervision process.

Discussing Suicidal Ideation and/or Attempts Using MI

Many community corrections organizations and staff have been trained and routinely conduct SI screening with their clients during the intake process using tools validated for use with justice-involved populations such as the Columbia Suicide Severity Rating Scale (C-SSRS) (Posner et al., 2011; Wilson, 2017). Training regarding the use of this scale discredits the commonly held myth that speaking directly about suicide can actually produce suicidality. This, and the fact that screening for suicidality is a routine practice that not only provides safety for the client, but at the same time minimizes risk and liability for the PO and organization, has assisted in its implementation. Nonetheless, suicide is a topic that reasonably produces a level of anxiety, especially when it arises outside the initial screening and assessment phase and during the ongoing relationship of community supervision (Nagdimon, McGovern, & Craw, 2021).

Due to a focus on evidence-based practices, increasingly, POs are being trained in Motivational Interviewing (MI), a conversation style to increase clients' motivation to change habits and behaviors in positive directions (Bogue, 2020; Clark, 2021; Miller & Rollnick, 2013). Drawing on internal motivations that are more likely to promote lasting change, MI has been used regarding substance use, health concerns, and prosocial behavior, and has recently been tested as a helpful method when clients may be suicidal. The goal is not to provide treatment for suicidal thoughts/intentions but to motivate clients to seek help (Britton, 2015; Britton, Conner, Chapman, & Maisto, 2020).

MI is used for areas where clients are ambivalent. Suicidal thoughts fall into this category, as clients often struggle between wanting to live and wanting to die (Brown, Steer, Henriques, & Beck, 2005; Britton, 2015; Mackenzie, Cartwright, & Borrill, 2018). Discussing such thoughts with an authority figure can be difficult, and clients may be wary to do this (Frey, Fulginiti, Lezine, & Cerel, 2018; Hom et al., 2017; Mackenzie et al., 2018; Sheehan et al., 2019). However, the focus on positive relationships, acceptance, and respect that are the foundation of the MI spirit enable PO staff to develop a working alliance that can open the door for difficult conversations (Clark, 2021; Frey & Hall, 2021; Stinson & Clark, 2017).

Besides the focus on a working alliance, the technical skills of MI that guide conversations include the use of open-ended questions, affirmations, reflective listening statements, and summaries (OARS) (Miller & Rollnick, 2013; Stinson & Clark, 2017). Simple reflections restate what the client has said, and complex reflections are statements from the PO that go beyond the words and into the possible meaning of what clients are verbalizing (Hohman, 2021; Miller & Rollnick, 2013). Reflections are used to engage clients by showing that the PO is truly listening and concerned. Reflections also encourage or evoke clients' change talk, or their statements about change, that includes the desire, ability, reasons, and need for change, on the topic under discussion. Sustain talk is the opposite of change talk and includes reasons why clients can't change. Sustain talk can be acknowledged by the PO, but the goal

is to have clients hear themselves talking about positive change, so the conversation is guided toward change talk. In instances of suicidal thoughts, this is considered "life talk," with a focus on reasons for living (Britton, 2015; Miller & Rose, 2015; Stinson & Clark, 2017). Usually, an MI interview also covers four processes: engaging the client, focusing on a topic around which to evoke change talk; evoking of the change talk; and then planning next steps (Miller & Rollnick, 2013).

Clients may be formally assessed for suicide at intake, which may be the last time it is mentioned, especially if the person is considered as low in psychiatric risk. Clients may also downplay any suicide ideation or attempts in an assessment or decide to keep it hidden (Mayer et al., 2020; Nagdimon, McGovern, & Craw, 2021). However, suicide ideation, planning, or previous attempts may come up in routine, run-of-the-mill conversations between the PO and client. Table 1 presents a model of how the four processes of MI can be a guide for addressing these topics, or hints at them, should they arise in a routine conversation. As noted, the OARS skills should be used throughout, although there may be times to ask closed-ended questions.

In the Engaging process, establishing a trusting relationship between the PO and client allows for more open conversations (Jobes, 2016). POs should be listening for client concerns that may put the client at high risk for suicide, as noted in Table 1, and be alert for client statements that may be indicative of suicidal ideation and follow up on them, even if the client does not seem to be depressed or at risk. Events may have preceded a meeting with the PO that seemingly have no significance but might increase suicidal ideation in a client. Clients may state suicidal ideation or planning directly or may be more vague, stating something such as: "I am not sure if I can go on," "It seems like there isn't much point anymore," "People would be better off without me," or "I'm not sure how much more of this I can take" (Freedenthal, 2018; Ryan & Oquendo, 2020; Sheafor & Horejsi, 2015).

