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**Researching suicidal behaviours by offenders serving
community based sentences: a near-lethal approach**

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**Researching Suicidal Behaviours by Offenders
Serving Community Based Sentences: A Near-
Lethal Approach**

Jay-Marie Mackenzie

A thesis submitted in partial fulfilment of the requirements of the
University of Westminster for the degree of Doctor of Philosophy

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Abstract

Suicide, a global problem, affects individuals from diverse backgrounds. Higher at-risk groups include vulnerable populations, such as offenders and prisoners. Most suicide research focuses on prisoners with little focus on probation populations. The lived experiences of probation clients who have made suicide attempts has not previously been explored. Furthermore, research on experiences of probation staff managing suicidal offenders is limited. Consequently, the current research explored the experiences of probation clients who made near-lethal attempts, as well as the experiences of staff managing these clients, and strategies to prevent suicide.

Study 1 explored probation staff experiences of managing suicidal clients through in-depth interviews. Findings indicate that staff felt inadequate in managing these issues, but training and experience facilitated better management techniques. Studies 2a & 2b explored the perspective of individuals serving probation sentences who had made near-lethal attempts. Findings suggest that the suicidal state was experienced in relation to perceived loss of control, which often related to their probation process. Clients felt that non-judgmental listening prevented suicide attempts. However, disclosure was sometimes unlikely due to a fear of being judged or lacking trust in others. Study 3 employed 3-6 month follow-up interviews to explore changes in clients' perspectives. Findings suggest that following reflection on their attempts, clients' time perception fluctuated. For example, time leading up to the attempt was perceived as slow whilst the actual attempt was quick and impulsive, and following the attempt time slowed down. This slowness in time prior to the suicide attempt could be an opportunity for interventions. Findings highlight the need for extra support regarding negative coping strategies in order to prevent offending and suicide. Moreover, clients receiving support for their suicidal feelings and maladaptive coping mechanisms did not make further attempts. Study 4 compared the experiences and views of probation clients with staff. Findings demonstrate similar views in terms of when and why suicides occur, and what can be done to prevent suicide. However, poor communication between the two parties was a barrier to suicide management.

The unique contribution of this program of research lies in its understanding of suicide from the perspectives of probation clients who have experienced it; providing unique understandings about clients at high risk of suicide, ways of preventing suicide, and what barriers exist for clients who need help.

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List of Abbreviations

AP	Approved Premises
BDI	Beck Depression Inventory
BHS	Beck Hopelessness Scale
CJS	Criminal Justice System
CJA	Criminal Justice Act
CoP	Cry of Pain
CRC	Community Rehabilitation Company
GT	Grounded Theory
IPA	Interpretative Phenomenological Analysis
IPTS	Interpersonal-Psychological theory of suicide
IMV	Integrated Motivational-Volitional
MINI	Mini International Neuropsychiatric Interview
NOMS	National Offender Management Service
NPS	National Probation Service
OASYS	Offender Assessment System
PD	Personality Disorder
PIS	Plutchik Impulsivity Scale
PTSD	Posttraumatic Stress Disorder
TA	Thematic analysis
TAS	Toronto Alexithymia Scale
SAD	Social Anxiety Disorder
SAPAS	Standard Assessment of Personality -Abbreviated Scale
VAS	Visual Analogue Scale

List of publications and presentations

Publications:

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Borrill, J., **Mackenzie, J.**, Cook, L., & Beck, A. (2015). Relationships in the context of suicide risk. *Probation Journal*, 62(1), 71-73.

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Declaration

I declare that all of the material presented in this thesis is my own work and has not been submitted at any other University.

1 Chapter One: Introduction

It is estimated that a suicide occurs every 4 seconds worldwide, yet suicide is still largely unreported by some countries (World Health Organisation, 2014). Worldwide initiatives have been set up to reduce deaths by suicide, with individual countries having unique strategies to reduce the number of individuals dying by suicide every year (World Health Organisation, 2011, 2014). In England the Department of Health is responsible for the development of suicide prevention strategies (The Department of Health, 2012). The most recent strategy devised by the Department of Health sets out six main goals for reducing suicide in England by 20%:

1. To reduce suicide in high risk groups such as offenders and individuals working in an at risk job such as farmers, doctors and agricultural workers.
2. To improve the overall mental health of particular populations such as foreign nationals.
3. To reduce access to means of suicide, for example by noting high risk locations and targeting these areas.
4. To provide better information and support to those bereaved or affected by suicide.
5. To support the media in presenting suicide and self-harm in a sensitive manner.
6. To support the monitoring of suicide, as well as research on suicide and self-harm at both local and national levels.

These goals draw attention to ‘at risk’ populations who are considered to be at a higher risk of dying by suicide than others. Suicide prevention strategies are therefore often tailored to meet the needs of these groups (Hawton & van Heeringen, 2009). Offenders are one group of individuals who are particularly at risk of dying by suicide (Fazel, Benning, & Danesh, 2005). Addiction, mental illness and other health related issues are prevalent amongst offender populations (Gunter, Chibnall, Antoniak, Philibert, & Hollenbeck, 2011) and are considered to play a role in suicide and self-harm (Joiner, 2005). UK based studies have found that male prisoners are five times

more likely to carry out suicide than males from a non-prison population (Fazel et al., 2005). Female prisoners were twenty times more likely to end their life by suicide than females of the same age in a non-prison population (Fazel & Benning, 2009). One large scale study in the United States, which covered 31 jurisdictions, found suicide figures to be more than nine times higher in large prisons and one and half times higher in small prisons, compared to the figures of those in the general population (Hayes, 1995). However the number of suicides by prisoners has continually fallen since 1998 until 2008, when a slight increase began (Department of Health, 2015).

Suicides in prisons have gained a considerable amount of attention from researchers, due to the perceived association between suicide and the effects of a prison environment, as well as the conditions of living (World Health Organisation, 2007). Yet offenders in the community who are not subject to the same environmental conditions seem to have been somewhat neglected, despite a small number of studies suggesting that there are comparable suicide rates between the two populations (Biles, Harding, & Walker, 1999; Pritchard, Cox, & Dawson, 1997; Sattar, 2001). One study even suggested that suicides in the probation population may surpass those in the prison population (Sattar, 2003). Moreover it is estimated that 500 people per year die by suicide whilst under the supervision of probation (Crook, 2010). Figure 1 shows the suicide rates in England and Wales for the general population, prison settings and probation settings according to gender. Data regarding general population suicide rates can be accessed via the Office for National Statistics. Data for self-inflicted deaths in custodial settings can be accessed via the Ministry of Justice website. However, data regarding the deaths of offenders serving community based sentences is more difficult to access (Gelsthorpe, Padfield, & Phillips, 2012). The data presented in Figure 1 comes from a report issued by the Howard League of Penal Reform in which data was gathered via a freedom of information request in 2011. This limited access in comparison to prison data creates difficulty for researchers who aim to highlight the need for better suicide prevention techniques in probation settings.

In 2009 241,500 people were under the supervision of the probation service (Ministry of Justice, 2010a). Research on suicidal behaviours is vital considering the Government's drive to decrease the prison population by making use of community sentences (Herbert, 2010; Ministry of Justice, 2010a), as well as the introduction of

the Offender Rehabilitation Act (2015) which will increase those monitored by probation (Ministry of Justice, 2015b).

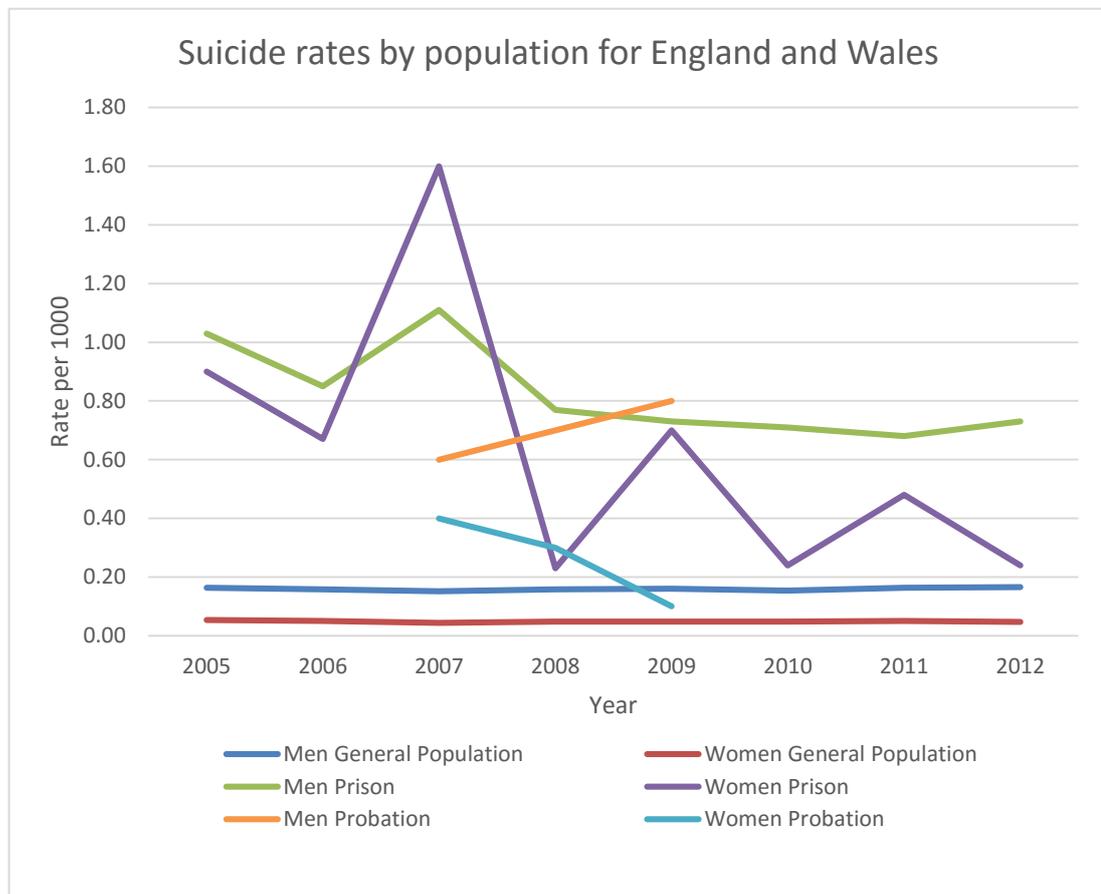


Figure 1: Suicide rates per 1000 people according to population and gender.

Until early 2014 the UK Probation service was monitored by the national offender management service who were responsible for the running of prisons and probation trusts in England and Wales (National Offender Management Service, 2012) (NOMS). All 42 probation trusts were accountable to NOMS and responsible for offenders who have been ‘sentenced by the courts to a community order, suspended sentence or released from prison on licence’ (National Offender Management Service, 2012). However, recent changes have occurred which have seen the probation service separated into two divisions; one private sector division run by Community Rehabilitation Companies (CRCs) who are responsible for ‘low to medium risk’ offenders in 21 different locations; and the national probation service who are responsible for high risk offenders in seven different locations across England and Wales (Ministry of Justice, 2015b). The current research was carried out before these

changes occurred therefore allowing the researcher to gain access to offenders at all risk levels (low, medium, high).

Community sentences are designed as an alternative to prison for offenders that are deemed not to be a risk to the public (Directgov, 2011a). The community sentence enables offenders to carry out their punishment in an open setting, refocusing them away from crime via the undertaking of rehabilitation programmes and restorative unpaid work in the community (The Howard League of Penal Reform, 2011). Overall there are three main groups of offenders under the supervision of the probation service; individuals who have been given a probation sentence, individuals that have been given a residence requirement and individuals who have to undertake some form of community payback. These can overlap with one another. Offenders who have received a probation sentence will need to report to their offender manager on a regular basis. There are three reasons that someone will need to report to an offender manager: it is part of their community sentence, they have been in prison for longer than a year and have now been released on licence and therefore need to be monitored, or they have been released early from prison on parole and need to be monitored (Directgov, 2011b). Community payback requires individuals to complete 40-300 hours of unpaid work with a minimum of 6 hours per week. The unpaid work will normally include a task that benefits the community, like graffiti removal (Directgov, 2011b). Lastly, some offenders will be given a residence order. A residence order means that the person will be told where he/she has to live. This can be at their own home, a family member's home or in an approved premises which is supervised by the probation service (Directgov, 2011c). This last group are now under the under supervision of the NPS only, not the CRCs.

Furthermore in 2005 a revision to the Criminal Justice Act 2003 (CJA) provides judges and magistrates with additional flexibility when sentencing someone to a community order. The needs of the offender can now be taken into consideration. Sentences can be adapted to include specific requirements suited to the offender. A maximum of twelve requirements can be given to an individual who is given a community order sentence (see Table 1). The CJA 2003 (amendment 2005) indicates that serious offences should have more requirements than less serious offences (Directgov, 2011c).

Table 1 The Twelve Requirements that can be given as part of a Community Sentence.

Supervision	<i>Offenders must visit their offender manager regularly and for a specified length of time (daily, weekly, monthly etc.)</i>
Unpaid Work	<i>A maximum of 300 hours can be given to one individual. Unpaid work can involve any form or restoration to the local community. Communities are often asked to nominate projects</i>
Partaking in designated tasks/activities	<i>Individuals may have to undertake a form of learning such as maths, literacy etc.</i>
Restriction of certain activities	<i>Offenders may be prohibited from taking part in certain activities like drinking alcohol.</i>
Partaking in accredited courses/programmes	<i>This will involve the undertaking of accredited courses that aim to change the offenders behaviour such as anger management programmes or driving courses</i>
Curfews	<i>This would involve the offender being restricted to a certain place for a number of hours during the day/night.</i>
Exclusion zones	<i>Where an offender is prohibited from entering a certain area</i>
Housing requirement	<i>Where an offender is required to live in a certain place such as an approved premises</i>
Mental Health treatment	<i>(only by consent of offender)</i>
Drug Rehabilitation	<i>(only by consent of the offender) both testing and treatment</i>
Alcohol treatment	<i>(only by consent of the offender) lasts for a minimum of 6 months</i>
Attending a centre	<i>Under the age of 25, offenders could be required to attend a specific centre, this will range between 12-36 hours for the whole sentence</i>

London is considered to be one of, if not the most culturally and ethnically diverse places in the UK; it is home to around 179 different nationalities (Vertovec, 2007). Currently the London CRC are responsible for the monitoring of approximately 25,000 low to medium risk offenders across the 33 boroughs of London (London

Community Rehabilitation Company, 2015), with NPS London supervising offenders in 13 approved premises and nine prisons (Ministry of Justice, 2015a). It is essential, given the large number of offenders that are monitored in London and the diversity that exists amongst them, that both the NPS and the CRC (London) have strict procedures in place to monitor suicide and self-harm. As part of the criminal justice system the probation service have a responsibility to prevent and reduce suicides and self-harming behaviour (Bridges, Owers, & Flanagan, 2008). In accordance with Department of Health strategies the NPS have a number of ways of assessing risk of suicide and self-harm in their clients (The Howard League of Penal Reform, 2011). The Offender Assessment System (OASys) was set up in 2002 assessing all types of risk in offenders including risk to self. In addition to this a multiagency approach to information sharing is taken by gathering records of self-harming behaviour from other agencies including prisons and the police (National Probation Service, 2006). Monitoring of risk is essential to reducing suicide (Beck & Casado, 2005).

London in particular has developed suicide and self-harm training for staff. This training, until the recent changes to the probation system, was available to all staff in London and is mandatory for those who work in probation run approved premises (Beck, 2014a). It is not clear whether the London CRC will continue to offer this training to their staff. Furthermore London NPS has a suicide and self-harm prevention forum, that has helped with the development of training and has implemented a number of suicide prevention strategies across London such as the introduction of ligature knives in all approved premises (Beck, 2014a).

1.1 An overview of the current thesis

The current research sought to investigate suicidal behaviours carried out by offenders serving community based sentences. Chapter 2 will provide an overview of the research on this topic and the aims and scope of the current research. Chapters 3 & 4 provide details of the methodology and methods employed in data collection and analysis. Chapters 5, 6, 7, 8, 9 present the findings of four studies carried out to investigate suicidal behaviours by probation clients, as well as providing short discussions of these findings. Lastly, Chapter 10 provides a general discussion of the findings, in particular drawing on what these findings mean and why they are important. Furthermore, what the implications of these findings are and what recommendations can be made to help prevent suicide in probation clients. Also what

this means for individuals working with these types of offenders. The constraints of the current research are also addressed.

2 Chapter Two: Previous research

The purpose of this chapter is to provide a summary of the relevant literature on suicide, near-lethal suicide and severe self-harm in the community offender population. The chapter begins with an overview on the current understandings of suicide and suicidal behaviours. Definitional issues, as well as theories of suicide are discussed. Factors relating to suicide in general and suicide in offender populations are then discussed. The chapter then specifically focuses on the research that has been carried out on suicide by probation clients. The research that exists on this topic is limited and much of what has been conducted has relied on retrospectively understanding suicide once the person has died. Studies that have employed methods which have used living participants are restricted to quantitative studies which do not consider suicide from the perspective of the person who has made a near-lethal attempt. This chapter concludes with an overview of the aims and scope of the current research.

2.1 Perceptions of Suicide: from crime to madness to prevention.

Perceptions of suicide and attempted suicide have changed dramatically over the last 500 years. During the Middle Ages suicide was condemned by the church and frequently associated with witchcraft. Families of individuals who died by suicide lived in poverty because they were no longer entitled to the deceased person's property, instead having to pay their debts (Williams, 1997). By the Tudor period the law was enforced much more harshly than before and many people suffered not only the loss of a loved one, but the financial burden that came after a suicide. Changes in perceptions of suicide did not come until the 1700's when suicide was instead viewed as the act of a person with an imbalanced mind, and often as a way to escape from harsh economic circumstance. Primarily suicidal individuals were kept in isolation to prevent them from hurting themselves. Yet, during the 1800's people were still arrested in London for attempting suicide. Religious penalties for suicide were not abolished until 1823 and secular punishments were still law until 1870. It was not until 1961 in the United Kingdom that suicide ceased to be a crime (Williams, 1997). The attitude towards suicide is now instead focused on suicide prevention and helping those who are suffering from suicidal feelings (World Health Organisation, 2014).

2.2 Suicide definitions: Practical problems for researchers

Much debate has occurred over how suicide and other 'suicidal behaviours' should be defined (De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2004). Caution should be taken when comparing studies internationally because of the differences in defining and recording suicide across different jurisdictions. In England and Wales, a coroner is responsible for deciding whether a person's death has been caused by suicide and a suicide verdict is only recorded if it is considered beyond reasonable doubt that the person ended their own life (World Health Organisation, 1974), for example based on the presence of a suicide note or other evidence of intent. In more ambiguous cases the death will be categorised as an open verdict or accidental death. The same situation applies in Australia (Paton & Jenkins, 2005). However, in order to ensure that all potential suicides are recorded and fully investigated amongst the offender population, the National Offender Management Service in England and Wales employs the terminology of 'self-inflicted deaths' to include 'any death of a person who has apparently taken his or her own life irrespective of intent' (National Offender Management Service, 2010). Other countries such as Denmark and Sweden use wider definitions, recording a death of suicide on the balance of probability. Many researchers include 'open cause' deaths, working on the understanding that not including these undetermined deaths may lead to missing some suicides (Paton & Jenkins, 2005). Coroners in the UK are increasingly using narrative verdicts - a description of the circumstances of the death and how it occurred (Gunnell, Hawton, & Kapur, 2011) - to describe deaths which would otherwise be labelled as an open verdict. However narrative verdicts also present problems for researchers coding official suicide statistics as they do not provide clear categories for researchers to work with (Gunnell et al., 2011). Overall definitional differences could potentially lead to problems when making comparisons between research findings. Studies that employ a stringent definition of suicide could potentially miss some individuals who have died by suicide, whereas using an 'open cause' definition may include individuals who have not died by suicide.

Often suicidal behaviours are difficult to define due to the issue of establishing the intention of the individual carrying out the behaviour (De Leo et al., 2004). It has however, more recently been argued that intention should not be the sole basis for definition, particularly for those that have survived suicide attempts (Hawton, 2002).

Regardless of intention research indicates that previous self-injury makes someone more vulnerable to eventual completed suicide (Hawton, Linsell, Adeniji, Sariaslan, & Fazel, 2013; Joiner, 2005) and those carrying out the behaviour often do not know their own intentions (Hawton, 2002). Therefore it has been suggested that an overarching term of 'suicidal behaviours' should be used to encompass the many variations of behaviour that individuals carry out relating to suicide (De Leo et al., 2004).

2.3 Explanatory Theories of Suicide

Suicide is a major health problem, however, it is complex and those who are confronted by it often struggle to understand why someone they know and love chose to end their life (Williams, 1997). For researchers, an even more puzzling question is why some individuals chose to end their life, whilst others who also experience extremely distressing situations do not ever consider ending their life (Wasserman, 2001). Attempting to understand and ultimately prevent suicide psychologists, sociologists, psychiatrists, and researchers from many other areas have developed theories of suicide to explain the factors that make some people more vulnerable to suicide than others. Whilst all theoretical approaches cannot all be discussed within the constraints of this thesis, an overview of four well established theories of suicide have been included; Shneidman's (1993) suicide as psychache, Pollock and Williams (2001) cry of pain model of suicide, Joiner's (2005) interpersonal model of suicidal behaviour and O'Connor's (2011) integrated motivational-volitional model.

2.3.1 Shneidman (1993) Suicide as Psychache

According to Shneidman (1993) suicide is a result of psychache; intolerable psychological pain which stems from unfulfilled or distorted psychological needs. He argues that depression, hopelessness and other psychiatric disorders do not cause suicide, but instead contribute towards psychache, the affective state necessary for suicide. Shneidman suggests that human acts are used to satisfy these psychological needs and that suicide is an act carried out to decrease the pain and frustration of thwarted or unfulfilled needs. Shneidman's theory stems from Murray's (1938) taxonomy of human needs, which proposes that if these unsatisfied/thwarted needs are addressed then suicidal outcomes can be reduced. According to Shneidman there are twenty psychological needs, split into two categories; *modal needs*, which define our personality day-to-day, and *vital needs*, which are the outcomes of conditions of

extreme stress. Vital needs are the needs that people are willing to die for. The pain experienced from thwarted vital needs results in psychache.

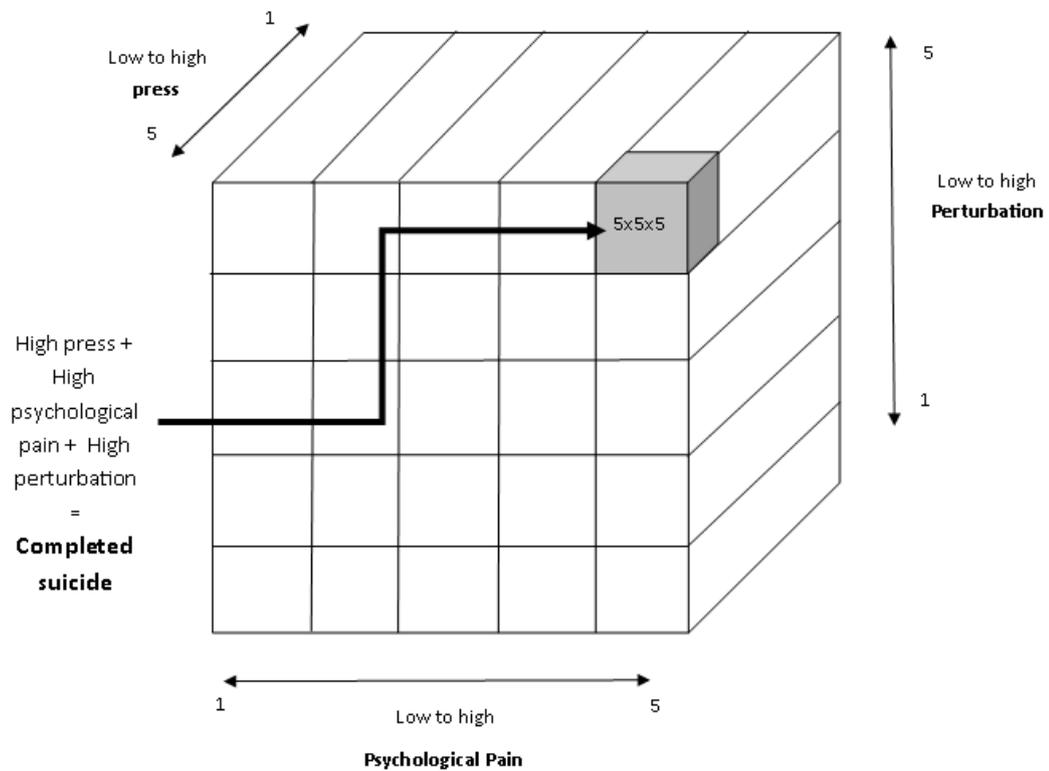


Figure 2: Completed Suicide Cube Model (Adapted from Shneidman 1993)

However, according to Shneidman there are specific conditions which are necessary for the suicidal state to occur. His cube diagram (See Figure 2) demonstrates the circumstances where suicide will occur: *Psychological pain*, which is the pain resulting from the thwarted or unfulfilled psychological needs, would be high (square 5); *Perturbation* – the state of being upset or agitated -would also need to be at its highest (5); lastly *press* which are the things that affect the individuals life and cause stress and worry would also need to be at its highest (5). Therefore according to this cube model of suicide, completed suicide will only occur if all three components are at their highest in cube five.

Shneidman recognises that each person’s suicide is unique to their own situation and context, however he suggests that there are certain components which result in the suicidal outcome, these are illustrated in Figure 3

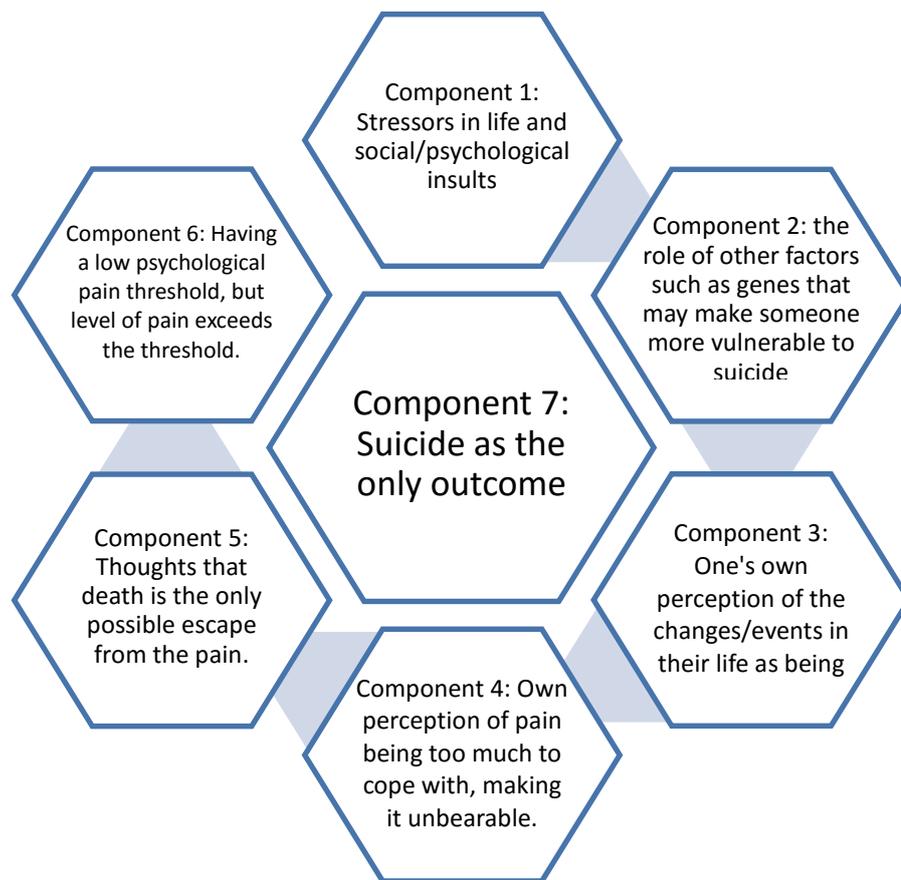


Figure 3: Shneidman's (1993) Seven Components of Suicide

Overall there is considerable support for psychache as a psychological concept (Troister & Holden, 2010). However, there are several limitations to the theory. Despite abundant support for the concept existing in some populations, there is mixed evidence for the concept existing in other populations, such as offenders, although this may be due the inappropriateness of the instruments used to measure psychache (Mills, Green, & Reddon, 2005). Furthermore, and like many theories of suicidal behaviour Shneidman fails to consider the differences or similarities between suicide attempts, completed suicide and suicidal ideations (Klonsky & May, 2014).

2.3.2 Williams & Pollock (2001) – Cry of Pain Model of Suicide

The Cry of Pain (CoP) hypothesis is a three component model of suicidal behaviour which builds upon previous theories of arrested flight (Gilbert & Allan, 1998) and escape (Baumeister, 1990), explaining suicide as a response to a stressful situation (Williams, 1997). According to Williams, suicide is not a cry for help as previous theories had suggested, instead it is a cry of pain. Williams posits that the 'cry for help' theories of suicide account for attempted suicide and self-harm, whereas a cry of pain applies to all forms of self-injurious behaviour, particularly completed suicide.

Pollock and Williams (2001) suggest that the development of suicidal behaviour and/or suicidal feelings always begins with a sense of *defeat*. This sense of defeat is normally due to external factors such as worries about family, employment, or the situation that the person finds themselves in. Drawing on the ideas of Gilbert and Allan (1998), Pollock and Williams (2001) propose that suicidal individuals will experience a sense of *defeat* and ultimately enact the *flight* mechanism. *Defeat* is a natural mechanism aimed at protecting the 'loser' from further harm. According to Williams, a person who feels defeated by a situation may then go onto feel a sense of *entrapment*. *Entrapment* is when a person can no longer see a way to escape from their situation.

Williams explains that *entrapment* can be mediated by perceived social support (see Figure 4). If a person perceives themselves as having suitable social support then suicide is less likely to be viewed as the only option. Another potential mediating factor is autobiographical memory bias. According to Williams the physiological changes that occur to the body during the depressed state, can have a lasting impact on problem solving and memory. Thus those with a history of depression are more likely to suffer enduring changes to their brain functioning and memory recall, often leading to the selective recall of negative memories making suicide a viable option for escape. Autobiographical reduction has also been linked to experiencing traumatic events (Kleim & Ehlers, 2008) including childhood trauma (Crane et al., 2014) and sexual abuse (Hauer, Wessel, Geraerts, Merckelbach, & Dalgleish, 2008). In these cases where a person experiences feelings of defeat and entrapment they are less likely to see alternative solutions to their situation and more likely to complete suicide. Williams proposes that prescription drugs and therapy may help to change this way of thinking.

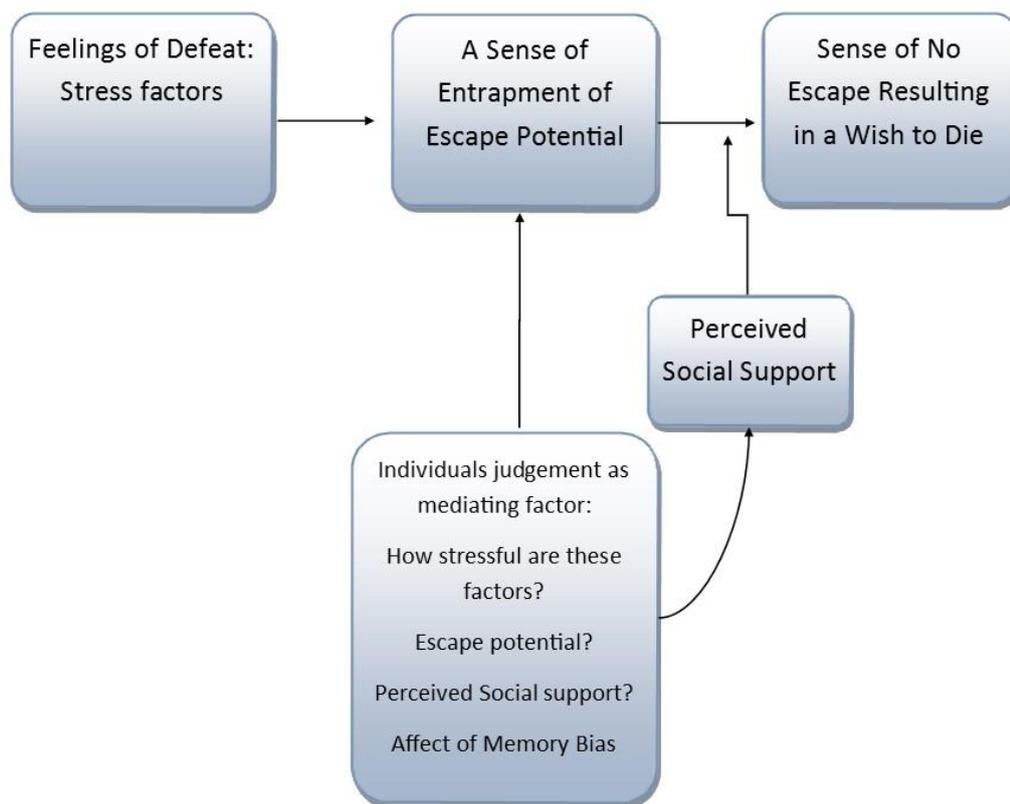


Figure 4: Williams Cry of Pain Hypothesis: Casual Pathway to Suicidal Behaviour adapted from Williams (1997)

Support for the CoP model is demonstrated by research with clinically suicidal populations (O'Connor, 2003). Furthermore, according to Williams (2014) the CoP model can explain why some populations are more at risk of suicide than others, for example prisoners. Williams suggests that many prisoners feel that they cannot escape prison or the bullying that they encounter whilst living in prison, which leads to a sense of entrapment. Research with prisoners confirms this prediction (Slade, Edelmann, Worrall, & Bray, 2014). However, there are several limitations of the CoP model including lack of clarity in terms of how *defeat* and *entrapment* relate to one another (Johnson, Gooding, & Tarrier, 2008) and whether they are two separate constructs or part of one construct that relates to suicidal behaviour (Taylor, Gooding, Wood, & Tarrier, 2011; Taylor, Gooding, Wood, Johnson, & Tarrier, 2011). Furthermore it is unclear whether *defeat* and *entrapment* lead to processing problems or vice versa (Tarrier et al., 2013).

2.3.3 Joiner – The Interpersonal-Psychological Theory of Suicidal Behaviour

Joiner's (2005) interpersonal theory of suicide offers an answer to the question 'why do people die by suicide.' The IPTS comprises of three components (see Figure 5)

which explain why someone may die by suicide; having an *acquired ability* to enact lethal self-harm; experiencing *thwarted belongingness*; and experiencing a *perceived burdensomeness* (Joiner, 2005).

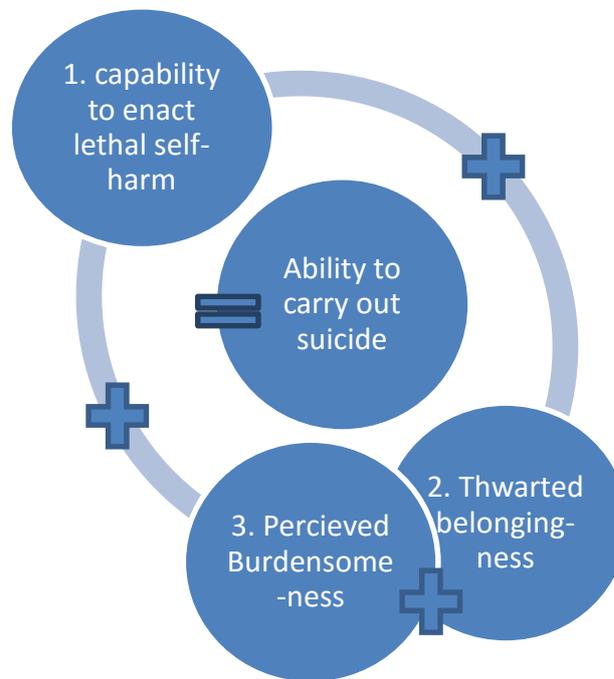


Figure 5: Joiner's (2005) Interpersonal Theory of Suicide

The first component, *acquired ability* to enact lethal self-harm, progresses over time. *Acquired ability* develops through the repeated exposure to provocative events or experiences. The person loses the normal fear or arousal that is created when being in a dangerous or provocative situation (Joiner, 2005). According to Joiner this is why some populations are more vulnerable to suicide than others; for example soldiers, doctors, and offenders. Their repeated exposure to dangerous and/or provocative events reduces the fear/pain which individuals would normally experience in these situation, and which they would have previously experienced. Joiner proposes that any repeated exposure to a painful experience can increase a person's tolerance of pain, this includes occurrences such as accidents, combat and violence. It does not necessarily have to be self-inflicted pain, or physical pain. According to Joiners theory this higher tolerance of pain is necessary for enabling the capability for someone to carry out suicide and/or self-harm, and it distinguishes those that could die from suicide and those that will not die from suicide (Joiner et al., 2009b).

Joiner's model recognises that some people will become habituated to pain, yet they will not necessarily have the desire to die by suicide. Joiner (2005) suggests that people will only die by suicide if they have the capability to do so, as well as the desire to do so. Desire to die by suicide is developed through two interpersonal mind states; *thwarted belongingness* and *perceived burdensomeness*. Perceived burdensomeness is the view that the person's own existence is so faulty or substandard that they are a burden to the people around them, particularly to their family and friends. According to Joiner, when a person perceives themselves to be a burden, they may also feel that their friends and family will be better off if they were dead. For a person to have the desire to die they must also have a sense of failed belongingness. Joiner proposes that people who experience thwarted belongingness will feel lonely, socially alienated and lack a sense of belonging. Both *thwarted belongingness* and a *self-perceived burdensomeness* will, according to Joiner's theory, cut all ties from life. Overall, it is these three components combined when a person is most vulnerable to carrying out suicidal behaviour.

The IPTS model has been applied successfully in a number of settings and with a number of at risk populations such as offenders (Cramer et al., 2012; Ireland & York, 2012) and adolescents (Joiner et al., 2009a), while mixed evidence exists for some populations such as military personnel (Bryan, Morrow, Anestis, & Joiner, 2010). As the IPTS is still a relatively new theory, further research is needed to confirm its applicability in different populations. However it has been argued that the tolerance to pain component of the IPTS model does go some way to explaining the higher suicide rates in males compared with females, and in specific 'at risk' populations (Joiner, 2005).

2.3.4 The Integrated Motivational-Volitional Model of Suicidal Behaviour

The IMV model of suicidal behaviour is a tripartite theory which incorporates previous theories of suicidal behaviour and attempts to distinguish between those who ideate about suicide from those who attempt/complete suicide. There are three stages to this model; *Pre-motivational phase*; *Motivational Phase*; and *Volitional Phase* (see Figure 6).

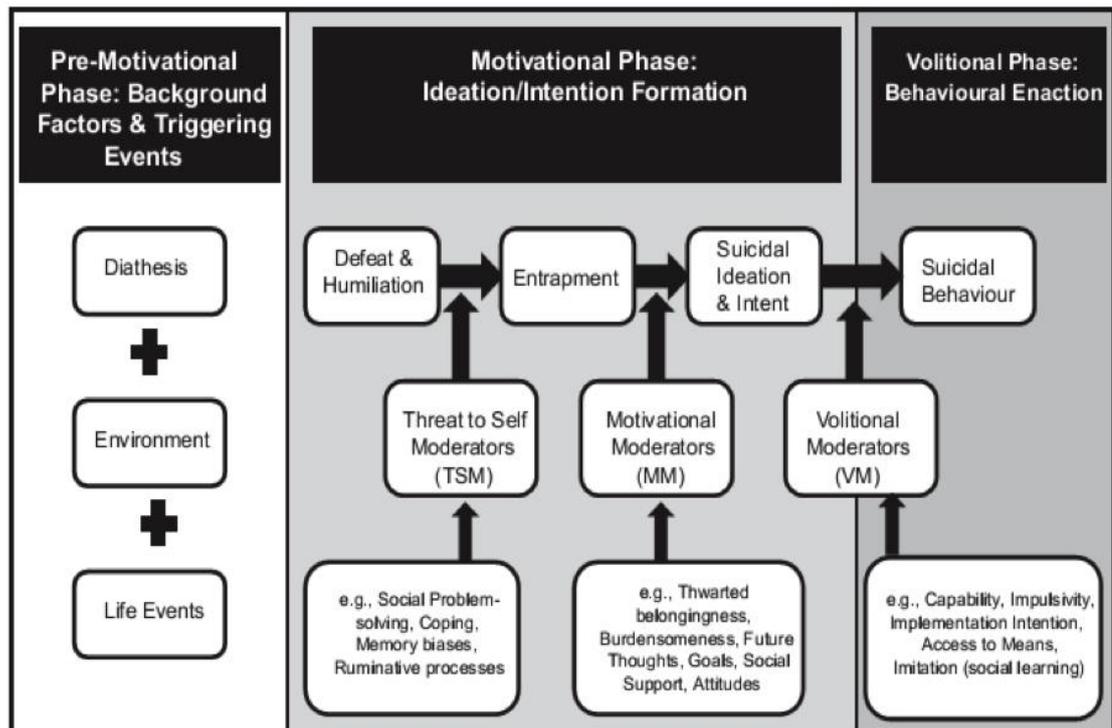


Figure 6: The Integrated Motivational-Volitional Model of Suicidal Behaviour, taken from page 184 O'Connor (2011)

The first phase, the *pre-motivational phase* is based on diathesis-stress hypothesis. This is a biopsychosocial aspect of the model which considers factors that may make someone vulnerable to suicidal behaviours (as shown in Figure 6), incorporating environmental and life events, as well as cognitive and biological factors. O'Connor (2011) proposes that these vulnerabilities will only be exposed if they are triggered by stress, for example experiencing a traumatic life event. The second phase of the model, the *motivational phase*, is based on the Theory of Planned Behaviour and concepts of Williams (1997) cry of pain model and later entrapment model of suicidal behaviour. The *motivational phase* is about the process of feeling defeated/humiliated, trapped, resulting in viewing suicide as the only option for escape. During this phase a number of moderators (see Figure 6) will impact on whether or not the individual will eventually reach the suicidal ideation stage. Stage three, the *volitional phase*, determines whether or not the person will enact suicidal behaviour, dependent on volitional moderators (see Figure 6) such as access to means, impulsivity, and capability. Overall the IMV model explains suicide as a process over time rather than a single cause or trigger and takes into account previous theories and models of suicidal behaviour, but also extends them.

Overall all four theories indicate that suicide cannot be explained by one factor alone and instead is an outcome of multiple issues and part of a process. All theories mentioned above do take into account the complexity of suicide and potential issues that could lead someone to end their own life. Yet, despite their usefulness these theories cannot draw out the individual differences related to the suicidal crisis and cannot explain the subjective experience of the suicidal state. Therefore it is also appropriate to consider some of the individual risk factors associated with suicide and suicidal behaviours in more detail.

2.4 Risk factors Associated with Suicide

There are a number of factors that may make someone more at risk of carrying out suicide and/or suicidal behaviours. Related to this is the increased risk of eventual suicide in some populations compared with others (Joiner, 2005). The following sections provide an overview of some of the risk factors associated with suicidal behaviours, particularly those associated with offenders.

2.4.1 Psychiatric illness

Suicide risk increases dramatically when an individual is suffering from a psychiatric disorder (Sattar, 2001). An inquiry carried out by the Department of Health in 2001 investigated mental illness in people who had ended their life by suicide (Department of Health, 2001). The study revealed that young people who suffered from schizophrenia, personality disorder and/or alcohol/drug addiction were at the highest risk of suicide. The inquiry focused on the occurrence of mental illness prior to their suicide, paying particular attention to contact between the individual and mental health services. Findings indicated that 20,927 (England and Wales), 2650 (Scotland) and 502 (N. Ireland) people had been in contact with mental health services prior to their self-inflicted death (Department of Health, 2001). These findings draw attention to the increased risk mental illness can have in relation to suicide. Even more striking was the potential underestimation of the figures used in the study, as not all individuals with a mental health condition who went on to carry out suicide would have been in contact with mental health services (Paton & Jenkins, 2005).

Psychiatric illness as a risk factor does go some way to explain why certain populations have higher rates of suicide than other populations. There is a vast spectrum of psychiatric disorders amongst the offender population (Humphreys, 2000)

with prisons throughout Europe and the United States detaining large numbers of inmates suffering from a mental health condition (Blaauw, Roesch, & Kerkhof, 2000). Recent findings from two case control studies carried out with prisoners indicates that psychiatric disorders are more prevalent in prisoners who have carried out a near lethal suicide attempt/incident of self-harm compared to prisoners with no prior history of self-harm or suicidal behaviour (Marzano, Fazel, Rivlin, & Hawton, 2010; Rivlin, Hawton, Marzano, & Fazel, 2010). Results suggest that female prisoners are more likely to be diagnosed with depression and post-traumatic stress disorders, whereas men are more likely to be diagnosed with major depression, psychosis, anxiety disorder and drug misuse (Marzano et al., 2010; Rivlin et al., 2010). Despite different rates between males and females, depression is common to both groups.

Comorbidity between suicidal behaviour and mental illness is not restricted to offenders in prison settings. Offenders serving community sentences are also at an increased risk of suicide and also have high rates of mental illness (Hatfield, Ryan, Pickering, Burroughs, & Crofts, 2004; Wessely, Akhurst, Brown, & Moss, 1996). A small scale study carried out by Pritchard et al. (1997) investigated 28 deaths of offenders in Dorset serving community sentences. Of these deaths, nine were identified as suicides, which was nine times the suicide rate in the general population, with psychiatric illness as one of the major risk factors (Pritchard et al., 1997). Furthermore a recent comprehensive study that investigated the prevalence of mental illness in a probation sample provided further support for an association between suicide and psychiatric illness (Brooker et al., 2011). Brooker et al. (2011) found high levels of psychiatric illness in a sample of 173 probation clients in Lincolnshire, which they linked to a number of characteristics including; suicidality, receiving benefits, and having a personality disorder. Both alcohol abuse (Cherpitel, Borges, & Wilcox, 2004; Cook & Borrill, 2013; Crosby, Espitia-Hardeman, Ortega, & Lozano, 2013; McGirr & Turecki, 2011; Rossow, 1996; Rossow & Amundsen, 1995) and personality disorder (Black, Blum, Pfohl, & Hale, 2004; Casey, 1989; Soloff, Lis, Kelly, Cornelius, & Ulrich, 1994) have separately been linked to suicidal behaviours.

2.4.2 Hopelessness

Hopelessness has been linked to suicide, depression and having a psychiatric diagnosis (Beck, Steer, Kovacs, & Garrison, 1985). Hopelessness, commonly measured on the Beck Hopelessness Scale (BHS) (Beck & Steer, 1993), has been shown to predict eventual suicide in psychiatric patients. Beck, Brown, Berchick, Stewart, and Steer (1990) found that during a 10 year follow-up study, 16 of the 17 patients who went on to complete suicide had previously scored 9+ on the BHS for severe hopelessness. Furthermore, hopelessness has been linked to near-lethal behaviour in male (Rivlin, Hawton, Marzano, & Fazel, 2013) and female prisoners (Marzano, Fazel, Rivlin, & Hawton, 2011), but little research has investigated this association in adult probation clients. One study in the United States explored the links between suicide proneness, depression and hopelessness in adolescents serving a probation sentence (N=233). Findings indicated that 11% of the population disclosed prior attempts, and hopelessness was found to be associated with suicidality (Langhinrichsen-Rohling & Lamis, 2008). However there is mixed evidence regarding whether there is a direct link between suicide and hopelessness, or whether it is the combination of hopelessness and other contributing factors such as psychiatric illness that is linked to suicide (Beck, Beck, Steer, & Newman, 1993; Dyer & Kreitman, 1984). Recent research suggests that the link between hopelessness and suicide is not clear, and hopelessness appears to predict suicidal ideation rather than eventual completed suicide (Klonsky & May, 2014). It has been suggested that positive future thinking may instead be a better predictor of suicide (O'Connor, Fraser, Whyte, Machale, & Masterton, 2008). More research is needed on the probation population to clarify the potential relationship between hopelessness and suicide.

2.4.3 Impulsivity

Impulsivity has been found to be a risk factor for suicide amongst offenders, although the suicidal act itself is not always impulsive but instead pre-planned (Smith et al., 2008). Furthermore some research suggests that impulsivity is related to self-harm in prisoners rather than suicide. Carli et al. (2010) investigated the role of impulsivity in male prisoners in relation to attempted suicide, suicide ideation and deliberate self-harm. Findings indicate that those with high impulsivity are more prone towards suicidal behaviour than those who are less impulsive. However, highly impulsive individuals were more likely to self-harm but were no more likely than the low impulsives to attempt suicide (Carli et al., 2010). Although, alternate case control

research does suggest a link between impulsivity and suicide in prisoners (Rivlin et al., 2013). It has also been suggested that there may be a link between impulsivity and suicidality in young offenders serving community sentences (Langhinrichsen-Rohling & Lamis, 2008). There are mixed findings regarding the role that impulsivity plays in suicidal behaviours in prisoners, and this role needs to be further explored in probation clients.

2.4.4 Alexithymia

More recently researchers have considered the possible link between alexithymia and suicide (Hintikka, 2004). Alexithymia is not categorised within the DSM and instead can be described as a personality construct (Lumleya, 2007). Individuals with alexithymia may have difficulty with identifying and/or describing feelings, have difficulty understanding perspectives other than their own and have a limited imagination (Lumleya, 2007). Alexithymia means ‘no words to describe feelings.’ Alexithymia has been linked with a number of mental health issues including depression (Hintikka, 2004) and panic disorder (Iancu, Dannon, Poreh, Lepkifker, & Grunhaus, 2001). Hintikka (2004) carried out an investigation into the effects of alexithymia and depression on suicide ideation in the general population (N=1,563). The findings revealed that those suffering from either alexithymia or depression are at an increased risk of suicide. Furthermore if the two are presented together the risk further increases (Hintikka, 2004). Alexithymia has also been linked to delinquency and criminality (Zimmermann, 2006). A case control study of young offenders revealed alexithymia to be more prevalent in offenders than in the general population (Zimmermann, 2006). Overall the research suggests alexithymia may be related to suicide risk or equally alexithymia may be more prevalent in populations who are particularly vulnerable to suicide, such as offenders or people who are suffering from mental illnesses. To the researcher’s knowledge there is no research that has assessed alexithymia in individuals in the probation service who have attempted suicide/carried out near lethal self-harm. Given that these type of offenders are at an increased risk of suicide (Sattar, 2001) compared to the general population it is of relevance to investigate whether there is a high prevalence of Alexithymia in this group.

Summary: Having information about factors that may cause some people to be at an increased risk of suicide compared with others is helpful for suicide prevention.

However, research that specifically focuses on populations who are at an increased risk of suicide can be more helpful for providing tailored prevention techniques. Therefore the following sections outline what is already known about suicide in the probation population and what needs to be done to increase the knowledge of this area.

2.5 Research on Suicide in the Recently Released Prison Population

Probation are somewhat neglected in the research, although some focus has been given to the recently released prison population, some of which will also be under supervision from probation. Offenders who leave prison have been found to be more vulnerable to suicide than the general population at that time (Binswanger et al., 2007; Hobbs et al., 2006; Kariminia et al., 2007; Stewart, Henderson, Hobbs, Ridout, & Knuiman, 2004) and although one study found released offenders to be equally as vulnerable to suicide as the general population (Krinsky, Lathrop, Brown, & Nolte, 2009). The first two weeks of release appear to be the most risky time for a suicide to occur (Binswanger et al., 2007; Kariminia et al., 2007). Pratt, Piper, Appleby, Webb, and Shaw (2006) investigated suicide in offenders released from prison within the past year. A database that contains information about suicides carried out by offenders who were released between 2000-2002 revealed that 382 of 244,988 died by suicide; 21% ($N=79$) of these individuals took their own life within 28 days of their release from prison. It was concluded that higher rates of suicide exist in the recently released prisoner population compared to the general population. These findings have implications for a number of services, including the probation service, who are still responsible for these individuals (Pratt, Appleby, Piper, Webb, & Shaw, 2010; Pratt et al., 2006). After leaving prison many offenders will need to report to an offender manager and may live in a probation supervised hostel. These studies help to alert probation staff that people who have recently been released from prison may be at an increased risk of suicidal behaviour. However, these findings do not provide specific information about the risk of suicide for offenders serving community sentences who have not been released from prison.

2.6 Research on Suicide in Offenders Carrying Out Community Sentences

Few studies have attempted to investigate suicide and severe self-harm in a community offender population (Powis, 2002; Wessely et al., 1996). A search of the literature was carried out using the following databases: PsycNet, PsycArticles, PsycBooks,

PsycInfo, Medline, Web of Science, Science Direct. The following search terms were used: *Suicide, Near Miss Suicide, Near Lethal Suicide, Attempted Suicide, Self-Harm, Self-Injury* (and) *Probation, Community Sentences, Offenders, community corrections*. The search revealed that research can be broadly grouped into three categories: studies that have focused on suicide by anyone who has come into contact with the criminal justice system; research that has focused on rates of suicide; and quantitative research on suicide attempts. All but a few studies have tended to focus on establishing suicide rates rather than the risks related to suicide.

2.6.1 Research on suicide by individuals who have had any contact with criminal justice system

Recent research has employed large scale studies into the association between suicide and coming into contact with the criminal justice system. Webb et al. (2011) used national registers to identify 27,219 Danish individuals who died by suicide between 1981 and 2006; controls were matched on age, sex and whether they were still alive at the time of the cases' death. National registers were also used to determine which individuals had come into contact with the criminal justice system after 1980. The results indicated that 34% ($N=6,291$) of men who had died by suicide had come into contact with the criminal justice system as well as 24% ($N=85,711$) of the male controls. 12% ($N=1,171$) of the female cases and 5% ($N=9,060$) female controls had come into contact with the criminal justice system. Suicide risk was twice as high in men and three times higher in women if they had any exposure to the criminal justice system. Findings suggest that not only were those who received a custodial sentence at risk of suicide, but individuals who received 'suspended sentences, charges conditionally withdrawn, acquittals and other verdicts' were also at an increased risk of suicide. The groups most at risk were identified as having been sentenced to psychiatric treatment or given suspended sentences (conditional withdrawals). These findings are particularly useful for probation staff as they highlight the specific risk associated with these types of sentence. The authors noted the difficulties in comparing suicides between different countries due to the differences in definitions of suicide. They also pointed to their use of the nationally used 'suicide only' verdicts rather than including undetermined deaths, as potentially leading to 'missed' cases of suicide (Webb et al., 2011).

A large scale register study, similar to the one by Webb et al. (2011), has been carried out in England and Wales (King, 2012). The research aim was to establish suicide risk in relation to the criminal justice pathways (King, 2011). Death records cross-checked with the police national computer system were used to gather for the data for the study. Findings indicate that 36% ($N=1,658$) of the sample who carried out suicide ($N=4,628$) had come into contact with the criminal justice system prior to their death and 41% ($N=682$) of those had contact with the CJS within the last 12 months preceding their death. Furthermore, 20% ($N=134$) of these people had been in contact with the probation service (King, 2011). Additionally a recent study that investigated the suicides of 78 individuals living in Cumbria has found 36% ($N=78$) had been in contact with the criminal justice system in their lifetime and 61% of those had contact within 12 months prior to their deaths (Brown, 2014). These studies highlight the increased risk of suicide by individuals who come into contact with the criminal justice system, including probation clients. However, they do not focus exclusively on the problem of suicide by offenders serving community sentences, therefore they can only provide a limited understanding of the problem. For example these studies cannot identify what might cause suicide by probation clients and why they specifically are at an increased risk of suicide.

2.6.2 Studies focusing on suicide rates of probation clients

Arguably more useful are studies that focus on establishing suicide rates in probation only populations. A small scale study by Pritchard et al. (1997) investigated 28 deaths of offenders serving community sentences. Nine of these deaths were identified as suicides, representing nine times the suicide rate in the local general population at the time. One of the major risk factors associated with suicide was psychiatric illness (Pritchard et al., 1997), emphasizing the role that this can play in suicidal behaviour. A small scale study carried out in Victoria, Australia, found that 29 out of 198 deaths (15%) of offenders serving community sentences during 1995-1995 were due to suicide (Biles et al., 1999). However, as it was a retrospective study of completed suicides the potentially valuable perspective of the client could not be gained. Similarly Sattar (2001) compared data on violent deaths including suicides, in both prisoners and offenders in community settings. An inclusive definition of suicide (suicide and self-inflicted injury) was used in order to minimise the possible problem

of underestimating the number of suicides due to definition. Suicide rates were calculated for both offender groups and compared to the suicide rates of the general population. Again, findings indicate that both offender populations were 7-8 times more likely to carry out suicide than the general public, and those in a community setting appeared to be slightly more at risk than those in custody. Of 1267 offenders who died in a community setting, 282 (22.3%) took their own life. Data also suggested that the community based offenders were more likely to die from accidental death than those in prison, linked to access to alcohol and drugs. Recently released prisoners were most at risk, with 10% ($N=28$) of suicides occurring within the first week of release and 50% ($N=141$) of suicides occurring within the next four weeks of release (Herbert, 2010; Sattar, 2001).

The findings from these types of studies indicate that probation clients are at an elevated risk of suicide, making this a troubling issue for the probation service. More concerning, the figures presented above may still underestimate suicide due to the difficulties in distinguishing between intentional suicides and accidental drug/alcohol related deaths (Herbert, 2010). These figures help to raise an awareness of the vulnerabilities of this offender group, and provide a good representation of the problem of suicide and self-harm within the probation population. However they are unable to provide explanations as to what causes this elevated risk and how does this level of suicide relate to the probation process. Additionally studies which are focused on establishing rates cannot provide insights into what it is like to serve a probation sentence and whether the experience of probation is perceived as relating to suicidal behaviours.

2.6.3 Studies on probation clients who have carried out suicidal behaviours

Studies that have gone some way to indicating what may cause an elevated risk of suicide by probation clients are those that have focused on risk factors associated with suicide, suicide attempts and suicidal ideation.

An early study in the UK reported that deliberate self-harm was prolific in probation clients, with 31% ($N=71$) of the sample having a history of self-harm (Wessely et al., 1996). The authors noted the importance of the self-harm and suicide continuum, and emphasised that self-harming behaviour should also be considered as a risk for suicidal behaviour. Many of the participants in the study described their self-harm as serious

attempts to carry out suicide (Wessely et al., 1996). However the sample population used was restricted to one area of the UK, making it difficult to generalise (nationally and internationally) to wider probation populations. Further generalisation restrictions apply due to the limited response rate which resulted in a small sample. This research has helped to highlight the issue of all forms of self-harming behaviour in the probation population, including suicidal behaviour. Although many authors agree that suicide is a separate behaviour from non-suicidal self-injury (NSSI) (Dixon-Gordon, Harrison, & Roesch, 2012) these findings demonstrate how over time NSSI can result in suicide or a near lethal suicide (Bergen et al., 2012).

More recently Pluck and Brooker (2014) investigated the prevalence of suicidality in a group of probation clients in England (N= 173). Findings indicate that when using data from living individuals, the prevalence is high with an estimated 32% (n=56) having a lifetime history of suicide attempts, and a further 5% (9) having carried out self-injury in the month prior to the study. 15% (n=25) also reported experiencing suicidal ideation in the month prior to the study. Younger participants were more likely to report self-harm than older participants. Although the study tells us little about the factors and triggers of suicidal behaviours in probation clients, it does draw attention to the urgent need to deal with this problem, as well as highlighting the association between self-harm and suicide attempts.

Gunter et al. (2011) directed a quantitative investigation into suicide ideation, suicide attempts, and self-harm in a sample of offenders serving community correction sentences in Iowa, USA. Unlike previous research in this population, the researchers used first-hand information in the form of the Semi-Structured Assessment for the Genetics of Alcoholism (SSAGA-II) designed to identify alcoholism, as well as life history and medical history. Community correction records were also reviewed and the Hare psychopathy checklist screening version (PCL: SV) was administered to participants. Of 337 participants 41% (N=139) had suicidal ideation, 19% (N=65) had attempted suicide and 14% (N=47) had harmed themselves without intent to carry out suicide (Gunter et al., 2011). Childhood trauma and having an increased number of exposures to accidental traumatic injury increased the chance of all three outcomes: suicidal ideation, self-harm and attempted suicide. Depression was found to be linked to suicidal ideation and suicide attempts but not to self-harm. Panic was linked to self-

harm, and drug dependence was linked to increased suicidal ideation. The use of living participants allowed the researchers to gather information on issues such as childhood trauma and accidental traumatic injury, which may not have been fully explored if the researchers had used a retrospective approach to investigate suicide. As this research was carried out in the USA there are likely to be differences between this study and findings from the UK (Crighton, 2000). However the importance of the research carried out by Gunter et al. (2011) lies in their use of first-hand information to establish possible risk factors.

These studies do contribute towards the understanding of suicide by probation clients, drawing attention to possible risk factors associated with suicide, such as experiencing early childhood trauma and self-harm. However, these risk factors are commonly reported in the general population (Dube et al., 2001; Roy, 2005; Roy, Gorodetsky, Yuan, Goldman, & Enoch, 2010). Therefore if suicide in the probation population is to be prevented it is also important to consider how the probation process itself is experienced from the perspective of probation clients. Further in-depth analysis is needed in order to understand how the context of the community supervision process, i.e. to identify which aspects of being on probation or living in supervised community premises, relates to suicidal behaviour. Of equal importance is the need to identify perceived ways of preventing suicide, which is yet to be explored by researchers. Therefore it may be more helpful to employ a different methodological approach to previous studies. One method that has proved useful in prison settings is the qualitative near-lethal approach, outlined below.

2.6.4 The near-lethal approach: A new way forward

The following sections provides details of a recent method of suicide investigation which has been used in prison settings and could be helpful if applied to probation settings. There is an abundance of literature on suicide in prisoners which has tried to understand suicide using retrospective methods. However fewer studies have focused on near-lethal suicide and/or suicide attempts. Near-lethal suicides are those that could have been completed suicides but for some form of intervention, medical or otherwise, regardless of the individuals' intentions (Biddle et al., 2010; Douglas et al., 2004; Hawton, 2002; Kresnow et al., 2001; Potter et al., 1998). Borrill (2005) used a qualitative approach to investigate 'near misses' in a small sample of women prisoners, who shared their accounts of their near-lethal behaviour via interviews.

Issues such as intentions and motives, factors leading up to the incident, care and support, and suggested preventions were all explored. The accounts revealed that a number of important themes were reported as playing a role in the near fatal incident. For example many women described themselves as carrying out the suicidal behaviour to stop the suffering they were experiencing in relation to bereavement. Furthermore women reported change of location and separation from the children as contributing to their suicidal feelings. Recommendations including staff training, change of regime and roles of specialists were made (Borrill, 2005). This study was replicated by the Oxford Centre for Suicide Research on a larger scale with 60 female prisoners who had carried out potentially lethal suicide attempts. The research was expanded to include a mixed method of investigation via objective measures of mental health and qualitative interviewing (Marzano, Rivlin, Fazel, & Hawton, 2009). Themes from the qualitative research that appeared to play a role in the female prisoners near-lethal incidents included; social problems with staff and other inmates; not enough distractions when in their cells; and withdrawal from substances including alcohol. Preventative themes also emerged including reduced access to means of harming oneself; having the chance to talk to someone about how they are feeling; distractions within their cell; and being treated better by staff (Marzano et al., 2011).