This can raise anxiety in the PO, but it is most helpful to be direct and focus on the client's suicide ideation or preparation: "Is it ok that we take a moment to discuss what you just mentioned? Are you thinking of killing yourself?" It is better to be direct than use vague language such as, "Are you thinking about hurting yourself?" (Singer & Erreger, 2016). Sometimes anxiety regarding suicide causes POs and even mental health therapists to "soften" the question (Nagdimon et al., 2021; NIMH, 2021). Directly asking may even help reduce suicide ideation (Dazzi et al., 2014; Frey & Hall, 2021). If the client answers "No," then the conversation can move on to some other topic of focus.

If the client answers "Yes" or "Maybe" or "Not really," the PO can move into the Evoking process, to explore what the client is thinking. An open-ended question, such as "Tell me more," helps to explore what the client is thinking along with the use of reflections. The next step is to ask, "What is your plan?" and make a lethality evaluation. Clients may have had thoughts with no plan or vague plans, or have very specific plans, some of which are more lethal than others, especially if they involve firearms, hanging, or drug overdose (Conner, Azrail, & Miller, 2019; Freedenthal, 2018). MI has also been proposed as a communication method for means restriction (eliminating access to various suicide means), wherein clients create their own plan to protect themselves (Britton, Bryan, & Valenstein, 2016).

As noted, in MI the focus is on "change talk" or "reasons for living" (Britton, 2015). For example, the PO could ask, "If you were to consider continuing to live, what might be the reasons for this?" Encouraging clients to give multiple answers through reflective listening and asking, "Why else?" with all of the answers summarized, allows clients the opportunity to hear themselves, multiple times, speaking to living and continuing to do so, in a compressed time frame. The PO does not tell clients why they should want to live, but works to evoke what matters to the client, including protective factors—whether they are relationships, family, religion, culture, or personal values. These are individualized to the particular client.

TABLE 1.
Use of MI to Discuss Suicidal Ideation/Preparation/Attempts

MI Process/ Skills		Suicide Assessment/Discussion	PO role
Engage	OARS	Establish trusting relationship Listen for concerns around high-risk psychosocial stressors: job/ housing loss, isolation, divorce, family deaths, illness Listen for specific or vague statements of suicide ideation (SI), preparation (SP) or attempts (SA)	Awareness of risk factors: • General population: past attempts, family history of suicide, depression, anxiety, loss, alcohol and drug use, poor health • Specific to probation clients: release from jail, upcoming court appearance, change in PO, lack of control over life, missed appointments
Focus	OARS	If hear specific or vague statements, Ask directly: "Are you thinking about killing yourself?"	Manage own anxiety Discussing SI/SP/SA does not cause it Avoid vague language such as "Are you thinking about hurting yourself?"
Evoke	OARS	Plan: "What is your plan?" Lethality assessment (means) Reasons for living/Values Protective factors Confidence to engage in life-sustaining activities	Build motivation to live/hope/confidence Understand contexts for SI/SP/SA: • Fear of hospitalization • Gender /Culture/Religion • Past discrimination in MH services • Fear of stigma
Plan	OARS	If Lower risk: • Safety planning/ Means restriction • Life-sustaining activities • Seek mental health or other counseling support Higher risk: • Follow agency guidelines • Possible hospital assessment	Strengthen commitment to living Know agency protocol Seek MH consultation "Warm hand-off"/collaboration with client & MH or other services Document conversation and outcome

Asking about other areas in their lives where clients have shown accomplishment as well as providing affirmations can help instill hope (Miller & Rollnick, 2013).

Of course, sustain talk can arise whereby clients can minimize their concerns or give reasons for not seeking help due to fear of forced hospitalization, gender roles, their religion, prior negative experiences with the mental health system, stigma around mental health in general, or just wanting their problems to end (Misra et al., 2021; Nagdimon et al., 2021). These can be discussed with guiding toward more change talk. Clients can be asked about life-sustaining activities or how they picture a life worth living and previous examples of success that give them confidence that they can achieve it (Britton, 2015).