Overall this type of method allows for the identification of information about suicide and the suicidal process that may be particular to certain populations, such as prisoners. The findings from both studies may not have been picked up on using traditional methods of suicide research. Therefore exploring near-lethal incidents in-depth in a probation sample will not only increase understanding of how to reduce and prevent suicide in this population, but will enable offenders who have survived to have their stories heard. Furthermore a qualitative approach will enable a better understanding of the probation process and how this is linked to the suicidal process.

2.7 Research with Probation Staff

Knowledge about suicidal behaviours by offenders serving community sentences should not be limited to knowledge about probation clients only. It is also important to consider the perspectives of probation staff and how they deal with suicidal behaviours. Recent research has indicated that probation staff are frequently exposed

to suicidal clients and are active in decision making about the level of risk that a client poses to him or herself (Cook & Borrill, 2013). Community sentences are on the rise which has also led to an increase in probation staff caseloads (Ministry of Justice, 2010b; Solomon & Silvestri, 2008), which may make it even more difficult for staff to deal with these sensitive issues. Probation staff can play a vital role in the prevention of suicide and management of self-harm in offenders, therefore training staff in how to handle these situations is vital (Gelsthorpe et al., 2012).

Training staff who work closely with individuals at risk of suicide and self-harm is one of the key objectives set out in the Government's current suicide prevention strategy for England & Wales (The Department of Health, 2012). A recent report by the Howard League of Penal reform on deaths in probation recommended that probation staff should receive full training and support in preventing deaths, including suicide (Gelsthorpe et al., 2012). The Ministry of Justice (2013b) specify that all staff who go through the current Probation Qualification training will receive training about mental health. However previous research indicates that mental health training received by probation staff is inconsistent (Brooker & Ramsbotham, 2014; Brooker & Sirdifield, 2009; Hatfield, Ryan, Pickering, Downing, & Crofts, 2005; Keene, Janacek, & Howell, 2003). It also appears difficult to identify what training is given to probation staff in the UK with regards to intentional self-injury and suicidal behaviours. Intentional self-injury training is compulsory for staff working in Approved Premises in London, however it is not mandatory for other London probation staff and instead they are simply 'encouraged' to do the training (London Probation Trust, 2013). London staff work in partnership with Together, a mental health charity which provides information to staff who work with offenders with mental health problems or carry out suicidal behaviours (Bryant, 2010). The National Probation Service London also has a suicide prevention forum which provides support packs to staff when they have a death by suicide on their case load. This has helped to boost suicide awareness training, and the forum has been active in the introduction of ligature knives in probation approved premises (Beck, 2014a). However it is unclear if these implementations will be continued by the London community rehabilitation company now that the probation service has been divided into the National Probation Service and community rehabilitation companies (Beck, 2014a). Furthermore there may be differences with regards to suicide training that staff are

given across England and Wales. Further research is needed to clarify the availability of training for staff, whether they feel prepared to deal with suicidal offenders, and how staff feel after dealing these situations.

Currently there appears to be limited research on the experiences of probation staff dealing with these issues. Previous prison studies have indicated that some staff have stereotypical attitudes towards repetitive self-harm and may see it as a form of attention seeking and manipulation (Ireland & Quinn, 2007; Kenning et al., 2010; Liebling, 2002; Short et al., 2009). Furthermore, prisoners are aware of these negative attitudes and that they may actually cause more harm (Ciclitira, Adler, & Marzano, 2012). However these findings may not be transferable to staff working in community settings who may have very different experiences of dealing with suicidal offenders.

One study focusing on the staff perspective was carried out with community correction officers in Victoria, Australia who had all experienced at least one client dying by suicide (Biles et al., 1999). Four main themes were found. Firstly, staff appeared to be very concerned about the duty of care that they had towards their client, particularly with regards to being in breach of care when their client died by suicide. Secondly, staff appeared unsure about the procedures that occurred after a client had died by suicide, particularly with regards the process of the coroner's report and what it is for. Thirdly, there was a consensus from staff that the support available to suicidal clients was insufficient. Lastly, the researchers found that staff experienced overwhelming emotional distress when their client died by suicide, which falls in line with findings from UK prison studies (Adler & Marzano, 2007; Wright, Borrill, Teers, & Cassidy, 2006). Staff were left with unanswered questions and commonly experienced feelings of guilt which was accompanied by a sense of 'could I have done more?' These findings appear to mirror findings from previous studies carried out with survivors of suicide which suggest that professionals working with individuals who complete suicide may be impacted emotionally (Grad, 2011).

More recently Cook and Borrill (2013) used the Offender Assessment System (OASys) to gather suicide risk records of offender being supervised by probation staff. The large scale (N= 38,910) study found that 12% (N=4498) of the sample had been recorded by staff as having a long term risk of suicide. Additionally 6% (N=1955) of the sample were considered to be at current or immediate risk of suicide. The strongest

predictor of staff recording their client of being ‘at risk’ of suicide was if their client had a history of suicide attempts or self-harm. Other perceived predictors of an ‘at risk’ recording included; coping skills; having a psychiatric illness; poor attitude to self; childhood trauma; current psychological problems such as depression; and having problems with close relationships. These findings are particularly important as they provide an insight into what staff perceive to be associated with suicidal behaviour in probation clients, and what causes staff to record their concerns that their client is potentially at risk of suicide. Research studies like those outlined above go some way to provide the important perspective of staff members dealing with suicide.

In summary there is limited existing research that has explored suicidal behaviour from the perspective of probation staff and no qualitative research within the UK (Biles et al., 1999). The Ministry of Justice detailed plans to divert more offenders with mental health needs and drug problems away from prison and into community treatment settings (Ministry of Justice, 2010b). If the number of offenders with mental health and addiction problems are likely to increase, it is essential that staff training is continuously reviewed and updated so that staff have sufficient knowledge to cope with and manage this client group effectively. Therefore the perspective of staff is an important one, as research into how staff currently manage and cope with suicidal clients is essential for understanding how training should be developed and what support needs to be provided for staff. Staff can also help to identify when individuals appear at an increased risk of suicide in relation to the probation process.

2.8 Gaps in the existing research

- There is currently no qualitative research that has been carried out on near-lethal attempts by probation clients, therefore in-depth research using first-hand accounts is needed. First-hand accounts could provide significant information and knowledge about suicide by probation clients, and how to prevent it.
- Currently research findings do not focus on what can be done to prevent suicide. Research with probation clients and staff can provide insights into what is perceived to be helpful for suicide prevention in this group.
- Existing research, does provide some information about risk factors for suicide by probation clients, but this risk is not considered in relation to the probation

process. First hand-accounts from clients and staff will help to identify if the probation process itself is perceived as being linked to suicidal behaviours. For example, do clients feel suicidal at particular points in their probation process?

- The staff perspective is less explored in the literature, with no qualitative studies existing in the UK. The staff perspective may provide vital information about how staff feel about; supporting clients, training, staff support and what they perceive to relate to suicidal behaviours by probation clients.

2.9 Aims and scope of the current research

- To explore the suicidal experience from the perspective of offenders serving community sentences using an in-depth qualitative approach. More specifically; what clients felt caused or triggered their near-lethal act? How did they perceive this to relate to the probation process? Whether they felt that anything could have been done to prevent their behaviour from occurring? Whether their perspective on the incident changed once given time to reflect?
- To explore the perspectives of staff managing these types of offenders and to gain their insight into important issues such as; perceived triggers and causes of suicidal behaviour by clients; how staff perceive these to relate to the probation process; how staff feel about the training they receive to deal with these types of behaviour; whether they feel supported for dealing with these types of behaviour; and what their views are on suicide prevention.
- To gain new insights into the problem of suicide by offenders serving community sentences by exploring the experiences of those who have made near-lethal attempts and the staff supervising them at the time. Both perspectives will help explore understandings of the suicidal process in relation to the probation process.

2.10 The Current Research

The current research consists of four studies which focus on staff and probation clients' experiences of suicide, suicide attempts, and near-lethal self-injury (see Figure 7).

Study 1 explores the experiences of London Probation staff in managing clients who have carried out suicidal or self-injurious behaviours. Understanding how staff view suicide and self-harm in clients is important for two reasons: 1) The possible inadvertent impact their views may have on their interaction with suicidal clients (Ciclitira et al., 2012); 2) The potential personal impact of the suicide and self-harm on staff (Marzano & Adler, 2007). There is currently little research that has explored how these experiences may affect staff and how they manage these types of incidents (Biles et al., 1999; Harding & Cameron, 1999). The aims of this study were to explore probation staff views on suicide and self-harm within probation clients by gathering in-depth information in the form of qualitative interviews. The following questions were considered important;

- What are the experiences of staff dealing with service users who have attempted suicide, self-harmed, or completed suicide?
- How do they manage these experiences?
- Do staff feel that they have adequate knowledge and training to deal with suicidal and self-harming service users?

Study 2a provides understanding of the psychological profiles of each individual probation client who took part in studies 2b & 3. Psychological and psychiatric measures (see section 4.5) were employed to provide a broader understanding of the sample, and to understand how the current sample fits with other probation samples. Psychological measures include; depression, hopelessness, alexithymia and impulsivity, as well as a psychiatric assessment. The aim of this study was to draw up profiles for each individual according to the outcomes of psychological and psychiatric measures and to develop these findings further in Study 2b by employing a qualitative approach, as outlined below.

Study 2b focuses on the experiences of offenders who have made a near-lethal suicide attempt (see section 3.3 for definition), whilst carrying out a community based sentence. Offenders living in the community are at a high risk of suicide and have comparable suicide rates to offenders in custody (Pratt et al., 2006; Sattar, 2001). The limited research that has focused on suicide in a community sentenced population has tended to focus on completed suicide rather than individuals who have carried out a near-lethal suicide attempts (Mackenzie, Borrill, & Dewart, 2013). Studying a near-lethal suicide attempts is characteristically close to a completed suicide and can help to shed light on issues that may be missed when employing an retrospective method (Hawton, 2002; Marzano et al., 2009). No study as yet has employed a qualitative near-lethal approach to investigating suicide in a probation sample. The aims of this research are 1) To explore and understand what probation clients perceived to happen during the time prior to the incident, and how they felt during this time frame, 2) To gaining an understanding as to what factors the probation clients felt contributed to their suicidal behaviour, 3) To explore the understandings of clients perceptions during the incident and after the incident, 4) To gain an understanding of how clients perceive their suicidal behaviour to relate to their probation process. Issues relating to the psychological and psychiatric profiles drawn up in Study 2a are commented on throughout the interviews where relevant. Overall, interviews will be used to identify what makes an offender in community settings vulnerable to incidents of self-harm or suicide, as well as what could prevent this type of behaviour.

Study 3 focuses on how the participants (probation clients) perspectives have changed or remained the same since their original interview (Study 2). Understanding suicidal behaviour cannot be accomplished in-depth through snapshot research, instead the use of follow-up interviews allows for a deeper understanding of the suicidal state to be gained (Murray et al., 2009). The aims of the study were to: 1) Carry out follow-up interviews with participants who took part in Study 2; 2) To understand if participants felt supported after the incident, with particular focus on support provided by the LPT; 3) To explore how participants felt about the incident once given time to reflect, and whether or not they have made further self-harm/suicide attempts. The purpose of this is to establish changes in the individual's perspective over time.

Study 4 employed a dyad approach to understanding near-lethal behaviour from the perspective of staff and their client that had carried out the behaviour. In studies 1 & 2b the research focus is on individual perspectives, however, it is also important to understand the incident from different perspectives to gain as much information as possible and understand suicide to the fullest extent. Considering only one perspective could lead to some information being missed. Previous studies with prisoners demonstrate the usefulness of this method for exploring differences and similarities in the perspectives of staff and offenders about suicide and self-harm (Ciclitira et al., 2012; Kenning et al., 2010). It is therefore interesting to consider how different subjective accounts about the same event may interact or differ to one another (Harden, Backett-Milburn, Hill, & MacLean, 2010). The use of multiple perspectives strengthens the analysis by triangulating the data (Guion, Diehl, & McDonald, 2011) and helps to provide a richer more detailed account of the event. Previous research that has investigated suicide has explored the perspectives of family, friends and loved ones of individuals who have completed or attempted suicide (Dransart, 2013; Grad, 2011; Myers & Fine, 2007). Including other perspectives such as family and friends can provide a more detailed account of the incident as family and friends may, for example, be able to provide information about problems that the person faced during the time prior to the incident. Due to the nature of the current study it was considered inappropriate to contact the friends and family of those that had made a near-lethal attempt, but instead to focus on the perspectives of both the individual who made the attempt and a member of probation staff supervising them at the time of the incident. Although, staff may not have knowledge about the personal factors leading up to the incident, they would have knowledge about the probation process of the client and be able to provide information about whether or not changes in their client's behaviour coincided with changes to their probation process. The aims of this study are to employ this qualitative dual perspective method, using dyad accounts of near-lethal suicide, taking into account both the individual who carried out the behaviour, as well as the member of staff supervising them at the time of the incident. In particular the aims were to explore and understand the differences and similarities in accounts of staff and clients' in relation to the near-lethal act.

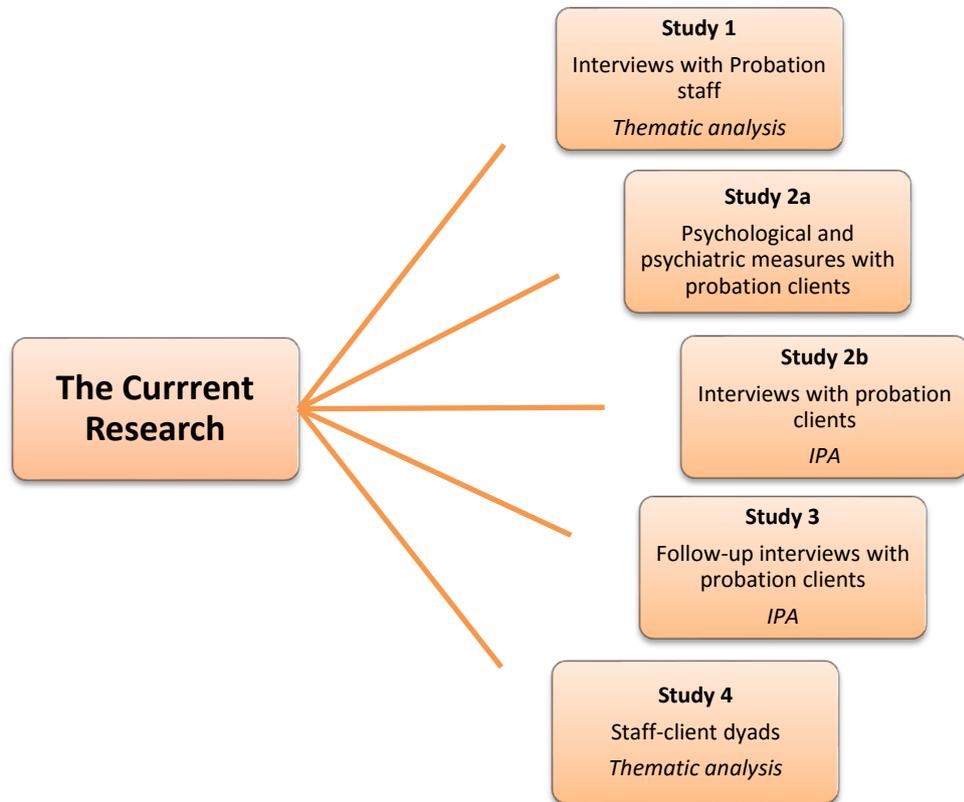


Figure 7: Overview of Research

3 Chapter Three: Methodology

This chapter provides an overview of the methodology used in the current research, followed by a discussion of the potential limitations of qualitative research. This chapter will also outline why each form of analysis was chosen for each study, as Braun and Clarke (2006, p. 97) state ‘your method of analysis should be driven by both your research question and your broader theoretical assumptions.’

Table 2. Overview of analysis

Study	Method of Analysis
<i>Study 1: Interviews with staff</i>	Thematic Analysis
<i>Study 2a: Case analysis of clients</i>	Psychological measures and MINI psychiatric interview
<i>Study 2b: Interviews with clients</i>	Interpretative Phenomenological Analysis
<i>Study 3: Follow-up interviews with clients</i>	Interpretative Phenomenological Analysis
<i>Study 4: Dyad perspective study with clients and staff</i>	Thematic Analysis

3.1 Qualitative methods

The near-lethal method of investigating suicide can be either qualitative, quantitative or a combination of both. Suicide and self-harm are topics that need to be researched sensitively; qualitative research enables the participants to discuss their own experiences (Smith, 1995) furthermore enabling the subjective experience of the near lethal act to be understood and interpreted (Borrill, 2005). The use of qualitative research enables rich detail to emerge regarding the participants’ own individual experience of the near lethal incident (Smith, 1995). Key themes that may be common to many can be identified and explored, unlike quantitative methodology which groups and categorises individuals (Smith, 1995). Despite previous research on suicide by probation clients being useful in terms of the identification of potential risk factors, there is a fundamental lack of understanding of how the probation process itself may interact with this risk and how these individuals experience near-lethal suicide attempts. Therefore understanding the subjective experiences of this population using

a qualitative approach was deemed to be useful as little knowledge currently exists about this topic.

3.2 Mixed Methods: Psychological and Psychiatric measures

Psychological and psychiatric measures were included to enhance the case studies of clients (see 4.5). Firstly by providing more information about the potential psychological difficulties of each participant and secondly, to establish whether these difficulties are reflected throughout their qualitative accounts. Measures of depression, hopelessness, alexithymia, personality disorders, and psychiatric illness were gathered from participants. These specific variables were chosen because all have been examined in prisoner and probation populations previously (see section 4.5 for a detailed overview). The aim of using these measures was not to carry out in-depth statistical analysis or to make generalisations about the population, but instead to further develop understanding of the client sample presented in the current research.

3.3 What is a near-lethal approach and why use it?

The near-lethal approach to suicide research does not explore suicides retrospectively through second hand knowledge, but focuses instead on gaining information from people who have survived a potentially lethal incident of self-harm or a near lethal suicide attempt. A near-lethal act has been defined by researchers as an incident having the potential to be a suicide but for medical treatment inside or outside of a hospital, other forms of emergency treatment or, in some cases, chance (Borrill, 2005; Marzano et al., 2009; Potter et al., 1998). A qualitative near-lethal method of investigation has not, to our knowledge, been employed to investigate suicide by offenders carrying out community based sentences in the UK.

Research on near-lethal suicide can potentially provide vital information regarding the experiences and feelings of individuals leading up to the near fatal incident (Marzano et al., 2009). Evidence suggests that a near lethal act is characteristically close to a completed suicide (Douglas et al., 2004; Marzano et al., 2010; Rivlin et al., 2010) and is a valid alternative to studying completed suicide (Marzano et al., 2010; Rivlin, Fazel, Marzano, & Hawton, 2012a; Rivlin et al., 2010). Information that cannot be gained from autopsy type studies such as the social and personal factors that

potentially led to the near fatal incident can be accessed and understood from research on near-lethal acts (Marzano et al., 2009). Autopsy type studies rely on past information that could be susceptible to a range of confounding variables. Studying near lethal acts allows the individual to explain the act from their own perspective, reducing the researcher's potential to make subjective assumptions as to why the behaviour occurred, as well as allowing a further understanding to be gained in relation to what can be done to potentially prevent suicide. The inclusion criteria for a near-lethal act used in the current study falls in line with previous research which has focused on near-lethal suicides; a) the act could have been lethal but for some form of intervention or chance; b) the individual employed a method associated with a high risk of lethality (Biddle et al., 2010; Borrill, 2005; Douglas et al., 2004; Kresnow et al., 2001; Marzano et al., 2009; Potter et al., 1998; Rivlin et al., 2012a).

3.4 Methodology

The following sections outline why each methodology was chosen for each study. Thematic analysis was chosen to analyse studies 1 (probation staff) and 4 (dyad perspectives client-staff) as it is particularly useful for drawing out key overarching similarities and differences between the accounts of individuals. Thus the use of TA for studies 1 & 4 meant that the researcher was able to highlight the broader concerns of the participants in relation to the probation context. IPA on the other hand was chosen specifically for studies 2b (client interviews) and 3 (client follow-up interviews) to draw out the individual experiences of each participant. Although TA can also be used to draw out key individual experiences, IPA provides more focus on the individual accounts and is particularly useful for sensitive and personal events. A brief discussion of these methodologies and their appropriateness for the current research is outlined below.

3.4.1 Study 1 & 4: Methodology

Thematic Analysis; what is it, why use it?

Thematic analysis is a flexible qualitative method that is used to analyse patterns in data (Braun & Clarke, 2006, 2013). TA is methodologically similar to other qualitative approaches such as grounded theory (GT) (Glaser & Strauss, 2009) and interpretive phenomenological analysis (IPA) (Braun & Clarke, 2006, 2013; Smith, Jarman, & Osborn, 1999; Spencer, Ritchie, & O'Connor, 2003). However, unlike

other qualitative approaches it does not tie the researcher to one specific epistemological or ontological framework, providing a flexible tool for data analysis (Braun & Clarke, 2006, 2013). Furthermore the procedures for carrying out TA are different to other qualitative approaches (see Braun & Clarke, 2006, 2013).

Thematic analysis was considered appropriate for studies 1 & 4 which aim to provide an overview of the experiences of probation staff managing suicidal offenders (Study 1) and to draw attention to differences and similarities between the accounts of staff and their clients regarding near-lethal suicide attempts (Study 4). IPA was also an option for analysis, however the flexibility that TA provides was more suited to both studies aims. IPA is idiographic in nature emphasising the individual account and story (Smith et al., 1999) and is concerned with psychological interpretations. Whereas TA's flexibility allows the researcher to consider both the meanings and realities of the participants (realist), whilst also considering the social and contextual (relativist) elements of a participants account (Braun & Clarke, 2006, 2013), therefore appropriate for understanding staff interpretations of clients suicidal behaviours. IPA also commands a highly interpretive element from the researcher and is concerned with description to some degree, but more focussed on psychological concepts (Smith et al., 1999). Interpretation and going beyond what is presented by the participants was considered important for studies 1 & 4. However, TA allows the researcher to also consider more surface descriptions of participants' experiences. This was considered to be particularly beneficial, for example, for exploring staff experiences of suicide training. Therefore TA allows the researcher to use both semantic (surface level descriptions) and latent (underlying themes) coding in their analysis (Braun & Clarke, 2006).

GT could also have been an option for studies 1 & 4 however GT is focused on social processes and social context (Glaser & Strauss, 2009), whereas the focus of studies 1 & 4 was to consider both social and psychological processes. Furthermore GT is interested in producing an overall theory or model, which is not the focus for studies 1 & 4 (Glaser & Strauss, 2009). Lastly the focus of Study 4 was to analyse the data with particular focus on three issues: 1) were there signs that the near-lethal incident might occur; 2) what was perceived to trigger/cause the incident; 3) what is perceived to prevent suicide. This type of deductive analysis is not normally carried out

with other qualitative approaches such as IPA and GT, however TA can be inductive or deductive (Braun & Clarke, 2006) making it particularly suitable for Study 4.

TA has also been used to analyse similarly sensitive topics such as schizophrenia (Saunders & Byrne, 2002), suicide notes (Kuipers, Appleton, & Pridmore, 2012), professionals' experiences of dealing with self-harming patients (Wilstrand, Lindgren, Gilje, & Olofsson, 2007), and patients' experiences of deliberate self-harm (Sinclair & Green, 2005).

Braun and Clarke (2006), among others, argue that good qualitative research dictates that the researcher should be transparent about their own ontological and epistemological underpinning. Ontology refers to the standpoints on the nature of reality – whether reality and the world is objective and independent or constructed subjectively through human knowledge, interpretation and meaning (Guba & Lincoln, 1994). Taking the objective stance, suggesting that reality is an entity independent of human knowledge, meaning and interpretation is commonly referred to as realism (Braun & Clarke, 2013; Harper, 2011). At the other end of this continuum is the relativist approach which posits that reality is wholly reliant on human interpretation, knowledge and meaning, and realities are constructed by those to whom they exist (Braun & Clarke, 2013; Harper, 2011). Closely linked to this is one's epistemological stance, which refers to how knowledge can be gained (Guba & Lincoln, 1994). Can knowledge be gained objectively, providing humans with absolute truths about reality or is knowledge subject and defined in relation to the way we interact and construct it (Braun & Clarke, 2013; Guba & Lincoln, 1994)? The realist assumptions of epistemology are conducive to positivistic notions of objective and absolute knowledge which can be free of bias, therefore the researcher is unlikely to influence the data or the findings (Braun & Clarke, 2013). In contrast relativists argue that no knowledge can be free of human bias, and that our knowledge of reality are subjectively constructed, therefore from a researcher standpoint we are providing only one possible interpretation of reality (Braun & Clarke, 2013).

Thus the current thematic analysis research takes a critical realist stance. Critical realists are positioned between realists and relativists, and posit that participants can provide accounts of their realities, however these accounts will not always provide

researchers with every detail that is needed for analysis (Braun & Clarke, 2013; Harper, 2011). Individuals will not always be fully aware of their experiences and why their experiences are perceived in the way that they are, therefore interpretation by the researcher is needed (Braun & Clarke, 2013; Harper, 2011). Therefore both latent (underlying themes) and semantic (surface level descriptive themes) themes are considered important.

Limitations of Thematic Analysis

TA has traditionally been criticised for an absence of clear and concise guidelines for data analysis (Antaki, Billig, Edwards, & Potter, 2003). However Braun and Clarke (2006) have developed guidelines for researchers making TA a relatively easy qualitative method, particularly suitable for less experienced qualitative researchers. The flexibility of TA means that researchers employing it can come from a range of theoretical and epistemological backgrounds, therefore making a number of different analytical decisions. This has its advantages, however a common criticism of TA is that such diverse qualitative approaches may not always be rigorous in their analysis (Reicher, 2000) and can often be perceived as lacking in transparency (Pope, Mays, & Popay, 2007). Lacking transparency in analysis can lead to inconsistent and weak research findings. However Braun and Clarke (2006) argue that this can be avoided if the researcher identifies their theoretical position from the outset. A further criticism is that TA can be descriptive in nature, providing less room for interpretation than other methods (such as IPA), thus losing touch with individual stories of participants (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005). This largely relates to the analysis of data across cases rather than within subject accounts. However, this is dependent on the researchers theoretical and epistemological position, as a researcher with an interpretative stance may wish to incorporate more interpretation into their TA, such as the stance taken by the current researcher (Braun & Clarke, 2006).

3.4.2 Studies 2b & 3: Methodology

Interpretative Phenomenological Analysis (IPA): What is it, why use it?

IPA is a methodology concerned with the in-depth examination of the lived experience, with a focus on sense making and meaning (Smith, 2011a). IPA is idiographic (focus on the individual) and has its theoretical roots in both **phenomenology** (the study of conscious experience) and **hermeneutics** (the theory of interpretation) (Shaw, 2010; Smith et al., 1999; Smith, 2011a). Based on the ideas of

Heidegger, IPA researchers seek to understand significant experiences through a detailed examination and interpretation of individual accounts (Smith, 2011a; Smith, Flowers, & Larkin, 2009). The researcher is part of a double hermeneutic process in which the researcher aims to make sense of the individual's interpretation of their own experience (Smith et al., 2009). At the heart of IPA is this dedication to the individual and an aim to explore in detail, experiences from the perspectives of individuals rather than groups. Although IPA does seek to establish commonalities between individual experiences of certain events, it also aims to draw out individual accounts and experiences in the analysis (Shaw, 2010; Smith, 2010; Smith et al., 2009). It is argued by IPA researchers that life events are unique to the person experiencing them and therefore may have different meanings attached to them (Smith, 2011a; Smith et al., 2009). IPA is concerned with 'major life experiences' which hold particular importance for us (Smith et al., 2009) and is no longer just part of our day-to-day lived experience and instead become an important significant experience that we are consciously aware of. The objective of the IPA researcher is to engage with, and explore in detail, a person's reflections, thoughts, and feelings about a major life event (Smith et al., 2009).

IPA was deemed appropriate for studies 2b & 3 which aim to: 1) understand the perspectives of individuals who have made near-lethal suicide attempts whilst carrying out community sentences (Study 2b); 2) explore how their perspectives changed once given an opportunity to reflect on their attempts (Study 3). IPA was chosen for a number of reasons, but particularly because of the nature of the topic being researched. Suicide is an event unique to the person carrying it out, or others affected by it. As IPA is an idiographic approach it is useful for drawing out individuals unique experiences (Larkin, Watts, & Clifton, 2006; Smith et al., 2009), whilst also recognising shared experiences of particular groups of individuals (Shaw, 2010). Furthermore suicide attempts are significant life events which deserve focused and detailed attention from those researching them. Unlike other qualitative research methods such as GT which focuses on building theory (Glaser & Strauss, 2009), IPA is concerned with the subjective experience of the individual. IPA encourages the use of a smaller numbers of participants so that in-depth and focused analysis can be carried out, allowing the researchers to draw on the subtle nuances and multiple facets of an individual's account (Smith et al., 2009), particularly important for

understanding a complex issue such as suicide. Theories of suicidal behaviour (Joiner, 2005; O'Connor, 2011; Shneidman, 1993) draw our attention to its complex and multifaceted nature, which deserves an in-depth form of analysis. TA was an option for studies 2b & 3, however TA is more focused on providing overall broad group themes and less attuned to drawing out individual narratives (Braun & Clarke, 2013; Smith, 2011b), important for studies 2b & 3. Furthermore IPA has previously been used extensively to investigate health related issues and the experiences of psychological distress (Begley & Quayle, 2007; Brocki & Wearden, 2006; Kuipers et al., 2012; Smith, Joseph, & Das Nair, 2011), demonstrating its suitability for research with vulnerable participants and sensitive topics. Unlike discourse analysis, which does not include a focus on an individual's underlying mental state, IPA encourages the interpretation of both what is said by the participants and their underlying emotional state (Willig, 2001).

Limitations of IPA

It has been argued that IPA is tautological in the sense that it does not consider the role of language as being important to the same degree as other methodologies such as discourse analysis (Brocki & Wearden, 2006). IPA instead views language as a tool for communicating experience, but does not take into account a person's ability to use that tool, furthermore how their ability to use language influences their perception of their experience in the first place (Willig, 2001). However, paying particular attention to, for example, the use of metaphors by participants and focusing on how a participant has communicated their experience allows the researcher to recognise the important role that language plays (Smith et al., 2009).

Another limitation of IPA is that it relies on participants being able to express their account to a degree which is beyond pure description, encompassing both their physical and emotional experiences (Willig, 2001). However, it could be argued that this criticism applies to all qualitative methods, as not all individuals will be able to communicate their accounts in this way.

It has also been suggested that IPA neglects the influence of context on how individuals experience their world (Todorova, 2011). In response, Smith (2011b) postulates that IPA acknowledges context since an individual's experience does not occur in a social or political vacuum. Furthermore, Smith (2011b) suggests that as

IPA grows as a methodology the consideration of context will become more apparent, although at the same times urges researchers to stay true to the core values of IPA which is to focus on the individual.

3.5 Validity and Reliability in Qualitative Research

It is argued that qualitative research cannot be judged by the same standards as quantitative research (Holloway, 2007; Yardley, 2008), although others disagree (Howitt, 2010), and instead should be considered by its merit in an entirely different way to traditional quantitative evaluation. However this led to a history of researchers trying to establish what can be considered as good qualitative research (Elliott, Fischer, & Rennie, 1999). A number of guidelines (Elliott et al., 1999; Larkin et al., 2006; Shaw, 2010; Yardley, 2008) now exist which serve to guide qualitative researchers in evaluating and producing good qualitative research. The current section will focus on guidelines provided by (Yardley, 2008) whilst also considering some points by other researchers.

Yardley (2008) suggests four main principles for evaluating validity and credibility in qualitative research; 1) Sensitivity to context; 2) Commitment to rigor; 3) Coherence and transparency; 4) Impact and importance.

Sensitivity to context: Both Yardley (2008) and Elliott et al. (1999) note the importance of sensitivity to context when conducting qualitative research. Elliott, for example, draws attention to the participant as individual, having their own individual context and what they bring to the research. Of particular relevance to the current study, Smith et al. (2009) suggest that IPA in particular pays close attention to the individual and therefore the individuals own context. Sensitivity to context was adhered to in the following studies in a number of ways; by the methods chosen, which were chosen to understand in-depth the experiences of the all participants and how these experiences relate to the probation context. The in-depth interview style which allowed participants to explore their own context, included open ended questions, enabling the participants to speak freely about their experience without feeling restrained by set questions. Furthermore as well as interview style, the researcher's background experience with issues relating to suicide (see 3.6) also facilitated sensitivity to context and ethical issues.

Commitment and rigor: Yardley (2008) argues that commitment and rigor are both key elements of good qualitative research and can be demonstrated through: comprehensive data collection; in-depth analysis of data; demonstration of methodological capability; and engaging thoroughly with the topic. Similarly Smith et al. (2009) refer to the need for a good skill set enabling the researcher to conduct quality interviews, particularly for carrying out in-depth interviews with participants on sensitive topics, as well as having the skills to choose the correct sample of participants. The use of in-depth interviews in the current research commands both commitment and rigor in relation to engagement with the topic (Smith et al., 2009; Yardley, 2008), as well as devotion from the researcher to ensure the comfortableness of the participant. The skills possessed by the researcher to carry out both in-depth interviews and in-depth analysis of the interviews are again reflected in her previous training in relation to talking and listening to suicidal individuals (see section 3.6). Furthermore, participants in the current research were carefully selected (see section 3.3) to match the aims of the study and the topic of focus.

Coherence and transparency: In order for research to be coherent, it must also be transparent for the reader. Elliott et al. (1999) refer to coherent qualitative research as being characterised by a sense of narration, enabling the reader to easily identify both the stories of the individual participants as well as the overarching framework (Smith et al., 2009). Yardley (2008) additionally suggests that coherence and transparency can be formed in relation to the researchers presentation of methods and data, as well as theory and philosophical perspective. In this sense the reader should be able to easily understand why the researcher has chosen specific methods, what their own philosophical stance is, and how data has been collected and analysed. Reflexivity is thus a key part of this process. See section 3.6 for the current researcher's reflexive account. Both Elliott et al. (1999) and Yardley (2008) draw attention to the importance of examples of supporting extracts throughout the results section in order to demonstrate the grounding of their findings.

Impact and importance: Lastly Yardley (2008) denotes that the value and validity of qualitative research can be determined in relation to its impact, importance and contribution to knowledge. In this sense a valid and valuable piece of research would have practical applications, theoretical applications, or contribute to knowledge about society or culture. The current project contributes to knowledge by exploring an under

researched topic, employing an underutilised method of investigation, which provides new insights in suicidal behaviours by offenders, and has practical applications for professionals working with these individuals.

3.6 Personal Reflexivity

My previous studies in Psychology and Criminal Law at college and Criminology and Psychology during my degree initially stemmed from my interest in both Psychology and criminal behaviour. Additionally I have been a Samaritan volunteer for 8 years and during that time have spoken to many people who wanted to end their life by suicide. During my time as a volunteer I began to understand that many people experience suicidal feelings throughout their life, and each of these experiences is unique to that person. I feel that this has shaped my beliefs about the human experience, particularly the role it can have in the construction of knowledge and understanding. On the whole I feel that allowing individuals to share their accounts can be a valuable source of knowledge which can provide insights and understanding into very personal experiences.

During this research process I have considered how my background could influence the research. One thing that stood out is my dual role as a researcher and a Samaritan. As a Samaritan I aim to prevent and reduce suicide via support and non-judgemental listening, with the aim that talking about feelings will help individuals to gain focus and think of alternatives to help them continue to live. In this sense the skills that I have developed through my experience of being a Samaritan and the training that I have undertaken, such as being non-judgmental and employing active listening, have been useful for talking to participants about sensitive and personal stories. Furthermore the ability to listen non-judgementally has, I feel, been beneficial for working with my participant group, who as offenders can face stigmatisation and judgments on a daily basis.

At times the Samaritan values of listening non-judgmentally and allowing people to speak freely about what 'they' feel is important to them, were a hindrance. For example I occasionally found it difficult to 'control' the interview, allowing participants to speak freely about things that were not on the interview agenda (resulting sometimes in long interviews). However, upon reflection during my

interview transcription I could see that this provided rich data and greater insight into the subtle nuances of my participants' characters.

Another issue potentially impacting on the research, particularly the interview process and therefore data collection, was the power balance between the participants and myself. I was acutely aware of the way that I presented myself to my participants, as I wanted to develop a rapport with them, and not make them feel uncomfortable. Firstly I didn't want to be viewed as too authoritarian, especially considering the already existing trust issues that many of my participants have with authorities. However, I also did not want to appear 'too young' and inexperienced. I wanted my participants to have the confidence in me that I would be capable of sharing their stories with integrity. Prior to my first interview I felt incredibly nervous and worried, however after this I found that my participants did not judge me, and instead were happy to open up and share their stories with me. I felt that they appreciated having someone to listen to them without judging them. For example when talking about what could prevent suicide one participant said "*I think maybe if I, say I had somebody like you obviously to talk to, I think that probably would have, because you are sitting there and you're listening.*"

Overall I have found the research process to be very enjoyable and hope that I have done justice to my participants, shared their concerns, and accurately voiced their narratives. I am privileged to have heard the stories of my participants. I have learnt from my research that suicide is a dark and isolating experience and I hope that the findings from my PhD research will help to prevent, and support those affected by it.

4 Chapter Four: General methods

The current chapter provides an overview of the methods used in the current research, including; how the research was set up; methods of data collection; ethical considerations; treatment of data; and participant information.

4.1 Ethics and Difficulty in Obtaining Participants

Researchers may encounter a number of difficulties when investigating suicide in probation settings or other community settings, such as: having restricted access to participants and difficulty in being granted access to participants; a need for extra vigilance due to potential vulnerabilities of participants; and managing potential risk to oneself and participants throughout the interview process. These problems may account for the limited amount of literature that currently exists on this topic (Powis, 2002). Participants may be unwilling to take part in the study due to the discussion of sensitive and personal material which can lead to small sample sizes (Wessely et al., 1996). It is therefore important that participants are aware that any information that they share will be kept anonymous and confidential (Banister, Burman, Parker, Taylor, & Tindall, 1994). Developing trust and a non-judgmental approach are important issues when researching a sensitive subject matter such as suicide, particularly when using an offender population (Patenaude, 2004). There is also potential for the participants to become stressed or upset when taking part in in-depth interviews (Banister et al., 1994). This is particularly important to consider in this offender population as they will have less post-interview monitoring compared to prisoners, and access to more means of suicide. It is essential that if the researcher identifies any suspected risk that the person may harm themselves, they have in place an appropriate referral or action procedure to deal with this. Despite this, past research has indicated that individuals who have experienced a near lethal suicide incident and have taken part in research have not found it to be a negative experience, and in some cases found the experience to be beneficial (Rivlin et al., 2012a). Prison studies in which researchers interviewed inmates about suicide attempts found that listening was a key issue for staff-prisoner relationships, and that prisoners appreciated having someone to listen to them (Borrill, 2005; Liebling & Price, 1999).

4.2 Ethical considerations in the current study

The research carried out as part of this thesis was conducted according to the British Psychological Society's (BPS) Code of Conduct, Ethical Principles and Guidelines and in particular adhering to the Principles for Conducting Research with Human Participants section. The University of Westminster Code of Practice Governing the Ethical Conduct of Investigations, Demonstrations, Research and Experiments provided was also ensured. Ethical approval for the study was obtained from the University of Westminster Ethics Committee. In addition to this, ethical approval and consent for the study to commence was obtained from the London Probation Trust. All stages of the research were discussed with the London Probation Trust suicide prevention research forum.

At all stages of the research it was ensured that any ethical implications that may have arisen were considered from the perspective of the participant. The researcher aimed to ensure that all of the participants had trust and confidence in her. Participation was voluntary and all participants were made fully aware that they had the right to withdraw from the study at any time. Participants were also made aware that they could withdraw their data from the study at any time unless the data had been published as part of the study. All individuals taking part in the research were fully briefed beforehand. All individuals taking part in the study were provided with a participant information form identifying the exact nature of the study and fully debriefed after. Thus, all individuals who took part were provided with verbal and written information about the study. All participants provided informed written consent to take part. Partaking individuals were given a participant information form and consent form to take away with them (see appendices 1 & 2). There was no direct monetary incentive offered to encourage participation in the study, although those that took part were provided with £20 to cover their expenses and travel costs. Staff were not provided with reimbursement as interviews occurred during working hours.

Due to the nature of this research special ethical considerations were made for studies 2b & 3 by the researcher. Individuals were only given the option to take part in the study if they were deemed stable enough to participate by their offender manager (see exclusion criteria 4.6). All data were kept confidential and no identifying material was used within texts. However participants were made aware before taking part in

the study that confidentiality would be breached if the researcher deems them to be at immediate risk of self-injurious behaviour or behaviour that will harm others; in such cases information would be passed onto the offender manager. The participant was also allowed to bring an appropriate person along to the interview for support if they wished to do so. This person had to sign a confidentiality (see appendix 3) statement and was also given a copy of the participant information forms. Considerations were made for the unlikely event that the research process may have a negative effect on the participant. The researcher is an active Samaritan volunteer and has been trained to listen and discuss suicidal thoughts, feelings and behaviours. The interview would have been terminated if the participant became visibly distressed. Furthermore a visual analogue scale was used to measure the wellbeing of the participants before and after the study; this was to ensure that the participant's wellbeing did not decrease after taking part in the study. All participants were provided with an information sheet which gave the contact details of help services that may be useful to them within the local area (see appendix 4).

Participants were all informed that they did not have to answer any questions that they did not want to and could terminate the interview at any time. All individuals who took part in the study were provided with the researcher's contact details to enable them to ask questions or discuss any concerns that they may have in relation to the research, prior to and after the research.

4.3 Setting-up the Research

Initial Preparations for the Research

Due to the sensitivity of the topic being researched it was vital to ensure that every potential issue was considered in detail before the study began. These issues were discussed vigorously by the researcher, the researchers' supervisors and with professionals within LPT. A number of initial preparations were made;

Setting up the Research with LPT

The first stage of this process involved having informal meetings with the head of research at LPT to discuss how the research would be carried out. This also involved gaining ethical approval for the study via LPT. The researchers then discussed the

study via informal meetings with two psychologists within the probation trust. Once the research process had been established, the researcher presented the research proposal to a panel at LPT. After the presentation it was agreed that the research could then be taken forward. The researcher then attended the London Probation Suicide Prevention Forum to get feedback on the study and the interview agenda. The researcher also attended the London Probation Personality Disorder Meeting to gain further feedback on the study and how participants could be recruited.

Attending Team Meetings & Forums

After discussions with the suicide prevention forum it was decided that staff might want to ask questions about the research before referring participants. The researcher attended a number of team meetings at London Probation offices and Approved Premises to talk to staff about the research and answer any questions. These meetings were also used to distribute information and posters about the research. The researcher continued to attend the suicide prevention forum to keep staff up to date with research progress and to encourage staff to refer potential participants to the study.

Informal meetings with Participants & Staff

When the research started it was vital that staff and potential participants understood what the study involved and had the opportunity to ask questions. It was also important that the participants felt comfortable talking to the researcher about this sensitive subject. This was achieved via informal meetings with individual staff members. Pre-interview meetings were also arranged with some case participants to allow them the opportunity to ask questions.

Recruitment issues

The recruitment process for the current research was challenging. Client recruitment relied on staff referrals which was particularly difficult as staff either did not read the information provided about the study, forgot to mention the study to their clients or did not have time to recruit. Lack of staff availability also resulted in a small number of staff interviews. Additionally a number of people were referred to the study but could not take part because their attempts were too recent and they were not well enough to participate (see 4.6). One client who was approached by a member of staff declined to take part without providing a reason. Another participant changed his

mind about participation after an initial meeting with the researcher but again did not provide a reason for not wanting to participate. However the small number of participants (13 staff, 7 clients, 6 client follow-up interviews) allowed for in-depth and focused analysis.

4.4 Data collection

Data were collected from 2011- early 2014 from London Probation Trust probation offices and approved premises. The following section sets out the procedure, location, and details of participants in each study.

Study 1 (Staff): 13 Participants (3 males, 10 females) were interviewed. Participants self-described ethnicity included; White British (N=7), Black British (N=2), White Irish (N=1), Brazilian (N=1), Black Caribbean (N=1), White Other (N=1). Their roles included: Probation Officer; Intervention Offender Supervisor; Forensic Mental Health Practitioner; Residential Assistant; Deputy Manager at an AP. Participants were aged between 25-60 years and had worked for the Probation service for 1 to 24 years. Experience of suicide and self-harm was not essential. All staff were included with a range of experiences of suicide and self-harm (see Table 3). All but one had previously dealt with a least one suicidal or self-harming Service User.

Table 3: Staff demographic information

<i>Pseudo Name</i>	<i>Referred client</i>	<i>Experience of suicide/self-harm</i>	<i>Age</i>	<i>Job role</i>	<i>Time worked LPT</i>	<i>Gender</i>
<i>Sarah</i>	Yes	yes	*	Probation officer	*	F
<i>Barbara</i>	Yes	Yes	60	Probation officer	10.5 years	F
<i>Harry</i>	Yes	Yes	55	Forensic mental health practitioner	3 years	M
<i>Jane</i>	Yes	Yes	32	Probation officer	4.5 years	F

<i>Kevin</i>	Yes	Yes	34	Probation officer	4.5 years	M
<i>Christine</i>	Yes	Yes	30	Probation officer	6 years	F
<i>Ruth</i>	No	Yes	34	Probation officer	10 years	F
<i>Tammy</i>	No	Yes	25	Probation officer	13 months	F
<i>Mary</i>	No	No	40	Probation officer	4years	F
<i>Nancy</i>	No	Yes	53	Intervention supervisor	9 years	F
<i>Paulette</i>	No	Yes	53	Intervention supervisor	24 years	F
<i>Wendy</i>	No	Yes	34	Residential assistant	2 Years	F
<i>Mark</i>	No	Yes	48	Deputy manager AP	10 years	M

Participants were recruited purposefully in order to include a range of job roles and level of experience in dealing with self-injurious Service Users. Recruitment was through posters displayed in probation offices and emails to all Probation staff. All staff in the probation trust who worked directly with Service Users in probation offices or in approved Premises (AP) were invited to take part, irrespective of their level of experience of working with Service Users at risk of suicide or self-harm. In-depth semi-structured interviews were employed, lasting approximately 40 minutes and were audio-recorded. Interviews were conducted face-to-face or by telephone depending on staff availability and preference. If interviews were conducted face-to-face they were carried out in a quiet room within the probation premises in which the participant was based for work. Participants were briefed about the nature of the research prior to the interview and provided written or verbally recorded consent to take part. Three topic guides were used during the interview (see section 4.6.1 for

details) and were chosen based on the level on their level of experience in relation to suicide and/or self-harm. Staff were then debriefed and thanked for their time.

Study 2a & 2b (Clients): The data for studies 2a & 2b were collected simultaneously during one meeting. Participants were all aged 18 or over, met the criteria of having made a near-lethal attempt whilst serving a community sentence within the last 3 – 6 months and did not meet any of the exclusion criteria. Near-lethal behaviour included: jumping from a height; cutting; fire setting; taking an overdose; and attempting to jump in front of a train. All participants either attended meetings at Probation offices or lived in a Probation Approved Premises (see Table 4 for demographic details). Some details of convictions were noted, including having 0-17 previous convictions. Most recent offences included: Theft – shoplifting ($n=2$); Common assault ($n=2$); Assault on a police officer ($n=1$); Burglary non-dwelling ($n=1$); Attempted murder ($n=1$). All participants were white British/Irish.

Table 4: Client participant demographics

Pseudonym	Gender	Age
Dave	Male	35
Kathy	Female	37
Freddie	Male	32
Dan	Male	24
Roy	Male	60
Mike	Male	32
Josh	Male	20

Participants were all approached about the research through LPT staff, who provided them with details about the study and asked them if they would be interested in taking part. If participants were interested, an interview was set up at a time that was convenient to the researchers, the participant and the member of staff. On the date and time agreed for the interview, participants were introduced to the researcher by the member of staff that had referred them to the study. Interviews were conducted in London Probation premises, either in probation offices or in approved premises. Interviews were carried out in quiet rooms, ensuring privacy, but which had a number

of safety precautions such as having a safety alarm bar around the perimeter of the room, as well as a CCTV camera which did not record sound.

Participants were briefed about the nature of the study by staff prior to the interview, however, they were also briefed again by the researcher when in the interview setting and provided with the opportunity to ask any questions. Formal written consent was gained from all participants. Participants were also asked if they would be happy to be contacted at a later stage regarding a follow-up interview. If the participant agreed they were asked to add their contact details (telephone numbers & email address) to their consent form. The participants were asked to complete 5 questionnaires measuring depression, Alexithymia, impulsivity, hopelessness, personality disorders and assessed on psychiatric illness using the MINI. All measures were self-administered by participants, excluding the MINI, however in cases where participants were unable or did not want to read the measures, the researcher instead read the questions aloud and asked the participant for their response. Once the questionnaires and interview were completed participants were offered the opportunity for a short break before the qualitative interview. Participants were once again given the opportunity to ask questions and informed of the procedure of the interview. Interviews were audio recorded and lasted 50 - 90 minutes. Once the interviews were complete, participants were once again asked to rate their emotional state using the VAS scale. Participants were then fully debriefed and thanked for their time.

Study 3 (Follow-up interviews): Follow up interviews were carried out 3-6 months after the initial interview with all participants, since all gave their permission to be contacted at a later date about the opportunity to take part in a follow-up study. The majority of participants were again contacted through the original member of probation staff who referred them to the initial study. One participant was contacted via telephone as he had finished his probation sentence. Due to difficulty tracing one participant, six participants took part in the follow-up interviews. The follow-up interviews were carried out in the same locations as the previous study, apart from one participant who opted for a telephone interview due to a change in location. Demographic information was recorded from Study 2a & 2b, however further information on suicide attempts and self-injury were gathered in this study (see Table 5).

Table 5: Further attempts

Participant	Further attempts or serious self-injury
Dave	Yes
Kathy	Yes
Dan	No
Roy	No
Freddie	Yes
Mike	No

Participants were briefed about the nature of study, provided with information and consent forms and given the opportunity to ask questions prior to the interview beginning. Participants were asked to rate their emotional state on a VAS. Interviews lasted approximately 40 minutes and were audio recorded. Once the interview had finished participants were once again asked to complete the VAS, debriefed and given an opportunity to ask questions, and thanked for their help.

Study 4 (Further Analysis - Dyads): Data for Study 4 were gathered from some of the participants who took part in studies 1 & 2b. Staff who referred a client to Study 2b, were invited to take part in an interview. If the member of staff agreed to take part they were then interviewed using interview agenda 1, which included specific questions about the near-lethal act carried out by the client they had referred for Study 2b. Clients' perspectives from Study 2b were then re-analysed using theoretical thematic analysis and compared with the accounts of the member of staff supervising them at the time of their near-lethal incident. There were 5 staff-client dyads (see Table 6). Both clients and staff were asked about similar issues including causes and triggers of the near-lethal act and whether anything could have been done to prevent it.

Table 6: staff-client dyads

Staff	Client
Jane (Offender manager)	Kathy
Sarah (Offender manager)	Dave
Christine (Offender manager)	Mike
Harry (Mental health worker)	Freddie
Kevin (Offender manager)	Dan

4.5 Psychological and Psychiatric Measures/scales

The following section provides details of psychological and psychiatric measures completed by participants. All measures have been previously used in either near-lethal research with prisoners, or probationers, or both.

- The *MINI* (mini international neuropsychiatric interview) has good to very good validity, reliability (inter-rater and test-retest) and sensitivity and specificity indices (Amorim, Lecrubier, Weiller, Hergueta, & Sheehan, 1998; Lecrubier et al., 1997; Sheehan et al., 1997). The MINI has been previously used amongst a prison based offender population (Rivlin et al., 2010) and amongst offenders carrying out community sentences (Brooker, Sirdifield, Blizard, Denney, & Pluck, 2012). The MINI includes both axis I and Axis II disorders for the ICD-10 and the DSM-IV (Amorim et al., 1998). However, previous research in prisons and in the probation population (Brooker et al., 2012; Pluck, Sirdifield, Brooker, & Moran, 2012) indicate a high prevalence of other forms of personality disorder (PD). As the MINI only investigates anti-social personality disorder it was decided that another measure of PD should be included in this research (see below). Due to time constraints, and after discussions with researchers who had used the MINI in prison settings (Marzano et al., 2010; Rivlin et al., 2010) the section on disordered eating was not administered to participants. In accordance with previous research (Marzano et al., 2010; Rivlin et al., 2010) a diagnosis for mania was only made if the participant met both the criteria for irritable mood and elation, and a diagnosis for OCD was made if the participant met the criteria for both obsessions and compulsions. Overall the MINI a relatively short administration time (25 minutes) and an ease of use for non-clinical staff (Lecrubier et al., 1997; Sheehan et al., 1997), particularly useful for the current study as the researcher was not clinically trained, although received training to use the MINI.
- *The Standard Assessment of Personality - Abbreviated Scale*: The SAPAS is a short screening tool designed to screen for personality disorder, but does not distinguish between the different clusters or subcategories of PD (Moran et al.,

2003). It consists of 8 questions with yes or no responses, and is administered verbally by the interviewer to the interviewee. All items receive a score of 1 if the participant answers yes, apart from item 3 which receives a score of 0. Scores can range between 0-8, with a score of 3 being the cutoff point that indicates possible PD. The SAPAS has acceptable internal consistency ($\alpha = 0.68$) and test re-test reliability (Moran et al., 2003), and has been found to be relevant for use in probation populations (Pluck et al., 2012).

- ***The Beck Depression Inventory:*** The BDI is a 21 item self-report questionnaire which measures levels of depression (Beck & Steer, 1987) and has previously been used in research with suicidal offenders (Rivlin et al., 2013). Each item is scored from 0-3 and scores are total to give an overall score of depression. Scores between 0-9 = not depressed; 10-18 = mild to moderate depression; 19-29 = moderate to severe depression; 30-66 = severe depression. The BDI has high levels of internal consistency (Cronbach's $\alpha=0.85$), stability and validity (Ambrosini, Metz, Bianchi, Rabinovich, & Undie, 1991).
- ***Toronto Alexithymia Scale:*** The TAS is reliable, well validated and used widely (Taylor, Bagby, & Parker, 2003). The TAS is a 20 item 5 point Likert style questionnaire, where participants are asked to rate how strongly they agree or disagree with statements. All items are scored 1- 5 (strongly agree – strongly disagree) apart from items 4, 5, 10, 18, & 19 which are reverse scored. TAS is considered as a continuous variable but cutoffs have been derived for the identification of individuals with high or low alexithymia. Cutoffs are as follow; ≤ 51 = low alexithymia; ≥ 61 = high alexithymia, therefore medium or possible alexithymia is reflected by scores of 52-60. The TAS is comprised of three subscales: '*Difficulty Describing Feelings* (Items 2, 4, 7, 12, 17); '*Difficulty Identifying Feelings* (Items 1, 3, 6, 11, 9, 13, and 14); '*Externally-Oriented Thinking* (Items 5, 8, 10, 15, 16, 18, 19, and 20).
- ***Plutchik Impulsivity scale:*** The PIS assesses disposition to participate in impulsive behaviours/acts often characterized by a perceived sense of losing

control. The PIS is a 15 item self-completion 4 point likert scale (almost never, sometimes, often, very often), with a possible range of overall scores 15-60. Scores are attributed 1-4 (almost never- very often) apart from items 4, 6, 11 & 15 which are reverse scored. Impulsivity is considered as a continuous variable, therefore there is no cutoff point of impulsivity instead higher scorers will reflect higher levels of impulsivity, although some research has considered a cutoff point of 25 (Ortega, Chapela, & Santoncini, 2012). The PIS has previously been used with an offender prisoner population (Rivlin et al., 2013) and has established good validity and internal consistency (Cronbach's $\alpha=0.74$) (Plutchik & van Praag, 1986).

- ***The Beck Hopelessness Scale*** (Beck, Weissman, Lester, & Trexler, 1974; Beck & Steer, 1988): The BDI includes 1 item that measures hopelessness, however after discussions with LPT it was decided that a measure of hopelessness should be included. The BHS consists of 20 items in which the participant has to circle true or false for each statement. The current research followed standard scoring conventions for each item (Beck & Steer, 1988). Scores range between 0-20. A score of 0-3 = none or minimal hopelessness; 4-8 = mild; 9-14 = moderate; 15= severe with a definite suicide risk. The BHS has good internal consistency ($\alpha=.97$) and reliability (Bouvard, Charles, Guerin, Aimard, & Cottraux, 1991), and has been used with offender populations (Gray et al., 2003).
- ***Visual Analogue Scale (VAS)***: Due to the sensitive nature of the research topic, monitoring of the participants emotional state was considered particularly important. Therefore a VAS was used to monitor the mood of participants prior to and after the interview, on which participants rated their mood from 0 ('worst mood I can imagine') to 10 ('best mood I can imagine'). This VAS has been used in previous research with prisoners and has been found to be a good monitor for mood changes (Rivlin, Marzano, Hawton, & Fazel, 2012b). A Wilcoxon signed-rank test showed that taking part in an interview about a near-lethal suicide attempt elicited a statistically significant positive change in perceived mood with mood being rated more highly after

the interview than before (see appendix 5).

4.6 Interviews

Semi-structured interviews were chosen to explore the views of participants and to gain an understanding of their experiences in a flexible way, allowing both the participants and researcher to further explore particularly important accounts, meanings and understandings. Although semi-structured interviews are not free from criticism (Potter & Hepburn, 2005), they were deemed particularly appropriate for the current research as they are useful for gathering the perspectives of those less likely to 'have a voice', and can help to empower disadvantaged groups of individuals (Potter & Hepburn, 2005). Furthermore, in comparison to self-complete questionnaires interviews are ideal for populations such as offenders, whose literacy rates are often low (Caddick & Webster, 1998; Dugdale & Clark, 2008). Additionally semi-structured interviews are appropriate for research which focuses on individual experiences and aims to understand perceptions and meanings of experiences (Smith, 1995).

4.6.1 Interview agendas

Study 1 (staff): The interview agendas were devised to tap into the experiences of staff in managing suicidal clients. The questions were devised through discussions between the researcher, researcher's supervisors, forensic psychologists employed by LPT and with members of the LPT suicide prevention forum. Three forms of the interview agenda were used depending on the individual's previous experience with suicidal/self-harming client. If the member of staff had referred a client to the study interview agenda 1 was used (see appendix 6) enabling the person to speak directly about the client that they had referred to the study, whilst also enabling them to talk about other experiences of suicidal clients and to discuss their views on LPT suicide training. If the member of staff had experience of a suicidal client but had not referred anyone to the study they were asked questions from interview agenda 2 (see appendix 7). Interview agenda 2 includes the same questions as interview agenda 1 but does not refer to a specific client. Lastly if the member of staff reported never having an experience with a suicidal/Self-harming client whilst working for LPT they were asked questions from interview agenda 3 (see appendix 7). Interview agenda 3 is again similar to interview 1 & 2, however it focuses on questions about 'what if this were to

happen' rather than 'when it happened.' Interview agenda 3 was designed to allow staff to give their thoughts on how they think that they would react and handle a suicidal/self-harming client.

Overall all three staff interview agendas covered three main areas; Experiences of suicidal/self-harming probation clients, views on support for staff who have to deal with suicidal/self-harming clients, and training for handling suicidal/self-harming clients.

Study 2b (clients): Questions in the interview agenda for Study 2b (see appendix 8) were based on topics focused on in previous interview agendas which have been used for research on near-lethal behaviour with prisoners (Marzano et al., 2009). However the current interview agenda was adapted to meet the needs of a probation population, tapping into the possible factors that may have played a role in the suicidal behaviour of probationers, and enabled the researcher to map their accounts of near-lethal behaviour onto the probation process. The interview agenda for Study 2b was again devised by the researcher, researcher's supervisors, LPT psychologists', and in collaboration with the LPT suicide prevention forum. Overall the questions were devised to cover five main areas;

- How they felt about their life prior to their near-lethal act
- How they felt in the moments leading up to the act
- How participants felt after the incident?
- What were the perceived causes and triggers to the act?
- What could have been done to prevent suicide and near-lethal behaviour?

Study 3 (follow up interviews): The follow up interview agenda (see appendix 9) was developed by the researcher in collaboration with the parties outlined above and were designed to address the following areas of interest;

- How did the participants feel about their near-lethal behaviour now?
- Has anything changed since their original interview, including changes to life, thoughts and feelings, and these changes linked to their near-lethal act.

- Have they carried out any further attempts, near-lethal behaviour or self-harmed since their original interview, and if so, what led up to this behaviour.
- Have they received any support from LPT or other sources since their near-lethal behaviour and have they found this to be useful.

Data handling

All data were recorded using an Olympus voice recorder, telephone interviews were recorded using an Olympus TP7 attachment for the Olympus voice recorder. All data were transcribed verbatim by the researcher using f4 transcribing software. Interview data was anonymised by removing any potentially identifying material and all participants were provided with pseudonyms.

Exclusion criteria

Participants were excluded from the research if they were deemed at immediate risk of further suicide attempts, or deemed too vulnerable to participate (two males were excluded on this basis). After discussions with LPT it was also decided that individuals who were unable to speak English would also be unable to take part due to potential issues of translation of sensitive material. However, no participants had to be excluded on this basis.

4.7 Analysis

4.7.1 Thematic analysis: Studies 1 & 4

The data for Study one was analysed using thematic analysis. Data for Study 4 was collected during the data collection phase of studies one and two and then were re-analysed using TA. As outlined in section 4.4 probation staff were interviewed, interviews were then conducted with probation clients who had made a near-lethal attempt whilst being supervised by that specific member of staff. The data gathered from this process were analysed for studies one and two, and subsequently re-analysed using thematic analysis for Study 4. A dyad approach was used to match the participant's accounts to one another, by drawing on similarities and differences between the accounts.

There are six stages of TA according to Braun and Clarke (2006) were followed during the analysis (See Braun and Clarke, 2006). The process of these stages in not linear,

instead encourages the researcher to continually assess and re-assess coding/themes for clarity, salience and substance. This cyclical process was adhered to during the analysis of studies 1 & 4. These six stages are;

1. Familiarisation with Data
2. Generating initial codes
3. Searching for Themes
4. Reviewing Themes
5. Defining and Naming Themes
6. Writing up findings

The researcher became familiar with the data by carrying out the interviews herself, transcribing them, and listening to them at least twice. Each transcript was transcribed verbatim and coded line by line to capture both semantic and latent content. The codes were then analysed within each transcript and between transcripts for re-occurring themes that presented meaningful and consistent patterns (see appendix 10). These themes were then reviewed and refined; collapsing some themes into single themes where necessary. A thematic map aided this process (see appendix 11). The researcher then defined and named themes to adequately represent the essence of each theme (see appendix 12 for an example). Themes were checked for accuracy and consistency by two other researchers and re-evaluated where appropriate.