In the Planning stage, clients are asked to make a commitment to living (Britton, 2015). For those who are willing to do so and are at a lower risk of suicide, this can also involve safety planning, which involves identifying social and community supports as well as restricting means of suicide (Britton, et al., 2016; Freedenthal, 2018; Stanley et al., 2018). The PO should provide a "warm hand-off" of the client to mental health services (if appropriate), which could include calling for an appointment with the client or even accompanying the client to the meeting (Nagdimon et al., 2021). The process of a "warm handoff" is fully consistent with the case management aspect of the PO, employing the balanced approach philosophy of supervision (i.e., equal focus on accountability and rehabilitative behavior change). Additionally, this process serves to facilitate "engagement" in treatment services as opposed to simply referring a client to services. Mental health professionals can also engage in a more formal safety planning process if need be. If clients are at high risk for suicide and cannot move forward in the Planning process, then agency protocol should be followed. This may involve a hospital-based assessment. As always, the PO should document the conversation and outcome.

Case Vignette and Dialogue

The following client vignette represents a composite of clients. We provide a sample MI conversation that a probation officer (PO) might have with the client. Louis is a 28-year-old biracial man who is on probation for a second Driving Under the Influence (DUI) offense and possession of a controlled substance. Louis had been drinking with his friends when they finished at their restaurant job, left, and drove into a tree. He had a blood alcohol level of .15 at the time, about twice the legal limit. Some non-prescribed oxycodone pills were found in his car. Louis stated that he had fallen asleep right before the accident. He sustained a concussion, lacerations, broken ribs and a fractured leg. He needed extensive surgery with a follow-up stay at a rehabilitation center.

Louis had been living with his girlfriend and their daughter, but she had left him several months previously, taking their daughter to another state. Upon discharge from the rehabilitation center, he moved in with his mother, as he couldn't live alone. Louis unknowingly contracted COVID-19 while at the center, which was then spread to his mother. She required hospitalization and later passed away. Louis lost his job due to his injuries and then the pandemic but received some unemployment benefits. He was able to remain in his mother's home, which he now owns along with his two sisters, who allow him to live there. Now he is well enough to go back to work and has recently found a job in the food service industry. Louis also has chronic pain from his injuries that he tries to manage with over-the-counter medication.

Because this was his second DUI along with the drug charges, Louis was placed on probation and was ordered to attend an 18-month DUI program of individual and group counseling, to remain substance and alcohol free, to give up his drivers' license, and to participate in random drug testing. His probation assessment indicated that he is at medium risk due to antisocial associates, antisocial cognitions, family history (his father had been involved with the legal system and killed himself when Louis was 8 years old), a sporadic work history, and substance use. His PO is having a follow-up meeting with him to discuss his compliance with the probation plan. MI skills are noted in brackets. Change talk is highlighted in bold.

PO: How are you feeling, Louis? How is your leg these days? [Open question]

CLIENT: I'm doing ok. I still limp when I get tired but I feel like I'm getting better. I can't take any pain meds, you know, but I am only in pain when I walk too much.

PO: You can tell that you've made progress. [Simple reflection]

C: Yeah, I'm doing a lot better. **I'm going to all those DUI meetings** too and doing it over Zoom makes things a little easier. It's ok. The people in my group are nice enough. Some of their problems make mine seem pretty small.

PO: Great, I'm glad to hear that you are attending, and I get reports that all your drug tests have been negative. I imagine you hear some interesting stories from the other clients in your group at the DUI and you've had some tough experiences too. [Affirmation; sharing information; simple reflection]

C: Yeah, well, it's been a rough couple of years for everyone, right?

PO: That's for sure. My job is to touch base with you and support you and it seems like you are doing ok with following your plan. I'm wondering what you might want to talk about while we are together today? We could talk about your [probation] plan or anything else that's important to you. [Providing information; Affirmation; Open question, focusing]

C: I'm good, nothing really. **I'm just trying to stay out of trouble. I'm not seeing my old friends and I've started a new job.** It's not the best but it got me a foot in the door.

PO: Even though the job isn't what you wanted, it's still good to be back to work. [Simple reflection]

C: The job is ok. I don't go out and I only basically see people at work, you, and the people in my group and my counselor, so it's a little depressing. I really don't know the people at work. But **I want to get off probation and also work on getting my girlfriend and daughter back.**

PO: It's important for you to move forward and have a relationship with them. [Complex reflection]

C: Yes, I miss them so much. My daughter will talk to me a little. She's only 2 so it's hard over the phone and her mom doesn't want me to call that often.

PO: You would like to talk more often. [Simple reflection]

C: Yeah, maybe then she would see that **I'm doing what's right**. You know, I never told anyone this, but that night of the accident? I was so depressed over her leaving me that I tried to kill myself. I ran into that tree on

purpose. I couldn't even do that right.