The researcher aimed to analyse the data for Study 1 inductively by focusing on what was present in the data rather than being guided by existing theory (Boyatzis, 1998). However, it is recognised that it is difficult to remain solely objective and the research data itself was guided by the topics of interest set out in the interview agendas (Braun & Clarke, 2006). Study 4 data on the other hand was analysed theoretically, whereby analysis was guided by three main areas of focus; potential signals and indicators of the near-lethal behaviour; potential causes and triggers of the near-lethal behaviours; and possible prevention for near-lethal behaviour (Smith et al., 2011). Furthermore, the researcher focused on both the manifest/semantic and latent content as she was interested in both what the participants directly expressed and the possible underlying

psychological processes or meanings of the participants accounts (Braun & Clarke, 2006; Joffe & Yardley, 2004). The use of semi-structured interviews allowed for flexibility throughout the interviews.

4.7.2 Interpretative Phenomenological Analysis: Studies 2b & 3

IPA is a iterative process which, according to Biggerstaff and Thompson (2008) can be grouped broadly into four main stages, although guidelines for ‘doing IPA’ are not set in stone and can be flexible depending on the researcher (Smith, 2011b):

1. Initial encounter with text and note taking
2. Identification of preliminary themes
3. Collating and grouping of themes into concepts/clusters, and identification of possible superordinate themes.
4. Producing a summary table of themes

The data for these studies were collected using semi-structured interviews (see section 4.6 for details of interview), a commonly used method for IPA studies and other qualitative research (Biggerstaff & Thompson, 2008; Shaw, 2010). The researcher audio recorded the interviews and transcribed them verbatim. Initial analysis was carried out on a single case, then subsequently on all cases. The researcher read and re-read the interview transcripts making both descriptive and interpretive notes about the content and anything that was perceived to be of importance (Smith et al., 1999). At this point during the analysis the researcher used Nvivo software to aid with note taking; notes are usually recorded in the left/right hand margin of the transcript but were instead included in the annotation section of Nvivo (Bazeley & Jackson, 2013). The researcher then moved onto the second stage of analysis where preliminary themes that ‘captured the essential qualities of the interview’ were identified (Biggerstaff & Thompson, 2008). At this point the researcher began to introduce psychological terms/concepts (Willig, 2001) and began to look for contradictions and connections between emerging themes (throughout individual accounts and between accounts). Earlier themes were also re-checked for consistency. During the third stage of analysis the researcher began to structure the groups of themes into a hierarchy of

subordinate and superordinate themes. Lastly a master table of themes was developed to demonstrate the essence of each superordinate theme and their subordinate themes. As the studies focused on 6-7 interview transcripts, this process was repeated for each transcript, continuously re-reading and re-checking each transcript for consistency and contradictions of themes (see appendix 13 for coding example).

Epoche/Bracketing: Traditional hermeneutic methods stress the importance of ‘epoche’ – removing one’s own pre-conceptions, views and judgements about a particular thing in order to understand its essence. However, IPA researchers recognise that it is not possible to completely remove these judgements and preconceptions (Willig, 2001). This appears to pose a problem as an integral part of IPA is the interpretative process of the researcher and therefore, in addition, their influence on the analysis. A technique which can be helpful during this process is termed ‘bracketing,’ in which the researcher aims to bracket off their own pre-conceptions and judgements about the topic in order to focus on what is presented by the participants (Biggerstaff & Thompson, 2008; Fade, 2004; Smith, 2007). It is argued that this can only be achieved if the researcher is aware of what they are ‘bringing’ to the research, which needs to be recognised through an introspective process and can be achieved by keeping a reflective diary throughout the research process. The current researcher has therefore provided a reflective account which draws on some of her key reflections during the research process, with comments on the possible interactions that her views, judgements, pre-conceptions had on the research as a whole (see 3.6).

5 Study One: Probation Staff Experiences of Managing Suicidal and Self-harming Clients

5.1 Introduction

The current study sought to explore the impact of suicidal behaviours on probation staff, in relation to their experiences of working with probation clients who have carried out suicide, attempted suicide or self-harm. Thirteen in-depth interviews were carried out with probation staff who had direct contact with probation clients in one probation area, and had varying degrees of experience of managing suicidal or self-injurious clients. These were analysed using Thematic Analysis. Five main overarching themes were identified (Table 7).

Table 7. Staff: Main overarching themes and subthemes

Main Overarching Themes	Subthemes
Understanding suicide and self-harm	-Views on mental illness -Perceived purpose of self-injury -Establishing seriousness
Learning How to Manage Suicidal Clients	-Training; Existence without uptake -Experience as a tool
Predicting the Unpredictable	
Supporting Suicidal Clients	-The power of talking and listening -Referring to specialists -Support via communication -Support via monitoring
Support for Staff	-Impacts of the Clients' behaviours -Support for staff

5.2 Understanding Suicide and Self-harm

Regardless of degree of experience with suicidal client's and suicide training received, participants always tried to understand why their client had carried out their behaviour.

Participants described making sense of their client's behaviour by finding ways to gain an understanding about it. For some participants this related to their broader attitudes towards mental illness, based on personal experiences or, in some cases, wider stereotypical attitudes:

"...when people are psychotic they are often at risk of harm to others, there are loads of murders where psychotic people push other people under trains."

(Barbara)

Participant views about mental illness were used to inform their understanding of their client's self-injurious behaviour, but when no diagnosed illness was identified participants instead relied on their pre-existing views about that client. For example, Christine contrasted the self-harm of two of her clients, attributing one client's harming to her mental health problem, whilst the other's was perceived as manipulation and under his control.

"...she would cut herself very differently to him... she had personality disorder and a drinking problem so it's quite common, but I think he is a bit different and is doing it for different kind of attention... to get what he wants."

Participants also attempted to understand the perceived purpose or motivation behind their client's self-injury. As in the example above and below, motivation to harm was sometimes perceived as a means for clients' to gain control over something external to themselves, and in these cases self-injury was referred to as 'manipulation' and 'attention seeking.'

"...he would become anxious and that is the time when he would start to self-harm as well. Or when people were rude to him or don't pay any attention to him, because he was a little bit of an attention seeker... when people wouldn't give him the time." (Wendy).

Such views were less common in those participants who had attended the suicide prevention training or had more direct experiences of suicidal behaviours. For these participants, suicidal behaviours were perceived as having an internal purpose such as a 'cry for help,' or self-harm as a 'release from frustration.' Mark, for example, commented on his client's self-harm: *"...he said that it was about a way of releasing pressure that had built up within side himself."*

Suicidal behaviours were also understood in relation to perceived seriousness. Clients who disclosed their feelings were viewed as less serious and therefore less likely to go on to complete suicide: *“they (the serious ones) don’t talk about it that much, and they just do it”* (Barbara). Whereas *“people who probably talk more about it are less likely to want to actually die”* (Ruth). Repeat self-harmers or those with previous suicide attempts were regarded as less serious and less likely to eventually complete suicide, which contrasts with research findings (Joiner, 2005).

“I remember that there was one when I was training... a man who had been in the system for years and he used to regularly attempt suicide... But none of them were serious, serious attempts on his life.” (Ruth)

However, this attitude changed when staff had experience of dealing with suicidal clients, where repetitive harmers were viewed as equally vulnerable as clients who had not previously self-harmed. Ruth reflects on her shift in perspective in relation to the client described above:

“I certainly didn’t take it as seriously as I would now. So I think that that comes with, once you have dealt with a few cases...”

5.3 Learning to Manage Suicidal Clients

Participants referred to the process of learning about suicidal behaviours through training and experience. An optional training course on suicidal behaviours and intentional self-injury is offered by the probation trust to all frontline staff but is mandatory for AP staff. Only 2 participants (Jane and Ruth) had completed the training, which was rated highly by both, whereas the majority of participants repeatedly referred to their lack of training. Ruth felt that the training *“helped with my practice”* enabling her to develop confidence in dealing with suicidal and self-harming individuals. In contrast, most participants expressed a lack of confidence in knowing the protocol if a client were to disclose suicidal feelings or self-injury.

“...there is no actual sort of flow chart of what to do if someone harms themselves or discloses that they are going to kill themselves... other than... do a welfare check.” (Sarah).

It is evident that training is available, however, participants' explanations for not attending suicide training included being overwhelmed with their current workload and feeling under pressure to attend other training sessions.

"I was told there are far more important... courses to attend than this one, like risk assessments..." (Wendy)

Participants also considered what information and skills they needed when dealing with suicidal clients, such as how best to talk to them:

"...the Samaritans must be trained in certain way for people ringing and saying I'm going to kill myself... I haven't had any training." (Mark)

Participants reflected on how experience prepared them for dealing with suicidal behaviours and raised their awareness of the potential issues related to these behaviours. Nancy disclosed how one incident in particular had developed her vigilance in relation to clients' behaviours and feelings.

"...I had a big lesson... now I really pay attention to how the residents look... if they look down, if they are not relating to anybody, if they are quieter." (Nancy)

In contrast, limited experience impacted on participants' confidence and ability to handle suicidal clients causing anxiety.

"I think I'd only been there for three days. You know and I was sitting there going 'I can't deal with this' I don't know what to do (laughs)." (Sarah)

5.4 Predicting the Unpredictable

Suicidal behaviours were perceived to be unexpected, unpredictable, and unanticipated even when clients were perceived by participants as feeling low:

"I was kind of shocked that it happened... Because you don't really expect it, and yeah he's going through difficulties, but you just don't see it coming." (Kevin)

Despite the perceived unpredictability of suicidal behaviours, participants tried to retrospectively establish whether their client indicated suicidal intent prior to their behaviour. For example Sarah referred to her client becoming upset during

supervision meetings prior to his suicide attempt; *“he had been tearful in interviews during the past”* (Sarah) and Barbara ruminated on how she *‘hadn’t understood’* the impact of her client’s forthcoming retirement in terms of losing his support network:

“...in supervision we had started to look at what would happen when his working life came to an end... perhaps I hadn’t understood... how much you know, what his coping mechanism in the future would be... a lot of his support came from his work place”

Some potential indicators or triggers of suicidal behaviour were specific to the probation process such as missing appointments or awaiting a court sentence.

“...he was on remand waiting to go to court, he was on bail not in custody, he then attempted to kill himself.” (Harry)

Uncertainty or change, including a changes to their sentence were perceived as potential triggers due to the stress it caused clients. Other changes included *“changing...medication,” “swapping GP’s and psychiatrists”* (Sarah).

“When he was uncertain... for example housing... he couldn’t find permanent accommodation... then I would notice that he would become anxious and that is the time when he would start to self-harm.” (Wendy).

Other triggers discussed by participants included arguments with loved ones. These were associated with an increase in impulsivity and subsequent attempted suicide/self-harm. For example Jane considered her clients’ violent relationship with her partner to be the main trigger for her near-lethal behaviour:

“...it had come after an assault by her boyfriend. She’d been on a bender, she’d been hit by him again, I think that had triggered her doing that (seriously self-harming).”

Additionally, alcohol was viewed by staff as a contributing factor to suicidal feelings and behaviour. Christine linked her clients serious self-harming to her alcohol use *“...because she was a drinker and it used to happen”*. It was recognised that alcohol could serve as a coping mechanism, potentially masking other issues such as depression.

“He was saying to me... when he does get depressed try and drink as much as possible really” (Sarah)

Participants reflected on the complexity of suicidal behaviours by considering the multiplicity of issues which led to suicidal intentions and behaviours. Multiple problems made it difficult for participants to identify one sole cause or trigger of their client’s behaviour. When participants were unable to explain their client’s actions they tended to refer to their limited control over the situation.

“There's nothing that you can do to prevent them self-harming, when they want to self-harm they will self-harm there's nothing that you can do.” (Nancy)

5.5 Supporting Suicidal Clients

Participants discussed a range of approaches for supporting clients depending on their individual needs and situation. Some participants tried to support their clients by listening and talking to them about their suicidal feelings. This was seen as providing an opportunity for clients to explore their feelings, particularly for those who had not previously disclosed their suicidal feelings to probation staff.

“Always talk about it with them. Because not everyone will be as open and as forthright as her (client who disclosed suicidal behaviour).” (Jane)

Participants felt that talking with a client enables them to gather information about what the client is planning to do and gain knowledge about how to provide them with the best support. Nancy said that it useful to *“...talk about consequences and the reason why they have done it... and if they have any other coping mechanisms around them.”*

However, in contrast some felt uncomfortable talking to their clients about suicide and were concerned that they would make the situation worse because of their lack of knowledge and expertise.

“...I didn't know what I was talking about, it wasn't my field. So I was very conscious about what I was saying, I wasn't sure if I was saying the right thing or not.” (Wendy)

Referring a client to a specialist for help was, in these cases, viewed as the most appropriate action. Specialists were regarded as an important source of support for

both staff and clients, and were particularly useful for participants who lacked confidence talking to their client about suicide. Having a specialist to turn to in a crisis helped relieve anxiety and stress.

“...we have got... the personality disorders psychiatrist and we have got somebody from mental health here, I feel more supported because I can go to them.” (Ruth)

Several participants had clients who were already accessing support for their suicidal behaviour/thoughts from other services. This pre-existing support from specialists was perceived as supportive for both the participants themselves and their clients.

“He had quite a lot of support already in place... I’m not sure how I would have reacted or if I would have done anything differently if he hadn’t had that support mechanism in place.” (Sarah)

Pre-existing support provided reassurance that their client would receive appropriate help for their suicidal feelings, as well as helping to relieve time constraints that staff already faced in their busy day-to-day roles.

“...to an extent I think what made it easier... he had an appointment with the PD (personality disorder) service... so I didn’t have to think too hard about any long term intervention because it was going to happen anyway.” (Harry)

Some participants sought to support their client by establishing communication with other parties involved in their care. This communication enabled them to gain a wider understanding of their clients’ needs and ensure their support is sufficient.

“...as he goes to the centre (mental health care centre) on a regular basis, my first port of call is that, is to go to the mental health resource team and alert them.” (Barbara)

Communication between probation staff was viewed as particularly important, and more so for those who work in AP’s where there is more opportunity to spend time with their clients than in probation offices.

“Communication with the resident is very important, as well as the staff, because when I am not here my colleagues continue the job of trying to find

out how the person is and being aware of the situation... communication is very important.” (Nancy)

Participants, particularly those who work in AP’s, felt that monitoring their client was important both in terms of providing appropriate support and preventative action.

“...We pay attention to everything that they do, the letters, the emotional state, health, everything...their everyday life, who they communicate with... If someone has a history of self-harm then I would do ... a monitoring chart... All the staff they look at it.” (Nancy).

However, for those working in probation offices, immediate monitoring is not always possible due to the time delay between a client disclosing suicidal feelings and their next appointment.

“...he rang me and said I can’t carry on. I’m going to kill myself I’m going to cut myself and came in a couple of days later and actually spoke to me about it.” (Sarah)

5.6 Support for Staff

Participants often experienced feelings of powerlessness when their clients carried out suicidal behaviours. This was particularly apparent if their client had died, and was often accompanied by a sense of guilt: *“I felt really guilty because I felt... I should have known.”* (Ruth). Moreover the participants went through a process of self-questioning:

“...I felt guilt for not noticing the person. And I know on one level I have nothing to do with it and on the other level you always feel responsible.... You think... maybe I could have done better, maybe I should have noticed. Maybe I should have spoke to that person before.” (Nancy)

Participants were thus left with unanswered questions about their client’s death, particularly whether anything could have been done to prevent their suicide. A particularly troubling aspect of this for participants was knowing that they would never get the answers to these questions.

“...you can’t ask the person why did you do that, so you’ll never get an answer to your question... it’s just like an unfinished book really, that’s the only way that I can describe it...” (Pauline).

Participants were affected by their clients’ behaviour irrespective of the outcome, with many experiencing feelings of anxiety due to their on-going concerns that their client would complete suicide following a suicide attempt:

“...it does make me worry at how much of a risk she is to herself... I suppose it makes me more concerned about her... I guess more anxious.” (Jane)

Furthermore, seeing the results of their clients’ self-injurious behaviour was difficult, for some:

“...you’re never really expecting to see the results... but when they come in and they show you their scars it can be pretty harrowing.” (Sarah)

Interestingly, Sarah also discussed how frequent exposure to self-harm and suicide can reduce the emotional impact and facilitate coping with the visual consequences.

“I think probably the longer that you are in the job the more, not hardened you get but I don’t know but you just find ways of dealing with it.” (Sarah)

All staff felt that support was available when a client self-harmed or carried out suicide. Nearly all were aware of the support they could receive from a confidential counselling service working in partnership with probation. The service had a good reputation amongst the staff, irrespective of whether they had used it. Participants also looked for support from senior colleagues, however, the availability and usefulness of this support depended both on manager attitude and participants’ willingness to seek out support.

“I think there is a big variance between various seniors, my one here... well I’ve not had a sudden death here yet but, I couldn’t imagine that I wouldn’t get the support I want. But... I’m extremely good at seeking out what I need.”
(Barbara)

In contrast, Ruth stated that: *“...my manager wouldn’t care less but others are more supportive of their staff.”*

The most frequent form of support came from discussions with co-workers and peers. For example, Mark felt that her co-workers had been very supportive when her client had attempted suicide *“I think that might just be more luck that there are lots of people here that are really nice. But I don’t know if that’s across the board...”*

Support from colleagues was seen as the most accessible and valuable. It enabled staff to off-load their feelings immediately after an incident and to gain a range of perspectives on different situations: *“...a lot of us just use peer supervision because that’s the thing that’s quite effective when you come out of seeing someone and you just start talking about it.”* (Ruth)

In contrast, some voiced concerns about the adequacy and availability of support particularly in relation to practical constraints, such as availability of senior staff sometimes leading to delays in accessing support.

“I would have felt that I didn’t have the right support in the office because I don’t know if my manager was in or not.” (Christine)

5.7 Discussion

The current study is, as far as the author is aware, the first qualitative study to be carried out with probation staff in England regarding suicidal behaviours by clients, and has gone some way to shedding light on the needs of staff and provide a focus for future work. The findings suggest that staff were aware of the complex nature of suicide, but also struggled to make sense of this behaviour particularly with respect to motivation and seriousness. Staff inconsistently reported taking part in training with several relying on their own experience and views about mental health which could be inaccurate. Staff with limited training or experience of dealing with suicidal behaviours struggled with knowing how to manage these clients. Nevertheless, staff were keen to develop their understanding of suicide and to provide support. Having health specialists available when they did not feel confident with managing the situation was perceived as particularly useful. Staff felt that support was available to them if they were affected by a client’s behaviour, however the availability and adequacy of line manager support appeared variable.

Unlike findings from prison research (Batsleer, Chantler, & Burman, 2003; Rayner, Allen, & Johnson, 2005), staff did not categorise self-injurious behaviours into ‘good’

or 'bad' but perceived them as having either an internal or external function. Internal functions included communicating feelings or expressing emotions such as frustration (Kenning et al., 2010; Pannell, Howells, & Day, 2003). However, staff interpretations of external motivation were sometimes based on negative stereotypes, with reference to 'manipulators' and 'attention seekers'. Staff without suicide prevention training were more likely to use external attributions which perhaps stemmed from a lack of confidence and knowledge about the issue (Liebling, 2002; Short et al., 2009). This finding is of particular concern since previous research has demonstrated that even when offenders admitted an underlying manipulative purpose to their actions, they were no less vulnerable to suicide (Hills, Dear, & Thomson, 2000). Furthermore, lack of knowledge on this issue may interfere with the day-to-day management of these offenders (Corrigan, 2004) affecting the way in which staff approach these individuals, and causing vulnerable clients further distress (Ciclitira et al., 2012). It is also important that staff do not over-focus on 'seriousness' of self-injury as a potential indicator for eventual suicide, as previous research indicates that lower levels of self-harm are linked with eventual suicide (Hawton et al., 2013; Joiner, 2005).

In contrast with research with community corrections officers (Biles et al., 1999), and despite difficulties outlined above, staff were satisfied with the support that they were able to offer their clients. Support methods employed were similar to those recommended for supporting suicidal prisoners and suicidal individuals in general, including; listening (Snow & Biggar, 2006; The Department of Health, 2012); referring to specialists; and good communication and collaboration between all parties involved in the clients welfare (Dear, 2006).

Staff in the current study experienced distress during the aftermath of a suicide, attempted suicide or serious self-injury by a client (Biles et al., 1999). Their feelings of guilt have also been described by other survivors of suicide (Grad, 2011) and have previously shown to contribute towards burnout in professionals dealing with suicidal individuals (Coffey, 1999). The current findings, therefore highlight the significant emotional consequences suicide can have on staff, as well as the need for sufficient support mechanisms to be in place for staff during an aftermath of a client's suicide, and after dealing with a suicidal client. Staff in the current study felt able to get support from a range of sources including a counselling service, and peers, although manager support was not always immediately available. Interestingly staff reported that having

some experience with self-harm/suicide helped them to cope more effectively, but some staff reported becoming numb and detached over time. This sense of emotional numbness has also been reported in other professionals exposed to suicide and self-harm (Crawley, 2004). Numbness is seen to provide an emotional coping or defence mechanism that enables people to deal with stressful or upsetting situations (Bowins, 2004), although repetitive exposure can also lead to desensitisation and a lack of empathy (Sanderson, 2013).

When faced with a suicide, staff went through a sense-making process to re-construct their clients behaviour and to understand causal factors, as found in other survivors (Dransart, 2013). This re-construction occurred through the identification of factors that could have been used to predict this unpredictable behaviour. During this process of sense-making, some staff concluded that suicidal behaviours are unpreventable (Marzano, Adler, & Ciclitira, 2013) – this helped participants to distance themselves from responsibility for the situation and may have provided them with a way to cope (Crandall & Perrewe, 1995), although long-term this may be unhelpful. Staff identified a number of factors as potential indicators and triggers for the suicidal behaviour which have also been found in broader research on suicide: excessive alcohol consumption (Cherpitel et al., 2004; Cook & Borrill, 2013; Rossow, 1996); arguments with loved ones (Bancroft, Skrimshire, Casson, Harvard-Watts, & Reynolds, 1977; Conner & Ilgen, 2011); and mental illness (Marzano et al., 2010; Rivlin et al., 2010).

In addition staff identified potential triggers and indicators of suicide and self-harm that are specific to the probation process, namely awaiting a court sentence and missing appointments. Awaiting a sentence has also been found to be a trigger for suicidal behaviours in offenders on remand in custody (Kimmet, 2004), however offenders in community settings cannot be as closely monitored as offenders in prison, therefore may be at heightened risk. Although offenders may miss appointments for other reasons, the results of this study suggest staff should try to explore these types of issues with clients in order to identify possible risk.

Overall these findings highlight the importance of adequate training for all probation staff working with ‘at risk’ and ‘potentially vulnerable’ individuals. Training staff who work closely with individuals at risk of suicide and self-harm is one of the key

objectives set out in the Government's current suicide prevention strategy for England & Wales (The Department of Health, 2012). Training for staff in the current study was optional for those who work in probation offices and only mandatory for those staff who work in approved premises. The probation area of the current study had training in place run by forensic psychologists, but not all probation areas in the UK have suicide and self-harm training available to staff. Furthermore, the probation area researched has a specific suicide prevention action plan and forum which informs the suicide prevention work undertaken. However this is not replicated across other probation areas. Educating staff about mental illness and self-injurious behaviours in other settings has shown to increase their confidence and reduce stereotypical attitudes (Daniel, 2006). Plans to decrease the number of prison sentences and increase the number of community sentences for offenders with mental health needs and drug problems (Ministry of Justice, 2013c), make it essential that staff training is continuously reviewed and updated across all NPS and CRC areas to ensure staff have sufficient knowledge to cope with and manage this group effectively. These findings also demonstrate that continuing to provide staff with a range of options for immediate and on-going support after an incident is essential (Grad, 2011). Furthermore, ensuring that support and training exist for those working with both the CRC and the NPS is particularly important, as many vulnerable clients are now being monitored by staff working for CRC rather than the NPS.

The current study used a small sample restricted to only one probation area in England, making it difficult to generalise these findings to other areas. Furthermore the participants in the current study were self-selecting which may reflect a particular interest in suicidal behaviour. However, it could be argued this makes the findings of particular note given the need for more knowledge and support felt by some participants. It would be useful for future research to include larger participant samples, and where possible include comparisons between the views and experiences of staff with varying roles within probation, for example comparing mental health workers with offender managers.

Conclusions: The findings from the current study demonstrate that probation staff in this sample perceived managing suicide as an important aspect of their work. They were positive about the support that they were able to provide, although sometimes lack of training or experience restricted their ability to know which form of support

was most appropriate. Not surprisingly staff felt emotionally affected by the behaviours of their clients and despite having support channels in place, they felt that support should be easily accessible after an incident. It is recommended that suicide prevention training continues to be provided and should be prioritised for all staff working with offenders in the community, including both NPS and CRC staff. Furthermore, the impact of suicide will affect CRC as well as NPS staff because suicides are found in clients with a wide range of levels of offending, not just those who are assessed as high risk of reoffending. Therefore managers have a vital role in supporting staff and should be provided with specific training to help them provide this support.

6 Study Two (a): Exploring Suicidal Behaviours in Probation Clients – Case Studies

The previous chapter examined how probation staff manage suicide, attempted suicide and self-injury. The work presented in this chapter should be considered complimentary to Study 2b which provides a detailed qualitative analysis of probation clients' experiences of near-lethal behaviour. The current study chapter is designed to provide a more in-depth understanding of each participant from psychometric and psychiatric measures. The chapter begins by providing a short description of each individual participant, as detailed from their psychometric scores. The chapter concludes with a discussion of the results, as well as some comments on limitations and implications relevant to the current study.

6.1 Individual Scores

The following sections draw out the details of each individual case in relation to their psychometric scores and outcomes from the MINI. Table 8 provides an overview of the participants' psychometric scores.

Table 8: Baseline measures for individual participants

Name	PD (3+)	Depression	Alexithymia	Hopelessness	Impulsivity (15-60)
<i>Dave</i>	Did not complete	27 (moderate to severe)	55 (possible)	Did not complete	43
<i>Freddie</i>	7 (yes)	34 (severe)	67 (high)	10 (moderate)	45
<i>Kathy</i>	3 (yes)	38 (severe)	63 (high)	10 (moderate)	45
<i>Dan</i>	3 (yes)	33 (severe)	79 (high)	13 (moderate)	55
<i>Mike</i>	6 (yes)	42 (severe)	65 (high)	0 (none)	45

Roy	5 (yes)	9 (none – mild)	– 34 (low non)	– Did not complete	21
Josh	5 (yes)	24 (moderate)	72 (high)	10 (moderate)	39

Dave: According to the Mini Dave has previously experienced recurrent major depression with melancholic features, as well as past manic episodes. Dave also showed a medium level of suicidality. These issues are further illustrated by Dave’s self-disclosed diagnosis of bipolar disorder during his interview, as well as the problems that he experienced in relation to his mental illness, including his excessive use of alcohol. *“I came up here and was assessed and got my diagnosis of bipolar and I was medicated... and I did start drinking, I had one or two slip ups.”* In relation to this Dave’s score on the BDI indicated that he was currently experiencing moderate to severe depression at the time of his near-lethal incident. This was also supported by his self-disclosed diagnosis of bipolar disorder, and the indication from the MINI that he suffers from mood disorders. In addition to this Dave’s score on the TAS reached the cut-off point for possible (medium) alexithymia score which suggests that he may face difficulty when trying to express, discuss and understand his own emotions and feelings. In particular Dave scored highly on subscale 2 suggesting that he may have more difficulty with identifying his emotions, rather than describing. Despite Dave having a good insight into his suicidal behaviour there were moments during the interview when he struggled to analyse how he felt; *“Interviewer: “How did you feel when all of this was happening?” Dave: “I don’t know how I felt.”* Furthermore Dave’s impulsivity score was toward the higher end of the possible range suggesting that he may have difficulty controlling urges and act impulsively. Dave’s near-lethal attempt appeared impulsive and unplanned, but this may have been linked to his excessive alcohol use at the time of the incident. Dave’s description of his use of alcohol appeared unplanned, impulsive and trigger by his low mood on the day of his attempt. *“I’m just boiling over, and walk out of the bank and opposite the bank there is an off-licence. I just thought you know what sod this.”* Dave did not complete the

SAPAS, although he did later refer to being diagnosed with PD but did not know what type. He then started to attend a personality disorders help group which he was referred to by his health worker.

Roy: Roy's MINI assessment did not indicate any psychiatric illness, but did show Roy to have high Suicidality. Roy disclosed previous alcohol abuse, but not within the 12 month time frame specified by the MINI. Interestingly Roy did not meet the criteria on either the MINI or BDI for depression despite saying *"I've been diagnosed with depression for years, fifteen, twenty plus years... I came off anti-depressants a couple of years back."* Roy described his past struggles with depression but did not feel depressed at the time of the incident. Furthermore Roy was one of the only participants to describe using techniques such as meditation to combat his low feelings. Roy's depression score also contradicts what is known about the link between depression and suicidal feelings. Additionally Roy did not complete the hopelessness scale but did say that at the time of his attempt that he felt *"at that point there was no purposeful future. Well not one that I could perceive. That is one of the key points, it perceivable."* Unlike other participants Roy's score did not reach the cut-off point for alexithymia, indicating that he does not face difficulty with identifying and expressing his emotions and feelings. He had a particularly low score (8 of 25) on subscale 1, suggesting that he does not have problems with describing his feelings. This was apparent during his interviews where he was clearly able to identify and express his emotions, however he did say that he did not talk about his feelings leading up to the attempt but that this was due to shame and embarrassment rather than not recognising how he felt. Roy: *"I should have said xxx talk to me, I'm feeling awful. But I didn't, I bottled it."* Interviewer: *"Why do you think you did that?"* Roy: *"Erm, probably embarrassment... And again, you know, I don't know because I'm more than extremely good at expressing myself and talking through my feelings."* Furthermore Roy's impulsivity score was low in comparison to the other participants, this could account his lack of criminal history as the offence he had been charged with at the time of his suicidal behaviour was his only prior offence. However, Roy's low impulsivity score does not reflect his suicidal act which appeared impulsive (taking tablets shortly after his release from prison without any prior plan to do so). *"It wasn't the assessment of oh right looking at all the things around me, weighing up all the pros and cons, it isn't worth it. It was a just sudden oh my god I can't cope... if they*

(tablets) hadn't have been sitting there I'd have just had a panic attack then gone to sleep and woke up the next morning and got on." Roy screened positively for needing further investigation into personality disorder, although did not mention ever being diagnosed with PD.