PO: Thanks for sharing that with me, that took some guts. You were that upset. Can I ask, are you thinking about killing yourself now? [Affirmation; Simple reflection; Closed question; Suicide assessment]

C: No, not really. That car accident was just so stupid, look what happened to me. **So I won't try anything else either.** Sometimes though I just feel so alone. And responsible for what happened to my mother. I know I was told it wasn't my fault but still, did she have to die? And die alone? If she were here, she'd be proud of me for what I am doing now. But she's not here. And she'd be so disappointed in me if I did try to kill myself again, after what she went through with my dad. She was Filipino and church stuff was very important to her. But sometimes I feel like that even if I do all this, stay sober and get off probation, that my girlfriend still won't take me back. And then how will I ever see my daughter?

PO: You feel alone and have lots of grief about your mom and maybe even your dad. One of the things that keeps you going is hoping that you can get back with your girlfriend or even just stay in a relationship with your daughter. You also want to be someone who would have made your mom proud. What are some other things that you might live for? [Complex reflection; open-ended question to evoke life talk]

C: I don't know. (pause) This job is really just doing dishes and some cleaning so it's not really what I want. **I'm hoping that I can get a chance to do cooking, so they can see my skills. I would like to really make a career out it.** I probably could now that I'm not using. It's just that it is a tough industry to work in when you are trying to stay clean. But I know some people who are clean. Maybe they could even help me out.

PO: So a career in food service is motivating you, especially if you can be with other people whom you trust. Why else might you want to live? [Simple reflection; open-ended question]

C: My two nephews really look up to me. I see them when they come visit with my sister. They are about the same age as I was when my dad died. My sister is single and **I want to be here to help her out as well. And I don't want them to go through what I did.**

PO: So you have these two little guys as well as your sister. Let me see if I got it all—and there may be more. You have been through a lot and feel pretty isolated and are hanging in there and doing what you need to do. You hope to re-establish a relationship with your girlfriend, and if that doesn't happen, at least still be involved in your daughter's life. You want to honor your mother's memory. You are going to work on getting a career going. You also want to stay involved with your sister and nephews and be a help for them. [Summary]

C: Yeah, that's right.

PO: You have felt suicidal at times but right now you don't have a plan to carry it through. [Simple Reflection to confirm]

C: Yes that's right. **I'm not going to do anything crazy** like before.

PO: What else might help you right now to stay on this forward path? [Open-ended question]

C: I don't know. What do you think I should do?

PO: Sometimes my clients talk to their DUI counselor or other times they work with a therapist in individual counseling, especially to focus on grief and loss. You have been through a lot and someone with a background in this can be helpful. [Providing information with choices]

C: **A therapist who specializes in grief might work.** I really don't want to talk about this stuff with my DUI group. The counselor, maybe. She might know of a good person for me to work with. Or do you?

PO: I have some names I can give you and we could make a few calls together now. It takes guts to talk about this stuff and to get some help. [Providing information; Affirmation]

The PO in this example has already established a prior relationship with the client, Louis, and did not need to spend a lot of time in engaging him. He (the PO) used an open-ended question to ask about his health, instead of beginning with the probation plan. This signaled to Louis that the PO was concerned about him as a person, not just his compliance. He also provided an affirmation about Louis' positive work on his probation plan.

The PO then moved to a focusing question, to see what Louis would want to talk about with him. The PO can always return to the topics he needs to cover, if needed. For instance, if Louis had missed a random drug screen test, the PO could have brought this up once the conversation covered what Louis wanted to talk about (Stinson & Clark, 2017). Providing choice to clients is one way to honor their autonomy, which is important in MI conversations (Hohman, 2021). Louis gave a hint that he wanted to talk about his isolation and depression by bringing up his lost relationship with his girlfriend and then revealed that his DUI accident was really a suicide attempt. The PO was not surprised, as grief and loss, family history, trauma, chronic pain, and alcohol misuse, and substance use are often related to suicide ideation and attempts (Mackenzie et al., 2018; Ryan & Oquendo, 2020). New research also indicates that suicide attempts are also more common in repeat DUI offenders, with the DUI event itself often as the method (Edson, Gray, Nelson, & LaPlante, 2020).