Josh: According to the Mini Josh has experienced recurrent major depression with melancholic features and past hypomanic episodes. Josh also screened for current panic disorder with agoraphobia and non-generalised social phobia (social anxiety disorder). These conditions co-occurred with current alcohol dependence and substance dependence (cannabis). Josh also showed high suicidality. During his interview Josh mentioned his excessive use of alcohol but said that he has now stopped using alcohol; *"I've stopped drinking because I realised that yeah it was helping at first but once it becomes the routine of drinking drinking drinking drinking drinking drinking drinking, then the only thing you can think about is the thing you don't want to think about. So I stopped drinking."* Interestingly Josh's score on the BDI indicated moderate depression, although he screened for recurrent major depression on the MINI. However, this may be due to his depression not being current, therefore making it less likely to be detected as severe by the BDI. Josh spoke about having to coping with both depression and his feelings of anger; *"With just depression I can sort of try and make myself happy, like watch a fun movie or something like that try and make myself happy. When you're anger you can try and calm yourself down but when it's both of them, when you're sad and angry you got really nowhere to go, you can try and get into the middle but if you can't find the middle you're stuck... it's not good when it hits that stage because that's when I believe, when you really hurt yourself. You have no control over it."* Josh's alexithymia score, which reached the cut-off point for having alexithymia, suggests that he often has difficulty identifying and expressing, and understanding his feelings. This could potentially restrict his capability to express his suicidal feelings to others when he is experiencing a depressive state. Josh scored had higher levels on subscales 1 & 2, suggesting he may have difficulty with identifying and describing his emotions, however he did say that it is easier for him to talk to certain people; *"If something's getting on top of me and I feel safe talking to someone then I will just talk."* Similar to his depression score, Josh's hopelessness score was moderate, suggesting that he does have some hope for the future. *"I think it was when I was told that I was going to go to prison because of*

I had previous... That was when it was more like yes I want to die, but then I started thinking, that is just what they're saying. I could go to court, talk to a duty solicitor and have what happened happened. Get on probation and stuff like that, and then I'd have a chance to sort myself out instead of taking the short road and killing myself and not knowing what would have come out of it." Josh's high impulsivity paired with his potential inability to explain how he is feeling may increase his risk of carrying out suicidal behaviour. However Josh said that his probation sentence had now helped him to control his impulsive behaviours including his self-harm; *"I was just doing what I wanted to do, doing stupid things, getting myself into trouble all the time. I'd say coming onto the sentence has helped to stop me getting into trouble... going on the thinking skills programme has helped. It's helped me control my emotions, work out how I can stop certain things from happening, like in the case of the self-harming work out the triggers."* Additionally Josh screened positively for needed further investigation in PD but did not comment on ever been diagnosed with any form of PD

Mike: According to the Mini Mike has experienced past manic episodes. Mike's assessment indicated that he experiences panic disorder with agoraphobia and non-generalised social phobia (SAD). These conditions are comorbid with current alcohol dependence. Mike showed moderate suicidality. Alcohol addiction was also something that Mike commented on during his interview; *"Well through my order they told me that I had a drink problem and all that because most of my offences is through drink and drugs."* However, Mike mentioned being diagnosed with a number of mental health issues, some of which were not indicated by the Mini. *"Basically I'm, I've got bipolar, and erh depression with self-harming and that. It's called self-harm, emotionally unstable and I've got schizophrenia."* Mike's score on the BDI indicated that he is suffering from severe depression, despite major depression not being indicated on the Mini. In addition Mike's high alexithymia score reached the cut-off threshold and suggests that he would find it difficult to understand and communicate his feelings, possibly restricting his capability of communicating his suicidal feelings. Mike scored (26 of 35) towards the higher end of subscale 2 indicating that he would face difficulty with identifying his emotions, but would be more able to describe them and think internally. During Mike's interview he spoke of both finding it difficult to talk about his feelings, but also times where he was able to express himself. *"I found it really hard. I thought I needed help, but I just locked up,*

I didn't want to talk to no one and I just kept on losing my rag." and *"I can talk to xxx (probation officer) easily... I explain to her how I'm feeling sometimes. You know I did say to her beforehand like I'm not in a good place at the moment, I feel really down and really depressed."* Interestingly Mike's hopelessness score seems to contradict his depression, suggesting that he remains hopeful for the future, this was also evident during his interview; *"Yeah I'm feeling positive in myself that I can change. Its early days, like I say, but I can feel something there on the borderlines. You know, I could change my life. Because I've not got the stress there to build up."* Mike did however score highly on the scale for impulsivity suggesting that he would carry out behaviours without planning or thinking about the consequences. This was apparent in his suicide attempt which, despite experiencing suicidal feelings beforehand, was not planned and appeared to be a reactive behaviour to the feeling he was experiencing in the short moments leading up to it; *"I just acted on it. I wouldn't say it was a change, I just acted... I just flipped, you know I get it in my head I see red and that's it. And I need to take that anger out on myself."* Mike screened positively for needing further investigation into PD but this was not something that he commented on during his interview.

Dan: According to the Mini Dan screened as having one current mood disorder, major depression, and having past manic episodes. Furthermore Dan's BDI score also suggested that he is experiencing a current major depressive episode, which he described experiencing prior to his attempt despite being medicated for his depressive symptoms. *"Yeah I was taking Diazepam, I've been told that antidepressants make you feel suicidal. So I didn't know."* Despite Dan's depression score he had moderate hopelessness and reported plans and hopes for the future in terms of employment options. Dan's Mini assessment also suggests that he has three current anxiety disorders including; agoraphobia without history of panic disorder, non-generalised social phobia (SAD) and current OCD current. Despite this Dan showed low suicidality. Dan did however score highly on the alexithymia scale, suggesting that he may face difficulty explaining his emotions and feelings to others, as well as understanding his own feelings. Dan scored highly on subscales 1 & 2 suggesting that he may have more difficulty with identifying and describing his emotions, rather than his internally orientated thinking. Dan's difficulty with expressing his feelings to others was apparent during his interview; *"I don't know, it's just how I am with people*

really. I don't really. I don't know. I do find it hard to open up to anyone really."

Dan also had high levels of impulsivity which was demonstrated in by the lack of planning for his suicide attempt; *"I was accused of something and that's when I just lost the plot and that's when I went to xxx train station. I was ready to jump off."* As with other participants, his inability to recognise and express his emotions, paired with the likelihood of carrying out impulsive behaviours, may make Dan at further risk of suicide. Furthermore, Dan screened positively for needing further investigation into PD but this was not something that was mentioned during his interview.

Kathy: According to the Mini Kathy screened as having two current anxiety disorders including non-generalised social phobia (SAD) and PTSD. These were comorbid with current alcohol and substance dependence (crack). Kathy showed high suicidality. During Kathy's account she described having flashbacks to violent attacks she suffered during a previous relationship, which may relate to potential PTSD; *"Two weeks in the relationship he was beating the hell out of me. But he scared the life out of me so much... he ruined my life."* Furthermore Kathy's BDI score indicated severe depression, an issue she had suffered with in the past. However she did not screen for any form (past/current) of depression on the MINI. Although her interview did reveal that she has a history of both self-harm and suicide attempts, and that she considered her to be *"a self-harmer."* However, it appeared that Kathy's self-harm may have also been related to alexithymia. Kathy scored highly on the TAS, reaching the cut-off point, suggesting that she may have face difficulty with identifying and expressing her emotions. Kathy did not appear to have extreme scores on any subscales, indicating that she may at times face difficulty with all aspects of emotional recognition, description and thinking. During Kathy's interview she said *"If I can't cry I have to cope."* In addition Kathy scored moderately on the BHS suggesting that she does have some hope for the future. Her narrative during her interview suggested that her previous self-harm has been trigger by feelings of hopelessness *"So it was like, why be good, so I thought you know what god if you want me have me. That was the first cut... they just get worse as the years go on."* Kathy had a high impulsivity score indicating that she may carry out behaviours without planning to and without thinking about the consequences of that behaviour. This was reflected in her offence where she spat on a police officer for pouring away here alcohol. Furthermore Kathy

screened positively for needing further investigation into having PD. Additionally her long history of self-harm may be an indicator of PD.

Freddie: According to the Mini Freddie was experiencing current major depression with melancholic features and a current manic episode at the time of his screening. This was supported by Freddie's BDI score which indicated that he was suffering from severe depression. Further to this, Freddie disclosed a having a history of self-harm and suicide attempts and said that he felt depressed leading up to his attempt; *"I was depressed as hell."* Freddie also screened for panic disorder (limited lifetime), current generalised anxiety disorder and non-generalised social phobia (SAD). These conditions co-occurred with alcohol dependence, something which Freddie commented on throughout his account; *"When I was sentenced last time they said that there would be an alcohol treatment thing which will also help with my depression and stuff."* Additionally Freddie showed high suicidality; an issue that he has struggled to cope with for many years. *"I've been self-harming since the age of, oh Jesus thirteen or fourteen. I would punch myself in the face and stuff like that, beat myself up, started self, started suicide attempts or self-cutting myself after I found my dad dead... there has been a few suicide attempts and self-harm and stuff like that."* In addition to this Freddie also scored highly on the TAS scale, suggesting that he may find it difficult to express his feelings to others. In particular he scored towards the higher end of subscale 2 indicating that he could potentially find it difficult to identify his emotions, but may be able to describe them. During his interview Freddie spoke of being able to open up to others about how he felt; *"I tell people how I feel and stuff, and I'm so tired in my life as the way it is, there aint going to be no miracles."* Despite having depressive feelings, Freddie scored moderately on the hopelessness scale, suggesting that he had hope for the future. In contrast at the time of his attempt Freddie said *"It was how my life was going, every year will be a new year and it never is, sort of thing, it never is... I'll just finish it off. Rather than having another year of torture."* Furthermore, Freddie scored highly on the PIS, which was reflected in his unplanned suicidal act and related to his alcohol consumption. *"That evening... I hit brandy hard... but I only drank a couple of glasses of brandy and I decided."* Freddie's SAPAS scored suggested that he would need further investigation into PD. Additionally Freddie disclosed being on a waiting list to attend a personality disorders clinic, but said that he did not know what PD is and what type he has been diagnosed

with. *“I was diagnosed with personality disorder. Erm, I don’t know what that means, I haven’t got a clue what that means.”*

6.2 Discussion

The current study helps to provide a fuller understanding of the client participant group. Findings indicate a number of important points which will be considered when interpreting the qualitative findings (see Study 2b, 3, & 4), as well as the near-lethal acts of each participant. Most striking about the current sample is the prevalence of possible personality disorders and psychiatric illness, issues which can have a number of implications for suicide prevention strategies. Furthermore, mirroring previous studies with probation populations, psychiatric comorbidity appears to be a significant issue with all but one client screening for multi-diagnosis. The complexity of the current sample is also exemplified by other issues such as clients having high levels of alexithymia, depression and impulsivity.

According to the MINI, individuals in the current sample are experiencing a large number of psychiatric conditions, with all but one participant having co-morbid conditions. These findings suggest that these participants are similar to other probation samples previously assessed using the MINI (Brooker et al., 2012; Lurigio et al., 2003). The most common group of disorders included anxiety disorders followed by mood disorders, again reflecting previous research findings (Brooker et al., 2012; Lurigio et al., 2003). Substance abuse was also reported by over half of the clients, which is not surprising considering the known links between offending and substance abuse (Fazel, Bains, & Doll, 2006), and substance abuse and suicidal behaviours (Conner & Ilgen, 2011).

Although the current research cannot draw conclusions about potential gender differences in relation to psychiatric illness, the differences between male and female suicides means that some consideration should be given to the differences in the current sample. In particular, the only participant in the current sample who screened for post-traumatic stress disorder (PTSD) is female. PTSD was also found to be more prevalent in a female prison population compared with male prisoners, with 53% ($N=32$) of females screening for PTSD compared with 35% ($N=21$) of males (Marzano

et al., 2010; Rivlin et al., 2010). Due to the limited research on mental illness in probation clients (Brooker et al., 2012; Brooker et al., 2011) it is difficult to assess whether there is a similarly higher level of PTSD in female probation clients compared with males. One study which has assessed levels of psychiatric illness in a community sample had a much larger percentage (86.7%) of male participants compared with females to reflect the composition of the local probation population. Only 4.6% (N= 8) of their sample screened for PTSD, without indication of whether these individuals are male or female (Brooker et al., 2012). Thus future research would need to consider the differences between male and female probation clients in terms of psychiatric illness, as well as how this relates to suicide.

Also of interest from the current study was the discrepancy between the BDI scores of the participants and the current major depression category of the MINI. Only two participants were recorded as having current major depression on the MINI, whereas 6 out of 7 were recorded with moderate to severe depression on their BDI scores, with a group average of severe depression. There are several explanations for this finding, including the possibility that, despite being used in previous research with probation (Brooker et al., 2012; Lurigio et al., 2003), the MINI does not always detect current depression in probation populations. Or alternatively, as the Beck has not been validated for use in probation populations it may be oversensitive to picking up on depression. Regardless of the cause, this warrants further investigation in larger samples.

Furthermore despite most participants scoring as severely depressed according to the BDI, this was not reflected in their BHS hopelessness scores. The participants in the current sample averaged a moderate hopelessness score, and past research suggests that a score of 9 or more indicates risk for potential eventual completed suicide (Beck et al., 1990; Beck et al., 1985). This finding could go some way to explaining why this group of individuals are alive, and may be useful in distinguishing between those who attempt suicide and those who complete suicide. This falls in line with previous theories of suicide which suggest that hopelessness for the future may predict eventual suicide (Troister & Holden, 2010). Again this would need further investigation in probation samples.

A further issue highlighted by the findings of the current study is the level of possible PD. All participants screened using the SAPAS ($N=6$) were identified as needing further investigation into possible personality disorder. This is not surprising as previous research with prison and probation populations suggests that PD is a particularly prevalent disorder amongst the offender population (Pluck et al., 2012). PD has been correlated with suicidal behaviour, self-harm and eventual completed suicide in the general population (Casey, 1989; Coccaro et al., 1989; Soloff et al., 1994) and the offender population (Lamis, Langhinrichsen-Rohling, & Simpler, 2008). Some forms of PD such as borderline PD have been more strongly linked to suicidal behaviours (Black et al., 2004). Despite the SAPAS only being a screening tool, which cannot diagnose PD (Pluck et al., 2012), the score from the current sample indicated a need for further investigation of PD, which could relate to their suicidal behaviours and the high levels of reported self-harm. However, further investigation into how personality disorder might relate specifically to suicide by probation clients is needed.

Additionally there have been mixed findings previously in relation to whether or not suicide is linked to alexithymia, with some studies suggesting that there is no relationship (Sayar, Acar, & Ak, 2003), or that the link is between depression and alexithymia rather than suicide (Taiminen, Saarijärvi, Helenius, Keskinen, & Korpilahti, 1996). Other studies have found a relationship between alexithymia and suicidal ideations (Hintikka, 2004). The alexithymia scores of the clients in the current study met the cut-off for alexithymia, indicating that there may be a relationship between their suicide attempts and alexithymia. However the current population also had high levels of depression, thus without statistical analysis it is difficult to assess if alexithymia played a role in their near-lethal attempts. Furthermore previous research has found high levels of alexithymia in the offender population in general (Christopher & McMurrin, 2009; Kroner, 1995), therefore the high levels presented in the current population could be related to their offending behaviour rather than their suicidal behaviours.

All but one participant screened for having dual high alexithymia scores and high impulsivity scores. The current sample had average impulsivity scores of 42 which are towards the higher end of the scale. This falls in line with what is known about

impulsivity and suicide (Simon et al., 2002), as well as findings from studies with prisoners who have made near-lethal attempts (Rivlin et al., 2013). These high scores reflect the impulsive nature of many of some of the participants the near-lethal acts, as well as their histories of offending. Interestingly the combination of acting impulsively and finding it difficult to identify and describe emotions may have made it more difficult for the clients in the current sample to identify and deal with their suicidal feelings.

A limitation of the current study is its small sample size, making generalisations impossible. However, the aim of this study was not to generalise but to provide an in-depth understanding of each participant in order to enhance the qualitative content in study 2b and give context to each individual's perspective. Overall these findings provide a deeper understanding of why each individual might have carried out their near-lethal attempt and what might have prevented them from seeking support, for example, their difficulty with expressing their emotions to others. Some issues mentioned in the current study will be explored further in the following chapter. In particular: Whether probation clients mention alcohol and substance abuse as relating to their suicidal behaviour? Whether clients felt that their near-lethal acts were planned or impulsive? Whether clients felt that psychiatric or psychological conditions such as depression related to their behaviour? Lastly, whether they felt able to express and identify their feelings before the attempt?

7 Study Two (b): Exploring Suicidal Behaviours in Probation Clients – A qualitative approach

The previous chapter outlined the potential issues and difficulties each client may face according to their MINI assessment and psychometric measures. The current study on the other hand sought to explore the subjective experiences of individuals who carried out a near-lethal attempt whilst serving a community sentence through a qualitative approach. The aims of the research were to understand how clients experienced their suicidal state, what meaning this event had for them, and how they perceived this in relation to the probation process. Seven participants took part in interviews and the data were analysed using IPA. The current chapter also sought to provide a broader understanding of the participants and their suicidal behaviours, by exploring their narratives in relation to the outcomes of the measures and psychiatric assessment detailed in the previous chapter.

7.1 Findings from Qualitative interviews with clients

From the qualitative analysis of the participants' interviews five master themes were found, as detailed in Table 9.

Table 9: Clients: Main themes and subthemes

Master Themes	Subthemes
Experience of Loss	<i>-Bereavement</i>
Difficulties with Trust	<i>-Losing trust</i>
	<i>-Rebuilding trust</i>
Control: Loss and Regain	<i>-Losing control</i>
	<i>-Negative ways of coping with loss of control</i>
	<i>-Regaining control</i>
Identity	<i>-The former self</i>
	<i>-The present self</i>
	<i>-The future self</i>
Struggles with Meaning	<i>-Lack of meaning</i>
	<i>-Searching for a purpose</i>

7.2 Experiences of Loss

Many participants spoke of having to deal with on-going turmoil related to loss; for several participants this was often traumatic and burdensome. Loss encompassed many different forms including loss of key relationships and support from others. But what stood out as the most significant form of loss was bereavement. Despite bereavement being a common experience, the current participants found bereavements particularly difficult to manage. Bereavements often added to current stressful situations; these bereavements frequently added to existing emotional turmoil experienced by participants and these losses also meant the removal of desperately needed social support. Experiences of loss had a long lasting emotional impact which contributed towards feelings of despair experienced during episodes of self-harm or suicide attempts. For example Josh's experience of losing his partner after a break up also meant the loss of emotional support he previously had from talking to his partner.

Interviewer: "...when you felt suicidal or depressed have you ever been able to talk to anyone about it, you mentioned earlier your friends and things?"

Josh: "Actually go into it no. I'd say the only person I could open up to was my ex-girlfriend because I was with her for a few years so she saw me at my best and my worse and it was just easier for me to talk than allow it to get to the worse... But since me and her broke up not really."

Despite Josh's alexithymia levels indicating that he may have difficulty expressing feelings to others, he was able to have an emotional outlet through his former partner. The removal of this emotional outlet suggests that he is now unable to express himself and confide in a person of trust, and can go some way to explain why this loss was experienced so traumatically. For other participants it was not former loss that continued to cause problems, but instead it was the anticipation of loss that caused them concern and worry. Dan's concise quote illustrates how his suicidal feelings were brought on by the anticipated loss of his children if he were to be given a prison sentence. Prior to his upcoming sentence Dan revealed that he had never previously felt suicidal or even depressed, but the intense concern about losing his children

triggered his suicidal feelings.

“I was worried about going to prison basically. Leaving my kids, that’s the hard thing, that’s what I was worried about.”

Similarly Roy’s account of worrying about his court sentence demonstrates his overarching concern about losing his freedom and his chance of a future.

“The figure that was banded around was 10 years, so I wouldn’t be entitled to a review until the first ten years. Erm, so I was 56, so I wouldn’t be entitled for a review until I was 66, at my age effectively that means that your life is over. Hence I was rationally and mindfully contemplating there’s no point is there.”

The expression ‘that means that your life is over’ indicates the true meaning that loss of freedom has for Roy, as it arguably signifies the ending of his ability to plan for his future, accompanied by a sense of hopelessness. Interestingly Roy’s reaction to this is to regain power. His expression ‘rationally and mindfully’ represents his solution to regain power over the situation by making a calm and rational decision to end his own life. Coupled with his low levels of impulsivity he is now in control of ending his own life rather than having this decision made for him.

7.2.1 Bereavement

Loss in the form of bereavement affected many participants, with several referring to the on-going trauma and pain that they had experienced in relation to particular bereavements. For example Kathy’s detailed account of losing her father during a difficult period in her life demonstrates the emotional affect that this experience had on her.

“...my dad died first of cancer in my arms... as he was dying I was going through the courts with my children to try and get them back, because I was in domestic violence. So it was like, why be good... That was the first cut...they just get worse as the years go on.”

For Kathy the trauma of losing both her father and children seemed to be a tipping point which led to feelings of defeatism and hopelessness, ultimately triggering self-injurious behaviour as a possible coping mechanism for her loss. Her moderate

hopelessness score during her recent attempt further reflects the lasting impact that this has had. Similarly Freddie's initial self-injurious behaviour was triggered by the suicide of his father.

"Started suicide attempts or self-cutting myself after I found my dad dead"

And

"I'm closer to my dad in death than I was ever close to him in life, you know. Completely I feel, I feel that he is always part of me. Erm, I never stopped speaking to him, I'm always speaking to him. I feel haunted by him, and I just, just the way it ended and yeah, yeah just haunted by him. I feel he is angry at me. I feel he is lost."

Freddie's use of the word 'haunted' illustrates his inability to escape from the loss, and his interchanging use of past and present tense emphasises the on-going trauma that he still faces. Freddie's account reveals how he feels close to his dad even though 'he is lost,' suggesting that his suicide attempt may have bridged this experience of closeness. Mike's account on the other hand exposes a sense of distance between himself and his lost loved one.

"Like my nan... she died before Christmas and things like that it really hits me the most and I just want to go and be with them... I just get ideas to take the pain away."

Mike has experienced a number of losses throughout his life, but he referred to the loss of his grandmother in particular as making him feel like he wanted to die. His use of the phrase 'take the pain away' signifies his ongoing battle to cope with the trauma of losing his grandmother and the sense of peace he predicts would come from his own death. Although as with other participants, this was not the only factor that contributed towards suicidal feelings, but instead one of a number of traumatic experiences. Like Mike, Dave experienced feelings of distance after loss. During an alcohol detox programme Dave built relationships with a group of individuals who were going through a similar experience, however when he lost this group of friends he also lost the support that they provided him with. In the extract below we can see how Dave's loss is characterised by loneliness.

“Well it’s strange I did it (rehab) and there was four of us in it. Four alcoholics. And two of them died whilst... in hospital. Then there was two of us left, we got discharged from hospital... and erm. there was me and another women left... and she died the, just as I got to second stage rehab, I heard that she died. So there is just me left.”

These bereavements are embodied by a sense of isolation, loneliness and being left behind to face his experience alone, signified by his repeated use of the word ‘left.’ Particularly significant here is the complete isolation Dave experienced due to all three friends dying.

7.3 Difficulties with Trust

Difficulties with being able to trust people and professional agencies was frequently referred to by participants, often relating to past experiences of having their trust broken. Participants’ reactions to trust and trust building were complicated, with many struggling to fully embrace trusting relationships with others out of fear or rejection and being hurt. What stood out as especially important were the times when participants were able to gain trust in others and how this trust developed. Gaining and re-building trust often revolved around key sources of support. Development of trust in others was aided by the participant having a feeling of being cared for, being listened to, being made to feel like they are important, and not having their concerns dismissed. Overall participants’ described trust as fragile but something that could be repaired if broken.

7.3.1 Losing Trust

For example Kathy’s mistrust in authority, particularly the police, stemmed from a number of perceived injustices that she had experienced and frequently commented on throughout her account. Interestingly Kathy’s exposure to these negative experiences led to a general distrust in authority and the criminal justice system as a whole.

“I’ve got no time for the system I’m sorry. Do you know what I mean. I’m not saying XXX (Probation Officer) is like that, because she is fair to me but the old bill. I don’t have time for them.”

Kathy's quote illustrates the difficulty the participants faced with re-gaining trust once they perceived it to be broken. In this case not even the positive experience with her probation officer could change her views on 'the system,' and the phrase 'I don't have time from them' suggests she is now unwilling to engage with or trust any person that she considers to be part of 'the system.' Similarly Dan's negative experience with the criminal justice system at a time when he was vulnerable led to an intensification of his suicidal feelings, demonstrating the potentially damaging impact that perceived inadequate management by authorities can have on suicidal individuals.

"...I was going to kill myself... the police got the wrong end of the stick somewhere and they just said that I said I was going to kill XXX (partner). So I got arrested. Got kept in a cell for two days. That made it a lot worse, yeah a lot worse."

Some participants perceived having their trust broken as a trigger for the occurrence of further negative events making them unlikely to trust others and open up to them again.

7.3.2 Re-building Trust

Some participants spoke of ways in which trust was able to be re-gained after the experience of a negative event. For example Josh spoke of his negative experience during a counselling session, but how he was later able to open up about his feelings to another counsellor and had a more positive experience.

"I went to the counselling session obviously with everything I said he looked like he was judging me. He looked disgusted and that made me feel bad. But then as soon as you realise that was just him then yeah. Like when I talked to other people and they actually helped..." (Josh)

Josh's switch between the pronouns 'I' and 'You' arguably represent his identification in relation to others, in this sense it is not just himself who can re-build trust but others as well. Interestingly Josh's high alexithymia level indicates that he may struggle with sharing his feelings with others in this way, yet is contradicted here. However, his potential difficulties with expressing and identifying emotions arguably highlight the increased significance of these types of trusting relationships. Similarly Dave felt that there are ways in which trust can be regained. Dave's overwhelming sense of mistrust

and feelings of injustice were scattered throughout his account, however, Dave referred to one example of how his probation officer had restored some of his trust in people:

“You know when she (probation officer) first mentioned it ‘we will see if we can get you some money for clothes and I thought yeah right, okay mate what do you think that I was born yesterday and then it happened and I thought no way its someone who actually, you are as good as their word, they mean what they say they stick to it and they really really want to help me, there was nothing in it for her, she didn’t have to do that. But she did just to help me and I was like what!” (Dave)

Like many of the participants Dave’s trust in people slowly eroded due to several different negative experiences, which resulted in him not believing what people told him. His account above demonstrates the surprise he experienced when he realised for the first time that he could trust his probation officer. For Dave this action by his probation officer was particularly important as it demonstrated to him that he would be able to trust this person and would be able to believe what she tells him. Dave’s close relationship with his probation officer meant that he was able to open up to her about his suicidal feelings, which may not have been possible without the development of this trust. What was also important here was the sense of being cared for that Dave gained from this relationship, which also had a powerful effect on other participants’ in relation to trust building.

7.4 Control: loss and regain

Participants experienced a loss of control throughout many areas of their lives, ranging from their jobs and family life to their mental state. This loss of control was often unexpected and unanticipated. Participants shared similar maladaptive ways of coping with their loss of control, which commonly resulted in negative outcomes and added to their already chaotic and adverse situations. Nevertheless participants made attempts to re-gain control, which was sometimes difficult to achieve but led to a sense of accomplishment.

7.4.1 Losing control

For many of the participants suicidal feelings were often characterised by a loss of

control. Dave's pithy account details his loss of control over his situation, feelings, and mental state leading up to his suicide attempt. Which may be accelerated due to his capacity for impulsivity, demonstrated by his impulsivity level.

"If I feel like I'm not totally in control of everything I start getting a bit, like rushing around, bit like a headless chicken sort of thing"

Dave's representational use of the term 'headless chicken' demonstrates his sense of powerless and inability to manage his emotions. As well as their mental state, participants also referred to losing control of their life situation prior to their suicide attempt.

"Worry about money, worry about court, worry about going to prison. It was more worry that made me want to escape." (Dan)

The expression 'want to escape' signifies Dan's feelings of entrapment where suicide is seen as a way out and arguably the only perceived solution to his problems. Loss of control was overpowering for the participants and was often triggered by a struggle to manage multiple problems at one time. Roy's narrative reveals how he struggled to cope with several difficulties when leaving prison, including depression, despite previously receiving therapy.

"It was just a whole serious of ' they just hurt my foot, it's my wedding anniversary, I still need to find somewhere to live, I'm stuck on the far side of London and I've got to get back, I haven't got much money in my pocket. And suddenly there's a, normally I know myself, the therapist taught me enough about myself to know when a depression is coming on, I can see it and head it off at the pass at it were. This one was (click fingers), next minute I know I'm sitting on a bed crying me eyes out and in a right state. Before I could do anything or think anything through."

Roy characterises his experience of losing control in relation to the speeding up of time, distinguishing between his usual ability to be able to identify the onset of 'a depression', in contrast to this experience when depression was quick and sudden. This is further demonstrated by the click of his fingers suggesting he had no time process what was happening. Interestingly this contradicts his impulsivity level which suggests that he has low levels of impulsivity and is unlikely to make quick impulsive

decisions. In contrast Mike's loss of control was characterised by a gradual build-up of events that reached a suicidal climax, reflecting his impulsive nature.

"I just think it got to the bubbling point where I just got out of control...it really got on top, it was really to the bubbling point where I thought I will take my life right now. I just don't want to live life no more."

7.4.2 Maladaptive ways of coping with loss of control

When trying to cope with loss of control participants often resorted to negative coping mechanisms, which often resulted in further problems and conflict. For example both Freddie and Dave detail how they turn to alcohol to block out problems and self-medicate.

"I hit the bottle, because I thought maybe, you know, I will drink myself into unconsciousness." (Freddie)

"I was self-medicating by drinking to lift myself as if like it's a bottle of anti-depressants, you know. To be fair for a couple of hours it is, but long term it's a depressant. Although I'm trying to lift myself with this short term miracle long term it was doing me more damage because it was pushing me lower and lower" (Dave)

Dave's interesting use of the phrase 'it' pushes him lower and lower suggests alcohol has control over him in contrast to him using it to lift himself from depression. Dave's account demonstrates how the coping mechanisms that participants used often led to further problems. Kathy also spoke of her loss of control over her use of alcohol, which she like Dave, initially used as a coping mechanism. Kathy initially started drinking alcohol to block out painful memories associated with the loss of her children and father.

*"But the day I lost my kids, I hit the drink bad... I could have put myself to college, but I thought f**k it, drink, forget the memories. Do you know what I mean. I think that's when I started self-harming."*

And later

"If I give up drinking that's when I've got to face reality and I think that's when myself harming is going to kick in."

Kathy's use of alcohol and self-harm was triggered by the sense of defeatism she experienced after losing her children. However, alcohol no longer used to block out her memories, but instead has to use to keep the memories from coming back. For Josh self-harm was used as an original way to cope, however he spoke of self-harm then taking over him and having control over him.

Interviewer: "And why do you cut yourself rather than other things?"

Josh: "Because you have control over it. If I know what I'm doing I have control over it."

In contradiction

"You can fight it (self-harm) for days and days on end until you think you're happy again. But then all of a sudden it's just bam bam you're doing it... That's how I see it, that's how I notice it, well that's how it is with me. I can fight it for as long as I want but then as soon as it gets control of me it's undone. I don't have a chance of fighting it." (Josh)

Josh's later contradiction arguably indicates his struggle between feeling in control of his self-harm whilst at the same time recognising his loss of control over it. Like Dave's previous reference to alcohol as an 'it' Josh refers to self-harm as an 'it' suggesting that self-harm is a thing in its own right that exists outside of Josh's control, despite him being the person carrying out the self-harm.

7.4.3 Regaining control

Some participants were able to identify aspects of their lives that they were able to regain control over. For example Kathy identifies a pivotal moment in her life where she lost control due to the violence she experienced from her ex-partner. Kathy's deals with this retrospective powerlessness by making an active decision to never allow this to happen again, to regain control and power over her own life.

"I let a man control my life... I will not be controlled by a bloke no more. Never ever you get yourself into that girl because it seriously destroyed my life."

Similarly Josh was also able to identify that he had lost control over his self-harm, but was able to regain control of it due to a ‘thinking skills’ programme run by Probation.

“Going on the thinking skills programme has helped. Its helped me control my emotions, work out how I can stop certain things from happening, like in the case of the self-harming work out the triggers so... I can nip it in the bud before it gets that bad that I have no control over what’s going on.”

Josh’s account demonstrates how the introspective skills that he developed during a thinking skills programme helped him to identify the triggers for his self-harm and enabled him to prevent himself from carrying out these types of behaviour. In comparison to his previous comments Josh is now in control of his self-harm rather than his self-harm having control over him. Unlike other participants, Freddie is still waiting to regain control over his life, but has identified a way in which he might be able to re-gain this control.

“I’m on the waiting list for this really good clinic... Yeah, I’m just waiting for that... It’s for counselling, it’s really intensive counselling for personality disorder. I’m curious you know, I’m willing, I’m getting tired of waiting, but erm, yeah I’m trying.” (Freddie)

Freddie’s repetitive focus on the word ‘waiting’ indicates that he feels as though there is nothing left for him to do but to wait until he has been given counselling in order to regain control over his life. Significantly Freddie screened positively for needing further investigation into personality disorder, supporting his need for treatment.

7.5 Identity

All of the participants narratives’ were woven with details about their identity and this was often expressed in relation to their perceived former identities and their future identities. The former self was a distant experience for several participants, but something they frequently struggled to let go of despite not wanting to encompass that ‘self’ again. The present self was a confusing entity for participants to come to terms with, with many unsure about who exactly they are. The present self was commonly defined in relation to their perceptions of how other people perceive them to be rather than their own understandings of their identity. Most striking about the current theme was how participants’ negative past identities shaped their views about their future

self. Participants regularly expressed negative and hopeless views about their future, which fuelled suicidal feelings and fears of further negative experiences.

7.5.1 The former self

The participants often referred to themselves in the past tense representing a shift in identity between their former self and their current self. Participants often associated their former selves with negative experiences.

“When I got into a prison, my life had gone completely pear shaped. I had become who I don’t like.” (Roy)

Interestingly the participants explored the nature of their past self in relation to the problems associated with their former identity.

“Probably why my drinking got to the stage where it was. Because that to me, I was a party animal in a way, I loved to entertain people, however it got, it went beyond that, I took it beyond that, I abused it to the point where it wasn’t fun anymore it was killing me, which it very nearly did.” (Dave)

Dave’s use of the past tense suggests that he no longer identifies with his previous self and that his previous ‘social identity’ had become detrimental to his health. Despite recognising the harm caused by his past identity, Dave still struggles to let go of his past self.

“My perspective on the last few years... I think moving away, you know when I went to rehab I had a feeling the day I left for rehab, I had a feeling that I wouldn’t be returning but that’s not necessarily what I wanted to happen, you know. I think, I just think it’s part of me, it’s where I always lived, it’s where I grew up, it’s where my family and my friends are. I think I’ve been home sick since the day that I left... I’m dealing with it a lot better now.”

Dave’s account demonstrates how his former self was moulded by a number of different things that he is no longer surrounded by. Similarly Mike also recognises that his past self was damaging, in particular how his identity was shaped by individuals around him who contributed towards him having a criminal record. Mike now recognises that in order to let go of his past self he must separate himself from the people that influence his identity.

“I was mixing back in with the old crowd who I used to hang around with, because we are a big name. We are a big gang. so I didn’t want to get mixed in, back in with the gang, so I kind of torn myself away from being in the quiet life to going back into the ragous life. You know.” (Mike)

Mike’s use of the term ‘we’ suggests that his identity was socially constructed. Furthermore his mixed use of the past and present tense arguably indicates that he is struggling to let go of this social identity, despite knowing that he may re-offend if he does become part of the group again.

7.5.2 *The present self*

Interestingly some participants were struggling to understand and make sense of their present self. For example Dan referred to his suicide attempts as not being him.

“I’m not a suicidal person and all this, I done it twice. Do you know what I mean, it’s crazy.”

Dan’s alteration in pronouns arguably represents a distancing between himself and the suicidal self, suggesting that he does not consider himself to be the conventional ‘suicidal person.’ Similarly Mikes account also reveals the confusion that he is experiencing about his current self.

“I’m just trying to find my feet. Because I’ve always been in a relationship and now being single and finding things on my feet after a long relationship. You know fifteen years was a long time of my life, do you know what I mean. Now I got to build up that scale of working those things out for myself now.”

Mike’s struggle with understanding his current self is due to the loss of his past self, which he associates with being in a relationship. For Mike there is a clear difficulty in knowing who he is outside of this relationship, again reflecting how his identity is very much socially constructed. However, other participants were better able to make sense of their current self. Dave, for example, now understands himself in relation to his diagnosis of bipolar disorder. Dave’s diagnosis enables him to make sense of and understand his past problems. The label that he has been given is more than a label, it is a positive way of understanding his own identity.

“I felt like, see I don’t like labels, but for me it answered a hell of a lot

questions. It really really did. It answered why I was like I am, I mean I've got two sisters and a brother... none of them are anything like me, I've always felt like the black sheep, always, always, always."

In contrast Kathy's account demonstrates the negativity that she associates with the labels applied to her identity. Kathy's severe self-harm has left her with a number of scars which people often comment on.

"...I'm not girlfriend material. I am a Looney. Not a bad Looney. But that's not normal behaviour (points to wrists). I could be sitting there, do you know what I mean. Something get in my head and that will be that. If I can't cry I have to cope... It's my way of hurting myself because I'm mad. It's mad. I can't even describe."

Kathy repeatedly uses the word 'mad' throughout her account, often switching between referring to herself as mad, and 'it' as being mad. For Kathy self-harm enables her to cope when she cannot express her feelings, however, it is also perceived as an abnormal part of her identity, which may be defined in relation to societies' definition of normality and an internalisation of societies views on self-injury. Kathy's inability to express her emotions may be linked to her high levels of alexithymia, arguably contributing towards her self-harm.

7.5.3 The future self

Sometimes the participants based their views about their future selves on their past experiences, therefore these views tended to be negative, with many feeling hopeless about their future. These negative predictions about the future self were particularly apparent during the period leading up to their suicide attempt.

"It was how my life was going, every year will be a new year and it never is, sort of thing, it never is, instead of making promises to myself that I can't keep... I'll just finish it off." (Freddie)

Other participants were plagued with worry and uncertainty about their future selves. Josh for example was anxious about going to prison and the potential effect that prison could have on his identity. Josh's perception of the prison environment along with his worries about prison potentially changing his identity, led to feelings of concern, anxiety and suicide.

“At first I was really worried. Just like the way I see is as soon as you enter those buildings you become institutionalised and fxxxed. You don’t know any better. I could get arrested for something like burglary and coming out of prison as a murderer because I’ve had to protect myself inside and it’s changed me. I don’t want that because I’m not.” (Josh)

The extract above demonstrates Josh’s fear that prison life will manipulate his behaviour, and lead to a loss of his current identity and creation of new undesirable identity. In contrast other participants were hopeful about their future selves. For example Roy discussed the potential positive outcomes of his future, despite also recognising that his future is uncertain.

“...I mean, they're not so much plans, because I've noticed that I can get very easily frustrated when plans get erm frustrated. It's more a matter of an image or where I want to be. In some ways you know, touch wood, work will occur somewhere... Erm, that I will end up living somewhere is a given... whether it's a one bed flat or a studio flat I don't care. Doesn't matter. You know, that I will continue with my poetry and hopefully get some published that's a definite.... That I will find a Buddhist community to join and continue with mediation.”

7.6 Struggles with Meaning

Participants frequently referred to the struggle they experienced when trying to find meaning and meaningfulness in their lives. A sense of meaninglessness and having no hope for the future was, for many participants, contributed towards their suicidal feelings. However, despite there being periods of time where meaning was inaccessible and distant, participants continued to explore how they could achieve a sense of meaningfulness. Searching for meaning commonly involved trying to find employment and develop social relationships. At times when participants were able to finding meaning, their suicidal feelings lessened. Having meaning was often attributed to a sense of belongingness and usefulness.

7.6.1 Lack of meaning

Participant’s narratives often reflected a sense of meaningless in their lives, with

participants referring to moments where they lacked achievement and were hopeless for the future. These moments were often accompanied by suicidal feelings and depression. For example Freddie encountered feelings of frustration just before his near-lethal suicide attempt due to a constant wait for a positive change to occur in his life, mirroring his wait to gain control over his life as previously mentioned.

“It’s all waiting. I’m busy doing nothing you know.”

And later

“See I can’t seem to hold down a friendship or a relationship, you know.”

Freddie’s extract represents many of the participant’s feelings of ‘nothingness’ experienced at the low points in their lives. Freddie’s feelings of nothingness were particularly defined by a lack of social meaning. Like Freddie, Mike also attributed feelings of emptiness and meaningless to his lack of relationships, however for Mike this was also accompanied by the loss of a previous relationship which not only triggered his loss of identity as mentioned in the previous theme, but also loss of meaning which triggered his suicidal feelings.

“I just felt at that time just give up. I’ve had enough of life...”

7.6.2 Searching for a purpose

When participants were unable to find meaning they explored ways in which meaning could be gained. For example two participants spoke of how having a job would give them a purpose in their lives, as well as stability.

“If I say I’ve been doing a plumbing course, that would be, I’d be doing that course but that would be the future to work in as well.” (Dan)

“...because I’m an animal handler we were trying to look into work. But now I just, it’s voluntary work, but I’m doing some work at the moment with rescues, with animal rescues.” (Mike)

Interestingly other participants felt that they would be able to gain purpose by helping others, particularly by helping those in situations similar to their own. However sometimes participants needed to make life style changes in order to achieve their goal of helping others. For example in Kathy’s account below she comments on ‘getting

off the drink.’

“I’d love to do this if I could do this, get off the drink and go and work with people like me. And then I could give it back to society. And that’s what I mean, why do you think that I don’t mind helping you out. There’s me that I feel better because I am helping someone out there that you might be able to save. Do you know what I mean. If it helps you to save someone.”

For Kathy the experience of taking part in the interview provided a purpose, in the sense that she felt it would help others. Her use of the term ‘people like me’ reflects the idea that shared and common experience gives the ability to empathise and understand others going through similar situations. This was similar for Dave who particularly felt that his experiences gave him the knowledge and capability to help others encountering similar problems. This could also help him to re-gain some of the shared experience that he was previously part of whilst in rehab. In this sense purpose would be gained from being part of a joint experience rather than being alone.

“If I hadn’t lived it then I wouldn’t even dream of attempting it... But yeah that is definitely one of the reasons I want to do it, to sit the other side of the desk and listen to someone who walks through the door exactly like I did. You know rabbit in the headlights, what do I do now. And just to be there to help them like what was done for me. As I said I have had some useless people but I’ve had some really good people as well.” (Dave)

Dave’s account provides a strong sense of personal meaning in relation to his lived experience of depression, suicide and self-harm. The phrase ‘rabbit in the headlights’ demonstrates how he previously felt frozen, stuck, unable to move, and by living through this experience he feels empowered to support others going through a similar experience.

Only Freddie referred directly to his suicidal behaviour as a way to find a purpose, which may be due to Freddie’s religious views and belief in an afterlife. Freddie has hope that he will find a purpose in death, more than he has in life.

“Scared I guess. Curious though, somehow... like what’s next. Yeah. There has to be something more, because.” (Freddie)

7.6.3 *Finding a purpose and having a meaningful life*

When participants experienced moments of meaningfulness it had a preventative impact on their suicidal behaviours. Two participants (Mike and Freddie) commented on how their pets gave them meaning.

“...because I would want to kill myself. I’m bored, I’m tired. I’m tired, I’m so fxxking tired. It’s my dog that keeps me alive. (Freddie)

And

“I mean like I know my life story (??) aint nothing but I just got myself a Freeview box, a DVD player, a TV, you know I’m building up slowly. I got three rats as well now, pet rats. Yeah. I love em.” (Mike)

Freddie and Mike previously mentioned the lack of purpose in their lives which was largely associated with a lack of relationships, although in the extracts above their animals provided a similar purpose for the participants, as they both felt needed. Being needed by others was commented on by many participants. For example Josh said that when he is alone that’s when it gets bad, and in the past these are the times when he has attempted suicide. However when he sees his family he realises that he is cared about and that he had others to care about – his family provide meaning and a reason to continue living.

“Once you're alone and you actually have no one that’s when it gets bad.” (Josh)

“It’s just seeing my fam, seeing my sisters and seeing my Nan as well.” (Josh)

Likewise Roy emphasises that importance of family, in addition to others things, that can give meaning to life.

“...mixing my work and my poetry, my meditation. And that’s its and my family.” (Roy)

Further to this, for Roy, learning how to deal with his depression and activities that give him the capacity to express his feelings are important and meaningful in their own right. It is clear from Roy’s account that the process of getting to know himself

and understand his depression has been an important part of his journey.

“...once you do get into something like CBT, Buddhism or whatever, finding a way through the talking therapies, through your issues, is remarkably successful. As soon as we abandon our obsession of feeding people with chemicals. You know too much, too many times its happened to me too much over my history. You know, you go to a doctor and say I’m feeling down, ping, have some citalopram. Erm and that’s the end of it, you know, that’s been an appalling waste of time in my life.” (Roy)

The extract above demonstrates Roy’s strong belief that having the capacity to be able to talk through his problems and actively reflect on his own thoughts and feelings, is a more helpful way to support a suicidal individual than medication. However Roy may be more capable of exploring his emotions in this way compared with other participants’, reflected in his low alexithymia level.

7.7 Discussion

The findings from the current study extend the literature and knowledge from previous studies on suicide and suicidal offenders. Participants’ accounts of their near-lethal act provided a picture of their on-going sense of frustration, loss of control, loss of identity, distress and hopelessness prior to their suicide attempt. Participants experienced traumatic events, bereavements, loneliness, social exclusion and felt that their life lacked meaning and purpose. These feelings and experiences were frequently described as relating to their suicidal behaviour, with many being pre-occupied with feelings of grief for their lost loved ones, or feelings of isolation and emptiness just before their attempt. These experiences and feelings have also been described by other suicide attempters (Lakeman & FitzGerald, 2008; Shneidman, 1993), but what was distinctive about this group of participants was the way in which their suicidal feelings and behaviours were linked to the process of serving their probation sentence.

When recounting the time that led up to their near-lethal act the participants said that they felt as though they had lost control, comparable to other suicide attempters (Crocker, Clare, & Evans, 2006; Maltzberger, 2004). For the participants in the current study loss of control encompassed both the loss of control over their mental

state, as well as over their life situation. Feeling out of control led to feelings of hopelessness, as reflected in their hopelessness scores (Beck & Steer, 1993), and a focus on suicide as the only solution or way out (Shneidman, 1993; Williams, 1997). However, unlike previous studies participants also commented on how their loss of control was sometimes related to or triggered by an event that connected to their probation process. For example participants spoke of how their perceived loss of control, feelings of anxiety and helplessness were all accelerated if they were awaiting a court sentence. For many participants an upcoming court sentence was associated with fear of being given a prison sentence, which meant losing contact with their family, and in some cases anticipation of the prison environment having a negative effect on their identity. Literature that has focused on the risk elements of the probation process identifies key time points where individuals appear most vulnerable, such as being released from prison onto probation (Binswanger et al., 2011; Pratt et al., 2006; Zlodre & Fazel, 2012) and being recalled to prison or awaiting a court sentence (Cook & Borrill, 2013). However the qualitative methodology employed in the current study enabled the participants to communicate their lived experience of these 'key time points,' explain how they felt during these stages of their probation process and discuss how these key events affected their emotional state. For example the account of one participant revealed how his struggle to cope with multiple problems when released from prison such as finding housing, getting a job, and reuniting with family and friends, led to overwhelming feelings of powerlessness, being out of control and ineffectiveness, ultimately contributing towards his suicidal behaviour.

When participants struggled to gain control they often resorted to more negative ways of regaining control including using alcohol and self-harm to block out emotions or deal with emotions, also found in other suicidal populations (McAllister, 2003; Nolen-Hoeksema & Harrell, 2002). These maladaptive ways of coping also reflected the impulsive nature of many of the participants. However, given the difficulties that this group of participants faced with being able to trust others coupled with their high levels of alexithymia, their ability to open up to others and talk through their problems to explore other ways of coping was limited. When participants were able to build trust with certain individuals, such as their offender manager, they were able to talk through their feelings, concerns and worries. Their accounts suggested that building

trusting relationships enabled them to talk through their problems, increased their capacity to reflect on their feelings and made them better equipped to handle the emotional turmoil that they often described experiencing.

It is not surprising that the participants expressed difficulties with trusting others, given that the previous literature indicates that suicide attempters and suicide completers demonstrate a social disconnection from others (Crocker et al., 2006; Lakeman & FitzGerald, 2008), and offenders in particular face difficulty in trusting authority even if they are in a helping role such as a therapist (Marshall & Serran, 2004). However, the current analysis allowed a detailed picture to emerge of how these difficulties with trust can intensify the suicidal spiral, but at the same time how trust can gradually be gained and re-built. For example one participant mentioned how receiving a clothes grant that was arranged by his offender manager was the first step in building a trusting professional relationship with her. Building one-to-one offender manager and client relationships are important and can increase the clients trust in their offender manager and Criminal Justice System as a whole (Burnett & McNeill, 2005). Having trust in their offender manager, as well other individuals, was viewed by the participants as key for being able to disclose their suicidal feelings, behaviours or feelings of depression. Overall participants wanted to be able to share their feelings without a sense of being judged. Therefore establishing trust is an important issue for both staff and clients as soon as the probation sentence begins, as many of the participants were already vulnerable to suicidal behaviours prior to their current probation sentence. The prevalence of potential PD, as noted in Study 2, could explain some of the participants comments about finding it difficult to trust others and seek support, commonly experienced by those who suffer PD (Burnett & McNeill, 2005; Cheng, Chen, Chen, & Jenkins, 2000; Fallon, 2003).

Additionally participants struggled to express and manage their experiences of loss both prior to their probation sentence and whilst serving their sentence. Loss encompassed, for example; loss of social support; friends and family; anticipation of losing freedom and/or loved ones; and loss by bereavement. Loss has been found to play a role in suicidal behaviours in other populations (Borrill, 2005; Cheng et al., 2000). Nevertheless the use of IPA in the current study enabled a detailed picture to emerge of how these losses were linked to the participants' near-lethal act, furthermore allowing the participants to focus on what concerned them the most about these losses.

For example grief that related to bereavement was recurrently explored by the participants as continuously affecting them even years after their loss, and many said that thinking of their loss often contributed towards their depressive states and suicidal feelings. Moreover participants spoke of being in a depressed state during their interviews and described experiencing prior to their near-lethal attempt. The potential link between depression and suicide have previously been investigated in the general population (Joiner, 2005; O'Connor, 2011; Shneidman, 1993) and in offender populations (Marzano et al., 2010).

Suicide in this sense appeared to be part of a process rather than an individual event with one sole cause, consistent with the Integrated Motivational-Volitional Model of suicidal behaviour (O'Connor, 2011) which suggests that suicidal actions are the outcome of a complex process of vulnerability factors, moderators and volitional factors. The participants' accounts of their near-lethal behaviour provided a complex overview of on-going issues as well as current problems that contributed towards their feelings of depression, suicidal ideations and ultimately near-lethal behaviour. Interestingly in relation to this process of suicide, the participants' poignant account of their suicidal process also demonstrated 'moderators' to their suicidal behaviour such feeling like their lives were meaningful. Having meaning in their lives affirmed the participants' self-value and worth, and provided them with a purpose and reason to live. Meaning was gained in a number of ways including positive relationships, jobs, family, having a home, providing the participants with a sense of belonging (Joiner, 2005). In contrast lack of meaning led to feelings of isolation, worthlessness and depression. Furthermore probationers may find it more difficult to attain meaning in the areas that they want to such as finding employment (Graffam, Shinkfield, Lavelle, & McPherson, 2004), finding permanent housing (Barton & Cooper, 2012), as well as social support systems. When participants were able to predict meaning in their future and their aspirations and goals were viewed as achievable, feelings of hopelessness appeared to decrease (Michel et al., 2001).

Despite the importance of these findings it is necessary to note several limitations of the current study. The population of interest are known to have difficulties with trusting others, particularly authority figures, therefore the participants may not have disclosed all feelings about their near-lethal behaviour to the interviewer. However, the interviewer felt that participants were fully open about their experiences of their

suicidal behaviour, which was also reflected in the participants VAS score increase after the interview (see appendix 5). Furthermore, the accounts provided by the participants were retrospective and may have been subject to memory bias or interference, as with other studies employing qualitative research with suicide attempters. Arguably, however, it would be difficult to capture the feelings, emotions and intensity of these experiences if a qualitative approach were not employed.

This study has added to the findings of Study 1 & 2a by providing the perspective of the probationer, nevertheless it does not explore the differences and the similarities between the probation client account and their offender manager, neither does it capture the potential change in perspective of the participant over time. The fourth and fifth studies in this thesis aim to extend the findings of Study 1, 2a & 2b by bringing together the perspectives of the offender and probation staff in order to gain a more in-depth picture of near-lethal behaviour, and to explore how the participants perspective on the near-lethal incident has changed when given time to reflect.

Summary: The themes present in the participants' accounts were distinct from one another but interlinked. The clients found it difficult to cope with multiple problems and often described experiencing a loss of control. This loss of control were often inter-related to the probation process such as having trouble finding employment, fear and concern about going to prison, trouble finding permanent housing. At times when participants felt like they were struggling to cope with these problems they said that they wanted someone to listen to them without feeling judged, particularly when feeling suicidal. However, participants also found it difficult to share their feelings with others because of the concerns that they had in relation to trust, although once trust was gained they were able to talk about their feelings, concerns and worries. In terms of prevention, having meaning in their life appeared to be a moderating factor in the sense that meaning provided participants with a purpose to continue living.

8 Study Three: Follow- up interviews with probation clients

Table 10: Participants who did or did not carry out further near- lethal behaviour since original interview

Participant	Further attempts or serious self-injury
Dave	<i>Yes</i>
Kathy	<i>Yes</i>
Dan	<i>No</i>
Roy	<i>No</i>
Freddie	<i>Yes</i>
Mike	<i>No</i>

8.1 Introduction

The previous study explored near-lethal incidents from the perspective of individuals carrying out community sentences. Findings suggest that feeling out of control, experiencing confusion about identity and losing meaning in life, led to suicidal feelings and near-lethal behaviour. On the other hand, being in control, having clear plans for the future, and having a purpose and meaning in life, helped to prevent suicidal feelings. The current study aims to build on this knowledge by understanding how these participants' perspectives on their near-lethal act have changed or remained the same after their original interviews. A particular focus of the current study was whether or not changes in the participants' lives since their suicide attempts have also led to a change in their perspectives about the incident. Additionally, if nothing has changed since the incident how the participant feels about it now. Comparisons are also drawn between those participants who went on to make further attempts, or carried out further self-injury (Table 10). The current chapter outlines the findings from the accounts of the participants (N=6) provided during their follow-up interviews, which occurred 3 – 6 months after their original interview, depending on the participants availability. One participant (Josh) was unable to take part in the follow-up interview as he could not be contacted. Furthermore, one participant (Dave) took part via telephone interview due to a change in location. The results are presented

below and followed by a short discussion of the themes and implications.

8.2 Findings from follow-up interview study

The following results include extracts from each participant’s follow-up interviews with their original interviews to demonstrate changes in perspective or strengthening of perspectives. Both the initial interviews and follow-up interviews were analysed using IPA and three new themes developed, although these themes are also complimentary to the themes found in Study 2b. The findings indicate three overarching superordinate themes (Table 11); *‘The suicidal state: slowing down, speeding up,’* *‘Dealing with pain: maladaptive ways of coping and expressing emotions,’* and *‘Positive and negative social experiences: You need people out there.’* These three themes were distinct from one another, whilst at the same time are all interlinked to varying degrees.

Table 11: Superordinate and subordinate themes follow-up study

Theme	Subthemes
The suicidal state: time speeding up, slowing down	- <i>Suicidal act as unpredictable</i> - <i>Boredom, waiting, patience & frustration</i>
Dealing with pain: negative coping mechanisms and maladaptive ways of expressing emotions	- <i>Maladaptive coping through alcohol use</i> - <i>Anger and violence</i>
Positive and negative social experiences	- <i>Judgements from others; being ‘normal’</i> - <i>Talking, listening and support</i>

8.3 The suicidal state: slowing down, speeding up

The current theme captures the way in which participants experienced their suicidal state and how during their follow up interviews compared with their initial interviews, this state was not perceived to be a single act but rather a process. Often the suicidal state was defined in relation to the participants’ perceptions of time, with several participants reflecting on their feelings of time speeding up and slowing down. The lead up to the near-lethal incident was characterised by a slow build-up of negative experiences, commonly associated with pre-existing distress from prior negatives experiences such as loss. In comparison the suicidal act was quick, sudden and

perceived to be uncontrollable with many participants describing this as the point of no return. Furthermore the suicidal state continued beyond the near-lethal incident, from which point participants experienced a sense of impatience, embodied by a slowing down of time, feelings of boredom, and a sense of waiting.

8.3.1 Suicidal act as unpredictable

During both their initial interviews and their follow-up interviews the participants reflected on the months, weeks and days prior to their near-lethal attempt, and how they struggled to cope with multiple problems, felt overwhelmed, stressed and lacked control.

“It all got on top of me really. It’s hard to explain.” (Dan follow-up)

“It was building up for ages. (Freddie)

This build-up of perceived problems, concern, worries and stressors was not sudden and instead part of a slow and gradual process until the participant reached a peak of desperation resulting in near-lethal behaviour. In contrast the near-lethal behaviour itself felt sudden, unpredictable and surprising for participants. For example Dan described his near-lethal incident as being completely out of the blue saying; *“Literally like sprung it on me.”* Dan had never attempted suicide or self-harmed before this incident which may go some way to explaining his perplexity as to why the incident occurred and why he felt that it was unpredictable. However all participants described their near-lethal incident in the same way, using phrases such as *‘I didn’t see it coming’* (Freddie, Dave), despite already having made suicide attempts as well as carrying out serious self-injury in the past. During Freddie’s follow-up interview he spoke of his lack of control over his self-harm and how the very nature of his suicide attempts and self-injury are often quick and impulsive.

“I just don’t know it seems to be out of my control now. I don’t plan it, I don’t sit there and say right I’m gonna have a drink tonight and self-harm. It just all happens at once sort of thing.” (Freddie follow-up)

The extract above demonstrates how time is perceived to speed up when the participant is carrying out near-lethal behaviour, furthermore Freddie reflects on reaching the point of being out of control, demonstrating how his awareness of likely self-injury also coincides with his inability to do anything about it. This quickening of time for

most participants also continued during the moments immediately after their near-lethal attempt.

“I don’t know how I felt. Everything was just moving too fast...” (Dave)

Dave’s account demonstrates how time was perceived to speed up after his attempt, leaving him little time to process his emotions and feelings. However perceived acceleration of time did not continue for more than a few hours after their near-lethal behaviour. Instead the period after the incident, in many cases the recovery stage of the suicidal state, was defined in relation to a slowing down of time. For example, Kathy expressed that during the weeks after her attempt the passing of time seemed to slow down, in contrast to what she really wanted which was to have her life instantly changed:

“... I wanted a magic wand. If someone could have put a magic wand and gone ‘boom’ there you go, have your life back. That’s what I wanted right there and right then. I wasn’t waiting for it, I just wanted to be better.” (Kathy follow up)

Kathy’s account demonstrates feelings of powerlessness, helplessness as well as impatience and frustration in relation to her feelings about her life situation after her suicide attempt. These negatives feelings were commonly experienced by participants after their attempts.

“I seem to have gone backwards five years in a space of a day. If you know what I mean” and “I suppose I felt like I’d erm wasted the last three years.” (Dave)

Dave’s account is again characterised in relation to his experience of time, particularly how his suicidal experience has mentally taken him back in time to a negative period of his life, triggering feelings of failure and disappointment, further signified by his use of the phrase ‘wasted the last three years.’ Participants who went on to make further attempts, including Kathy, Dave and Freddie, experienced a continued sense of time slowing down, which coincided with a perceived lack of progress and in some cases an experience of going backwards. Conversely those who did not go on to make further suicide attempts felt that taking things slowly provided them with the

opportunity to re-build their lives and make thoughtful decisions about the things that are important to them. For these participants change came from now feeling able to manage their lives at a more comfortable pace. For example during Mike's initial interview he said:

"No I feel alright... you know I'm building up slowly." And "Like I'm getting there slowly but it's gonna take a bit of time, do you know what I mean."

"Just be happy. Erh get on with life, and hopefully get more work." (Mike follow-up)

During Mike's follow-up interview he spoke of how taking things slowly had enabled him to gradually re-build aspects of his life one by one, focus on being happy and develop the areas of his life that he valued.

8.3.2 Boredom, waiting, patience and frustration

Interestingly several of participants voiced concerns about relapsing and making a further suicide attempt, even if they had not gone on to make a further suicide attempt since their initial interview. They often associated these concerns with feelings of boredom and impatience, mirroring the feelings experienced prior to their near-lethal incident. For example during Dave's follow-up he had introspectively become aware that his self-harming was likely to occur during times of boredom, however that he could also potentially prevent his self-harm by keeping busy and 'rushing around everywhere.'

"I mean I have to keep busy. I can't not. I can't sit in a flat doing nothing. I can't, it would drive me mad and that's when the bad stuff starts that when I will get bored, I will possibly start drinking again, self-harm, you know. The less I've got to do the lower I seem to get. As long as I'm busy and I'm rushing around everywhere helping people then, yeah, you know I'm happy with all of that." (Dave follow up)

The extract above contrasts with Dave's initial account in which he describes the speeding up of time and lack of control he experienced being related to the period immediately before his near-lethal behaviour. In this sense Dave is now in control and is actively making the decision to keep busy at a pace he feels comfortable with rather than feeling overwhelmed and out of control. In contrast Freddie encountered a more negative experience after his near-lethal attempt, specifically he felt impatient, frustrated and stressed due to the lack of support that he had received in relation to his personality disorder. During Freddie's original interview he said that he did not mind waiting for this support.

*"I'm not the only one, I know there is other people, I don't mind waiting."
(Freddie)*

However, during his later follow-up interview Freddie had grown tired of waiting, desperate for help and did not know when he would receive this support.

"Still on the waiting list. I don't even know where I am, I know sickening. And you need them people. It's over a year... I was on waiting list for the induction a year before that then I got the induction and now I'm waiting for. (Freddie follow-up)

Freddie went on to make a further attempt since his initial interview, which arguably linked to this lack of progress and change in relation to getting support for his condition. The frustration expressed by Freddie was also experienced by Roy, however Roy did not go on to make a further attempt, but making a further attempt worried and concerned him. During Roy's initial account he spoke of his suicide attempt being linked to his release from prison, and like other participants, feeling unable to cope with multiple problems at one time. However, for Roy being placed in a probation hostel had helped him to gradually tackle each problem step-by-step, such as look for housing and finding a job.

"I'm patient enough to wait for it now." And "I'm in no great hurry. Because it's quite good for me, because apart from the little petty rules don't worry me at all. It's a good, quiet, stable place to concentrate on getting a job from and getting housing sorted out without it all becoming a crisis. Which is what

trigger the crisis as I call it in the first place. So that's quite good from that point of view. So hopefully round about spring of next year I'll be nicely established." (Roy)

In contrast Roy's later follow-up account revealed feelings of frustration, anger and depression due to stagnation and a lack of progress. During his previous account Roy predicted that a slow pace of change would help him manage his problems, however after a number of months this perception began to change.

"They haven't changed for the better when I hoped they would have done. So the frustrating and rather depressing thing if I pause to think about it too much is that another two months have gone past, still haven't got anywhere with housing, still haven't got anywhere with employment. erm, and that's it. Time is going fast..." (Roy follow-up)

Interestingly Roy's contradiction that things have not changed quickly enough, but yet 'time is going fast' demonstrates the complicated meaning that time has for the participants. Roy desires a balance between managing his life at a pace that he is comfortable with; quick enough that meets his expectations and ambitions, but slow enough that he does not become overwhelmed. Roy's perception of the slowing down of time is characterised by feelings of boredom, meaninglessness, and frustration. Below Roy considers how he attempts to manipulate his perception of time to deal with his boredom, and furthermore how he takes active steps to prevent suicidal feelings from developing.

"I mean I spend my time, my days out of here. I've been to the situation where it's got that sad where on a Saturday afternoon, where I've been to the library and I've done the bits and pieces I want to do... I'll go and travel the buses and the tubes... I don't want to go drinking, I don't want to go anywhere else... Sad old bxtard travelling around on buses just to kill time." (Roy follow-up).

Both extracts above present a clear qualitative change in the feelings Roy expressed during his initial interview and the feelings being expressed during his follow-up interview, and further reflect his awareness of the potential impact that boredom and meaninglessness can have on his frame of mind. In a sense Roy is aware of the triggers

to his suicidal behaviour and takes active steps to prevent these triggers, in contrast those participants who went on to make further attempts were less aware of their triggers with many using phrases such as ‘it could be anything that sets me off.’