Because Louis disclosed that he had attempted suicide, the PO asked him if he was currently thinking about an attempt again. Louis indicated that he wasn't, "not really," which is a bit lukewarm of a denial. He went on to state he had no means or plan. The PO confirmed this later on. Louis gave a few reasons for wanting to die, or sustain talk, which the PO acknowledged and he then evoked or asked for reasons why Louis might want to live. Louis was able to talk about relationships and work that might be meaningful for him. He began to set into place a plan of his own. The PO summarized the reasons for living and the beginnings of Louis' plan. He then asked for other next steps or planning. Louis asked for ideas. The PO provided him with two choices and Louis thought that he might want to work with someone around grief and loss. Not framing Louis as having depression but as someone who has gone through a lot of loss was most likely less stigmatizing and more appealing to Louis. Of course, it is not the PO's job to diagnose Louis.

If Louis had admitted that he was still having suicidal thoughts or was preparing for another attempt, the PO would need to discuss with him next steps to keep him safe, which could include an assessment by a mental

health professional or possibly inpatient hospitalization. The PO would need to not jump too quickly to one of these types of plans and instead seek supervisory guidance around agency policy. Moving quickly out of fear for the client can result in worsening the situation (Freedenthal, 2018).

Louis might be seen as an "easy" probation client in that he is compliant with his probation plan, is attending DUI counseling, is employed, and has stable housing. He is however at risk for suicide, as well as drug use, due to his family history of death by suicide, his own prior suicide attempt, significant grief and loss over his relationship with his partner and death of his mother, prior substance use, and history of hospitalization for a traumatic physical injury (Borrill, Cook, & Beck, 2017; Cardarelli et al., 2015; Clark et al., 2013; Cook & Borrill, 2015; Henden, 2017; Mackenzie et al., 2017; Sirdifield et al., 2021). Louis is in counseling already at his DUI program but has chosen not to disclose his past attempt but to do so with his PO where he must feel some sort of safety, that is, that his disclosure will be handled without judgment (Frey et al., 2018). It is important that the PO makes sure that Louis follows through on his plan to see a therapist and perhaps even be able to communicate with that therapist about his concerns.

Discussion

Those in the criminal justice population have a higher rate of suicide attempts and deaths than the general population (Yu & Sung, 2015). MI has already been introduced into probation work (Stinson & Clark, 2017) and provides a method of communication when clients are experiencing suicidal thoughts or have attempted suicide. The goal in an MI conversation between a PO and client where this is the focus is to motivate clients to seek help, as most clients are experiencing ambivalence about wanting to live versus wanting to die (Britton, 2015). Discussion of suicidal thoughts and/or attempts is intimidating and sensitive, but these conversations can be extremely influential in moving clients in a positive direction (Dazzi et al., 2014). PO staff may be concerned about liability (Viglione, 2019) or believe that engaging in such a conversation is beyond their scope of practice. Use of MI by POs may also be uncomfortable, particularly for those who are used to more directive communication methods (Viglione, Rudes, & Taxman, 2017). The presented model, however, provides a guide for using MI in these difficult conversations. Although it may not always make these discussions "easier," it provides a framework to instill hope as well as options to access more professional assistance, paving a new way forward for staff. POs also need to know community mental health resources. Co-location of, or inclusion of, mental health professionals as routine team members promotes a more comprehensive interprofessional approach to meeting the complex needs of the large population under community supervision.

POs may want to be especially attentive to establishing and maintaining a structure to their work with clients as well as approaching them with the spirit of MI. This assists in developing a trusting relationship as well as a sense of predictability and safety for the client (Clark, 2021). Maintaining regular meeting times, location, referred providers, and assigned PO whenever possible also create a sense of control over one's life and a sense of connection (Borrill, Cook, & Beck, 2017). Missed appointments at a job site, with a mental health provider, or an actual PO meeting may signify emotional distress and require follow-up. Risk is still possible even if the client denies suicide ideation or preparation, especially in the context of psychosocial stressors (Nagdimon et al., 2021). These stressors can be addressed with assistance with housing, employment, financial issues, and the like (Yu et al., 2014).

Interprofessional training between probation and mental health providers could include MI to help enhance PO engagement skills as they seek to develop behavior change with probationers and parolees. It can also simultaneously provide necessary support to POs responding to mental health needs, including suicide ideation and attempt risk, which maximizes the safety and successful reentry of probationers and parolees (Twitchell, Hohman, & Gaston, 2021). Training should also include professionals' personal attitudes towards suicide ideation and attempts. Stigma and shame around suicide are prevalent in our culture and often quiet the voices of those who need to speak about it (Mayer et al., 2020).

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