Summary: Overall this theme encapsulates how the participants experienced their near-lethal behaviour as a process rather than one single act, demonstrated in their reflections on different phases of their behaviour and how these phases relate to perceived duration of time. Participants associated feelings of frustration, boredom and impatience with the depressive state leading up to their near-lethal attempts. On the contrary keeping busy and being occupied were reported as positive actions that prevented these suicidal feelings from re-occurring. What was particularly interesting about the current theme were the introspective reflections of the participants during their follow-up interviews, which suggested that they had grown more aware of ways in which their suicidal behaviour could be prevented in the future, even if they had gone on to make further suicide attempts since their initial interviews.

8.4 Dealing with pain: maladaptive ways of coping and expressing emotions

The theme of ‘dealing with pain’ captures how the participants tried to cope with and express their emotional pain, distress and upset prior to their suicide attempts. Participants commented on negative ways of coping such as using alcohol and drugs, as well as maladaptive ways of expressing their feelings such as violence, self-harming and suicide attempts. Maladaptive coping mechanisms were also explored by participants during their initial interviews, however it was interesting how their use of these mechanisms had changed since.

8.4.1 Maladaptive coping through alcohol use

During their initial interviews many participants’ spoke of not being able to cope with and manage their feelings, and instead resorting to alcohol use to avoid or mask their mental pain. For example during her interview Kathy explores her relationship with mental pain, claiming that she is not a ‘mad’ person but instead someone that does not have the knowledge to deal with her pain: “*I mean I’m not mad... I don’t know how to deal with my pain.*” Her use of the word ‘know’ indicates that she feels that she lacks the ‘knowledge’ to deal with her pain in a more appropriate way. Kathy’s account

leads to the question; is it that she does not know how to deal with her pain or that she does not want to deal with it? Kathy later provides the answer to this question during her initial account.

“That’s why I don’t want to go into detox to be honest with ya. Because If I give up drinking that’s when I’ve got to face reality... and that’s when my self-harm is going to kick in...” (Kathy)

During Kathy’s initial interview the prospect of giving up alcohol provoked great fear and concern, as alcohol was used as a way to prevent herself from experiencing anguish, sadness and grief in relation to the loss of her father. Despite Kathy’s concerns that detoxing would trigger her self-harm, Kathy went on to carry out further self-harm after her initial interview and prior to her detox, suggesting that alcohol was not an effective form of coping. During her later follow-up interview Kathy spoke of the anxiety that she experienced when she had the courage to give up alcohol.

“...it was scary, because I had to face up to everything. I’m still doing it now, it all came back. A week off the drink I was like shxt my mum and dad are dead. And then I started getting on low ones, but they put me on happy pills, so.” (Kathy follow up)

Her predictions of having to face the pain relating to her bereavements became reality, however she did not make a further attempt after the detox. Arguably is due to the support that she was provided with, including being prescribed with anti-depressants. However Kathy resorted to another negative coping mechanism indicating that she still feels unable to manage her pain and instead is suppressing it.

“...all I’ve done is replace the drink with puff. It aint like I’m all normal, I’m on cloud nine, I’m stoned. Do you know what I mean. But I’m a better person for it. At least I will know what is going on around me. I might be a bit dopey.” (Kathy follow-up)

Kathy perceives her new coping mechanism, cannabis, to be more helpful in comparison to her previous use of alcohol, describing herself as a ‘better person.’ However, her account suggests that this battle is tenuous and that relapsing is still a concern for her. A common concern amongst participants was relapse into using unhelpful coping mechanisms.

“I was worried about possibly being put in a hostel with, erm, with people who drink, you know and who are on drugs and that because, that’s somewhere I’ve been in my past and obviously dangling it in my face is temptation and I was really worried about that... so, they got me in, I’ve got a one bedroom bedsit... its perfect for me. (Dave follow-up)

Alcohol cessation in particular was a mutual experience expressed by all but one participant (Dan). For all of these participants finding ways to cope, other than through alcohol was a struggle. Some participants were desperate to get help with their drinking but felt that there was no support available to them; these were also often the participants who went on to make further attempts. For example during Freddie’s initial interview he directly related his suicidal behaviour and self-harm to his use of alcohol, and wanted to explore other more positive ways of coping with his depression rather than through alcohol.

“...I’m curious, are there other ways of helping myself instead of than turning to the bottle. Turn to the bottle, whisky, you know. Mainly whisky, I turn to the whisky.” (Freddie)

Freddie’s use of alcohol had accelerated by the time of his follow-up interview; his reflections detail a cycle of using alcohol as way to try to lift his mood, but instead causing his mood to lower, and then using alcohol again as a way to cope with this low mood.

“I’m trying to knock the drink on the head because I’m only drinking and getting even more upset and stuff.” (Freddie Follow-up)

Unlike Kathy who, after carrying out further self-harm, eventually received help with her alcoholism through a detox programme, Freddie perceived there to be a lack of support available to alcoholics.

“Don’t seem to be any help there either with the drink, I don’t know where to go. I’m not sure if alcoholics anonymous are just for alcoholics or people who have trouble with drink as well.” (Freddie Follow-up)

It is interest that Freddie does not recognise himself to have the label ‘alcoholic’ instead viewing himself as someone that has trouble with drink, arguably limiting his

ability to get support.

8.4.2 Anger and violence

Despite alcohol being the most commonly expressed method of coping, some participants spoke of the use of multiple coping mechanisms at one time. For example Mike's narrative revealed a lethal combination of negative coping mechanisms such as alcohol and drugs, which related to both depression, suicidal feelings and self-harm, and furthermore fuelled aggressive outbursts and criminal behaviour.

“Well through my order they told me that I had a drink problem and all that because most of my offences is through drink and drugs. (Mike)

Interestingly the participants also commented on the difficulties that they faced with being able to express their feelings in a more positive way, with many referring to their inability to cry, having violent outbursts or bottling up their emotions which climaxed in a suicide attempt or serious self-injury.

“I just flipped, you know I get it in my head I see red and that's it. And I need to take that anger out on myself. The only thing that I can do is hurt myself to take some of the anger out or hurt someone else. I'd rather do it on myself because knowing me if I hurt someone I can do some damage do you know what I mean.” (Mike)

For Mike anger takes over him and encompasses his whole mind set, the term 'that's it' represents the lack of control that he experiences during these periods and how the action of hurting himself rather than other people is the only control that Mike perceives to have. During his initial account Mike spoke of multiple occasions where he had got into physical fights with other people or dealt with his anger, frustration and tension through self-harm. With such a complex interplay of problems getting support may be difficult, however several participants commented on the usefulness of the anger management programme run by Probation. Which was deemed to be helpful for not only anger issues but also for learning how to regulate their emotions, and helped to prevent them from making further suicide attempts.

“Especially as well, with (offender manager) the anger management, that helped out a lot. Like just the way to deal with my anger. Because what

happened was I was getting angry and then from the anger something else would happen and then it would just get worse and worse and worse. So now I've learnt to control that. (Dan follow-up)

Summary: The current theme represented a change regarding the ways in which the participants initially described coping with their grief, sadness, depression, and frustration often experienced prior to their suicide attempts, and how they later described coping with these emotions during their follow-up interviews. Having an awareness of these negative forms of coping and expression were apparent for many participants during their initial interviews, however they frequently experienced uncertainty in relation to other more productive ways of coping or expressing themselves. During their later follow-up interviews the participants commented on having found new ways of coping or new ways of expressing their emotions, which they perceived to be more helpful, less damaging, and more controllable than their previous methods and helped to prevent them from making further suicide attempts. When their coping mechanisms did not change and participants were unable to find new more effective ways of coping they often made further attempts or carried out further self-injury.

8.5 Positive and negative social experiences: “You need people out there.”

During the participants' initial interviews and their follow-up interviews it was clear that socialisation, society, friendships, relationships and communication were very important aspects of their lives and often interacted with their suicidal feelings. 'People' and 'others' were viewed as a source of support which enhanced meaning in the participants' lives. However without adequate social support the participants often lacked meaning, belonging and experienced feelings of loneliness and inadequacy. For example socialising or 'being social' for Dave was a core part of his personality, without the opportunity to socialise Dave spoke of his loss of confidence.

“Erm and it just sort of made me realise that the last three years I have just been existing erm. And, you know it's not me, it's not me at all. I always have been such a people person I bounce off people... I just felt that's where I

needed to get, I needed to get back into the group environment... It was sort of I loved it, it gave me confidence, it really did.” (Dave)

In contrast during Dave’s follow-up interview he spoke of starting to regain his confidence after returning to a group environment in the form of a personality disorder support group. Dave felt that this social group had increased his support regarding his suicidal behaviours and enabled him to share his experiences with others suffering from the same diagnosis. During the period between the initial interview and the follow-up interview Dave made a further suicide attempt, but did not go on to make another attempt after finding a new source of support and after being diagnosed with personality disorder.

“I think that I feel like I have got a lot more a support around me. Erm, I also now, attend erm a daily support group, yeah once a day and there’s a least five groups a week I can get to, yeah I try and do every one.” (Dave follow-up)

Dave’s account demonstrates how important ‘being social’ and having other people to share their feelings with was for the participants. At times where participants lacked strong relationships or when their existing relationships were perceived to be unstable the participants experienced feelings of loneliness, isolation and depression, which often resulted in suicidal feelings and a sense of ‘thwarted belonging’ (Joiner, 2005). Freddie for example felt extremely alone and isolated during his first interview, also describing a further suicide attempt during his follow-up interview which he linked to an argument with a friend. However during his follow-up interview Freddie went onto explain how the relationship with his mother had provided him with a purpose to keep living.

“People think that I’m a loser... That’s their reaction to it, yeah, I can’t keep friendships for some reason. And I’m cursed to be by myself and I don’t want that at all.” (Freddie)

“The only friend I’ve got is my mum, you know and that aint, at least I’ve got someone you know...” (Freddie follow-up)

During Freddie’s initial interview he expressed feeling lonely, isolated and having very few key relationships in his life, and furthermore a lack of hope in relation to the situation improving. His interesting use of the word ‘cursed’ reflects his deep sense

of unhappiness and perceived lack of control over the issue. However during Freddie's follow-up his view had shifted from feeling completely alone to recognising the importance of the relationship between himself and his mother, who he described as 'his rock.' In this sense Freddie was able to recognise this relationship as a key form of support, despite not having other friendships and relationships.

8.5.1 Judgements from others; being 'normal'

Participants frequently spoke of the difficulty that they experienced in relation to forming relationships with others, often due to concerns and worries about other peoples 'reactions' to them and 'being judged.' For example, as previously mentioned Roy's feelings about being in the probation hostel had changed since his original interview, instead of viewing the hostel as a form of support regarding his suicidal behaviour he instead felt oppressed and restricted, arguably linked to feelings of stagnation and non-progression. What was also interesting was the way in which Roy felt judged, stereotyped and labelled by the very presence of being in the hostel.

"The problem with this place, erm it's still a prison. And everywhere I go on the outside everyone is treating me like a normal person, the people I'm trying to get jobs from, my family. I go out, my bank. I come back here I'm treated like scum again. And I dread it. I dread walking up here and coming, because I'm going to be treated like scum again." (Roy follow-up)

The extract above demonstrates how Roy felt judged, stereotyped and penalised by the individuals who were originally perceived to be a source of support. Feeling judged by others was commonly experienced by the participants in relation to both their crimes and suicidal behaviour. During Dan's follow-up interview he spoke of the judgement that he anticipated from others when starting his unpaid work placement, and instead the shock that he experienced when he did not feel judged and instead felt accepted.

"It was good. Like the people there they weren't like you would expect them, because they would see me as a criminal. That's what you would expect, but nah I got there and they was fine. They just treated me like I was a normal person." (Dan follow-up)

In the extracts above both Dan and Roy refer to 'a normal person,' also discussed by

other participants. In this sense the ‘normal person’ was arguably defined by society in relation to social norms, which the participants felt they did not match due to both their criminal and suicidal behaviour. It is not that the participants themselves feel abnormal but instead feel that other people do not view them as being normal. When participants felt this way they referred to ‘putting on an act’ ‘playing a part’ ‘becoming someone else’ instead of being themselves in order to preserve their self-esteem and avoid being judged. The anticipation of judgement from others often prevented the participants from seeking help, support and from sharing their feelings with others, which often resulted in suicidal behaviour. For example during Dan’s initial interview he spoke of potential judgement from others as being a barrier to him expressing his suicidal feelings to others and talking about his suicidal feelings before his attempt. These feelings are affirmed with his use of the phrase ‘do you know what I mean,’ in the extract below.

“It is me, I stop from telling people. I don’t know why, I probably think that they would think differently of me. Do you know what I mean.” (Dan)

However, during his later follow-up interview it was evident that exposure to non-judgmental sources of support such as counsellors, family, friends and probation staff had enabled Dan to develop the confidence that he could share his feelings without being judged. Dan said that being able to talk about stress, depression and suicidal feelings may be helpful for other people in a situation similar to his own, and could help to prevent suicide.

“Erm, to help other people I’d say that they need to not deal with it themselves. Like with me it was thinking, I’d sit there and then I’d be thinking and I’d get depressed and then I’d be even more depressed because I’d keep thinking about these bad things and then, so I think if people had more chance to go to a counsellor or something like that. To talk to someone about it, I think they’d be a lot better.” (Dan follow-up)

8.5.2 Talking, listening and support

Like Dan many participants referred to positive social experiences increasing their confidence and perception of support, including having someone to talk to about their feelings, and importantly not feeling judged when they shared these feelings with

others. During her initial interview and her follow-up interview Kathy spoke of the difficulty that suicidal people and self-harmers may face when attempting to share their feelings with others, but how talking was a useful form of support once these barriers were overcome.

“I mean if you had asked me like a few years ago to talk to you I would have gone nah. Because I kept it all in. I have learnt now that you can’t keep it all in, you need people out there. Because if you are a self-harmer and you are keeping it all in no one’s gonna ever hear you.” (Kathy)

Later

“I didn’t want to admit that I wanted help, I’m a tough cookie. But you do need help sometimes.” (Kathy follow up)

Kathy’s use of the phrase ‘you need people out there’ reflects the essence of the current theme by demonstrating the important role that other people play in the suicidal process, particularly in relation to prevention. The idea that no one will ever hear Kathy if she does not share her story was commonly expressed by the participants, but what stood out was ‘who’ they felt able to share their stories with and ‘why’ they felt able to share their stories with certain individuals. For example if the chosen confidant was viewed as being similar to the participant then the participants perceived them to have more of an understanding of their feelings, enabling them to feel more confident in confiding their stories.

“I’ve met new friends... and it makes me, it perks me up, because my mate’s girlfriend has got the same illness as me so she can understand borderlines, but she’s never self-harmed. But she knows, you know, where I’ve told her, I don’t know how to explain myself but she went yeah I understand I’ve got the same illness. You just act on it, you don’t think, you just act.” (Mike follow-up)

During Mike’s initial interview he spoke of having very few people who understood his condition, and how this meant he would need to put on an act and ‘be the hard man.’ However the common experience shared by Mike and his friend normalised his feelings, increasing his feeling of being accepted, and permitted Mike to no longer put

on an act but instead be himself. Similarly Dan spoke of the importance of shared experience, explaining how on the day of his attempt he was able to relate to the experience of the police officer who was sent to help him.

“It was weird because from my experience with police it’s been like I’m a criminal, do you know what I mean... They just came and sat down, offered me a fag. Do you know what I mean... spoke to me. Just told me that it’s stupid, he said he lost his wife a few years ago and he got in this sort depression and wanted to kill himself. But he kept strong and all this. Do you know what I mean, he told me his own experience so it was just, totally helped me. I don’t understand how, but it just did. Do you know what I mean. It was really good.” (Dan follow-up)

Dan’s repeated use of the phrase ‘do you know what I mean’ indicates the significance of communicating this story with the interviewer. For Dan the positive experience of being treated with respect and dignity by the police officer was unanticipated. The realisation that other people also experience similar feelings arguably helped Dan to deal with his own experience and feelings, additionally developing his trust for the police. Importantly those who reported feelings of acceptance and integration, did not go on to make further attempts, indicating that feeling understood by others may be protective.

Summary: Overall the current theme represented the negative and positive roles that other people can play in suicidal behaviour. Encountering negative social interactions, feeling lonely, isolated, and lacking belonging often led to negative feelings such as depression and suicidal thoughts. However when participants felt that they were able to relate to others by sharing their feelings, having a shared experience with other people or feeling like they were accepted, their suicidal feelings appeared to lessen. Most participants, during their initial interviews, spoke of more negative social experiences compared to positive social encounters, however during their follow-up interviews participants also commented on how positive social experiences had helped them to deal with their suicidal feelings and feelings in general. Those participants who went on to carry out further attempts or self-injury since their initial interviews reported having fewer positive social experiences since, whereas those who did not make further attempts seem to have benefitted from acceptance from others.

8.6 Discussion

Findings from the current study add to the broader literature on suicide and suicide attempters, and enrich current knowledge about suicide by offenders, particularly probation populations. By means of a qualitative methodology and through the use of follow-up interviews, methods which have previously been neglected within this population (Mackenzie et al., 2013; Wessely et al., 1996), a more comprehensive understanding of the suicidal process of probationers has been established. Expanding on the findings of Study 2b which suggest that suicide is not one single act, but instead part of a process, the current study demonstrates how for survivors of suicide attempts and/or near-lethal self-injury the suicidal process continues after the attempt. Participants in the current study were still vulnerable 3-6 months after their original attempt, with many describing further forms of suicidal behaviour since their original interview. Significant about the current study was the preventative effect that emotional support had; participants who were provided with support after their attempts were less likely to make further attempts, whereas those who felt unsupported reported making further attempts and/or self-harming. Furthermore, particularly striking about the participants' accounts was the heightened sense of self-awareness that they gained from experiencing the suicidal process. Participants felt able to predict occasions when they could potentially be vulnerable to further suicide attempts; in particular periods when they faced feelings of boredom, impatience and frustration, characterised by a perceived slowing down of time. Some of this increased awareness was arguably a result of taking part in the current study, giving participants more of an opportunity to reflect on their experiences, allowing them to talk about their experience and be listened to by the researcher.

It is well documented from previous research that for depressed individuals time is often perceived to slow down (Bschor et al., 2004; Gil & Droit-Volet, 2009; Kitamura & Kumar, 1982; Sévigny, Everett, & Grondin, 2003), and there has been some research that documents this perceived slowing down of time in suicidal individuals (Neuringer & Levenson, 1972). Participants' from the current study experienced a perceived slowing down of time during the months, weeks, and days before their suicide attempts. However these findings also demonstrate that, during and immediately prior to a suicidal act, participants' instead perceived time to speed up. Participants said that this left them feeling less able to process their own thoughts,

feelings and behaviours during these moments. Past research has considered the impulsivity of the suicidal act (O'Donnell, Farmer, & Catal, 1996; Simon et al., 2002), but not how this relates to the suicidal individual's perceptions of time. Furthermore the current findings highlight how once given the opportunity to discuss their near-lethal attempt and reflect on their experience, individuals may be more insightful about the perceived causes and triggers of their behaviour.

The current findings draw attention to the phenomenological experiences of the participants, in relation to perceived changes in time duration throughout different phases of the suicidal experience. Furthermore participants commented on the period after their near-lethal incident, in which they were plagued by worries and concerns over re-experiencing the thoughts, feelings and emotions associated with the period prior to their near-lethal behaviour. For example participants commented on the active steps that they took to prevent themselves from becoming bored, as the 'bored' state was associated with their progression into the suicidal state. This finding has important implications for those who work with survivors of suicide attempts, as helping them to retrospectively recognise their phenomenological experience of their suicidal process may help them to prevent further attempts, by increasing their awareness of their own suicidal triggers. Participants in the current study who reported being provided with support for their suicidal feelings and mental health problems since their initial interviews reported not making further attempts since receiving this support. Participants who were still struggling to cope with their depressive and suicidal feelings, and who had not received support regarding these issues reported making further attempts and/or carrying out self-harm. Therefore it is important that survivors of suicide attempts are provided with adequate support after their attempt and helped to identify effective ways of coping with their depression, stress, and suicidal feelings if they reoccur.

Ways of coping and expressing their feelings were frequently referred to by participants. Negative ways of coping and negative ways of expressing their thoughts, feelings and emotions were used more often than positive forms of coping. This finding is not surprising as the literature suggests that suicidal individuals often employ negative coping mechanisms (Hufford, 2001; Pompili et al., 2006), of particular interest in the current study were the positive ways of coping that participants had developed. These positive forms of coping often developed through

help from external sources such as; probation run anger management courses, alcohol treatment programmes, and counselling services. In comparison to the findings of Study 2b, participants who had now been provided with support for unhelpful coping mechanisms were also indirectly helped to reduce and manage their suicidal feelings. Providing suicidal and self-harming individuals with other more positive routes for coping with their feelings, thoughts and emotions, helped alleviate suicidal feelings. However, it is important to note that participants needed to be willing to accept help from others, which they commonly reflected on during their follow-up interviews. Participants often referred to barriers in the past that had prevented them from seeking support that predominately centred on the belief that other people would judge them.

Previous research has considered how offenders who have a mental illness or addiction problem face more stigma than offenders who do not (Hartwell, 2004). Findings suggest that probationers who attempt suicide and have mental health problems often anticipate stigmatisation and rejection from others based on both their criminal history as well as their mental health condition. Being judged a criminal and suicidal caused participants fear and concern. What made a difference for the participants was having positive experiences where they did not experience judgement from others, and in some cases experienced non-judgmental forms of listening. The current study, as well as studies 1, 2a & 2b suggest that non-judgmental listening is particularly important to suicidal probationers and should be readily available and accessible to all probationers.

There are of course some limitations to this study. Retrospective accounts were provided by the participants which, as with all retrospective data, could be subject to memory bias or contamination. However, the aim of the current study was to explore how these accounts had changed or remained since the original interview when participants were given time to reflect on their experiences. The use of qualitative follow-up interviews was therefore the most appropriate and useful method to achieve the aims of the current study. However, a further limitation of the current study was the difficulty in tracing the participants, which is a common problem when employing follow-up interviews (Cotter, Burke, Stouthamer-Loeber, & Loeber, 2005; Kleschinsky, Bosworth, Nelson, Walsh, & Shaffer, 2009). Furthermore, community offender populations are even more difficult to trace due to their often change in

location and often only serving short sentences, hence the follow-up interviews being conducted 3-6 months after the original interview. Fortunately six participants were traceable and willing to take part. One participant was only able to take part via a telephone interview, which arguably has limitations (Berg, 2001), however this participant wanted to take part and a telephone interview was the only option for doing so. Reflecting on this the interview did not appear to lack any depth in relation to the other interviews, therefore the use of a telephone did not seem to restrict the data gathered. Furthermore a rapport between the participant and the researcher was already gained during the initial interview which took part face to face.

Overall the findings from the current study draw attention to the on-going distress experienced by the participants during the suicidal state and how suicide is not a single act but instead part of a process which begins in the years, months, weeks, and days before the attempt and then continues after the attempt. Participants were still vulnerable after their near-lethal attempts, but when they were able to establish alternative methods of coping with their emotions and feelings, their risk of suicidal behaviour appeared to decrease. Most significantly, being provided with support regarding suicidal feelings, mental health problems and maladaptive coping mechanisms prevented further suicide attempts. Recognising that suicidal individuals are still vulnerable after an attempted suicide and that increased support regarding methods of coping could prevent further suicide attempts. Furthermore, participants introspectively experienced a heightened sense of awareness in relation to the potential triggers to their suicidal behaviour and were actively able to take steps to prevent themselves from carrying out these types of behaviour. Being able to develop a sense of self-awareness may, therefore, help to prevent suicidal behaviours.

9 Study Four: Additional analysis of client and staff perspectives – A dyad approach

9.1 Introduction

The aims of the previous studies presented in this thesis were to understand and explore individual accounts of near-lethal suicide by probation clients and by staff who work with these clients. The previous study (3) specifically focused on the change in perspectives experienced by participants since their initial interviews. Findings suggest that suicide is part of a process which is characterised in relation to perceptions of time duration. Furthermore, those who are provided with support after their suicide attempt and who are helped with learning more positive ways of coping are less likely to make further suicide attempts than those without support. However, to understand such a complex experience it is important to consider the perspectives of a number of individuals who are affected by suicide rather than just one. Considering only one perspective could lead to vital information about the possible causes and prevention being missed. The current chapter explores near-lethal incidents in a dyad format, drawing on the perspective of the client who carried out the near-lethal behaviour, as well as the perspective of a member of probation staff who supervised the client in some capacity at the time of their near-lethal attempt. The data were analysed using a descriptive thematic approach and the researcher focused on differences and similarities between the accounts of the participants. Particular focus was given to understanding the relationships between the client and staff, and how these relationships interrelated with both the probation process and the suicidal process of the client. The following study focuses on the accounts of five clients and five members of staff (see Table 12). One client dyad could not be included in the current study (Roy) because no member of staff responsible for his supervision was able to take part in the interview.

Table 12: Staff-Client dyads

Staff	Client
Jane (Offender manager)	Kathy
Sarah (Offender manager)	Dave
Christine (Offender manager)	Mike
Harry (Mental health worker)	Freddie
Kevin (Offender manager)	Dan

9.2 Results

Three main themes encapsulated the essence of the participants accounts; *Signs and Indicators; Causes and Triggers; Prevention*. The theme of ‘signs and indicators’ demonstrates the participants’ reflections on perceived warning signs and indicators that a near-lethal incident might occur, including anything that they noticed during the time leading up to the incident, or identified retrospectively after the incident had occurred. The theme of ‘causes and triggers’ communicates the perceived causes and immediate triggers of the near-lethal behaviour. Lastly, the theme of ‘prevention’ incorporated both the participants’ views on what could have prevented the near-lethal behaviour from happening, as well as what could be done to prevent this type of behaviour from re-occurring in the future.

Table 13: Themes and subthemes staff-client dyads

Theme	Subthemes
Signs & Indicators: ‘He was always quite vulnerable’	- <i>Previous self-harm and suicide attempts</i> - <i>Change in engagement with Probation</i>
Causes and Triggers	- <i>Vulnerable stages in the probation process</i> - <i>Lack of support</i>
Prevention	- <i>Talking, confiding and listening</i>

9.3 Signs and Indicators: ‘He was always quite vulnerable’

The current theme depicts how, both clients and staff, were able to identify warning signs and indications of the near-lethal incident prior to its occurrence, as well as retrospectively during the interview process. Staff and their clients often described similar risk indicators and signs, however there were also differences in their accounts, with some staff viewing their client as a vulnerable person, but not necessarily someone who might feel suicidal. The most common signals and indicators referred to included: having a history of suicide attempts and/or self-harm; and change in

engagement with the probation process. Some staff were able to pick on indications that their client was feeling low or indicated suicidal feelings, whilst the client said that they could not see that they were going to attempt suicide. Or in contrast some clients described feeling very aware of their suicidal feelings and intentions prior to the incident, but staff said that they were unaware that their client felt this way.

9.3.1 Previous self-harm and suicide attempts

Having made previous suicide attempts and having a history of self-harm was common to all but one client (Dan) and indicated their vulnerability for making further attempts. These clients' spoke of their history of suicide attempts or self-injury during both their initial and follow-up interviews. Staff accounts on the other hand demonstrate a lack of awareness of their client's history regarding suicide. For example Sarah felt that she knew and understood her client's behaviour, recognising that he often found it difficult to cope, felt depressed and struggled with managing his bipolar disorder. The narratives of Dave and Sarah, overall, characterise a strong professional relationship which, in most circumstances enabled Dave to share his feelings, problems and concerns with Sarah during difficult periods of his probation sentence. However despite this, Dave did not disclose the severity of his previous problems with alcohol, drugs and self-harm to Sarah.

Sarah: "He had been tearful in interviews during the past. Erm, and you know he had bi-polar and all that sort of thing. And I'd known him for quite a while before all of this kicked off so I had quite a good grasp on what he was like."

Interviewer: "Has he ever talked to you about self-harm or anything before?"

Sarah: "Not really other than he did say that he had done it in the past. But, erm it was quite a while ago."

In contrast

"I have had years and years of drink, drugs, problems with self-harming and what not." (Dave)

Dave's lack of detailed disclosure arguably restricted Sarah's awareness of the potential increased risk Dave posed to himself, furthermore limiting her ability to recognise potential warning signs prior to Dave's near lethal incident. It was not

uncommon, or unexpected, that probation staff did not know the historical background of their client's self-injury or past suicide attempts. As often was the case, staff had little time to get to know their clients, with many members of staff referring to having only briefly met their client prior to the near-lethal incident, and sometimes having to rely on client disclosure regarding historical suicidal behaviour. In particular three members of staff felt that they did not know their client well enough to notice changes in their behaviour prior to the attempt. This also made it difficult for staff to identify and assess the risk that their client posed to themselves, despite in some cases having records to say that their clients has self-harmed or attempted suicide in the past. Kathy's offender manager Jane illustrates the difficulties staff face when they have limited first-hand knowledge of their client.

"I don't know if it was out of the blue... it wasn't really that there was a change, well I suppose I wouldn't really know if there was a change because I hadn't known her that long but she, I knew that, it (self-harm) was something that she did quite regularly..." (Jane)

Even having only known Kathy for a limited amount of time and not having prior knowledge of her suicidal feelings, Jane felt that Kathy indicated underlying suicidal feelings, on account of her historical self-harm and her apparent mind-set at the time prior to the near-lethal incident.

"Not explicitly, not about attempts, but she had sort of said look you know if I didn't wake up tomorrow I wouldn't care, that kind of thing. And that, erm, so she had kind of indicated that she didn't value her life very much, definitely". (Jane)

Through her limited contact with Kathy, Jane was able to identify signs that Kathy may be at risk of suicidal behaviour. However unlike the other members of staff Jane's ability to notice these types of warning signs could be related to her voluntary position in a suicide prevention charity, which provides training to spot signs of suicidal intentions and feelings. Demonstrating the importance and usefulness of staff training. Interestingly Kathy felt that her suicide attempts were not foreseeable as Jane described, but were instead impulsive and likely to occur at any moment if she felt sad: *"I don't know when I'm going to do it, I just, just getting on a downer."* (Kathy).

Not all staff were able to pick on the possible signs or indications of their clients suicidal feelings, particularly if they felt that their client would usually communicate these feelings to them. For instance Christine felt that her client Mike would disclose suicidal feelings to her, however Mike said that he had been feeling low for a few months but had not spoken about it.

“I mean he keeps in regular contact anyway and he's, he tells me what he is thinking and stuff but no there hadn't been any changes in behaviour or anything.” (Christine)

In contrast:

“I boil up for a bit and I probably act and then talk after. That's if I don't do nothing you know really stupid.” And “A few months maybe longer, and then I just think it got to the bubbling point where I just got out of control.” (Mike)

The mismatch between Mike and Christine highlights the difficulties faced by staff when trying to identify warning signs for suicide risk. Examples similar to Mike and Christine were common, with many staff feeling that their client would have the confidence to disclose these types of feelings, whilst their client said that they had not disclosed their suicidal feelings. These examples draw attention to the importance of asking clients directly about these types of feelings even when the client is not perceived to be feeling suicidal or depressed. Staff who struggled the most with identifying their clients' suicide risk were those staff whose clients who had no history of suicidal behaviours. For example retrospectively Kevin felt that he may not have noticed any changes in Dan's behaviour leading up to the time of his near-lethal incident because it was not looking out for it, and had no reason to be concerned about.

“Nothing really, nothing outstanding that warranted concern... unless I missed something... but I didn't notice anything... if I'm honest with ya I didn't focus on that area because it's not something that had been brought to the forefront.” (Kevin)

In contrast Dan spoke of noticing changes to his mood and memory prior to his near-lethal attempt. Dan did not communicate these worries and concerns with Kevin, therefore Kevin did not perceive Dan to be vulnerable or at risk of suicide.

“My memory started going and all this sort of thing. That’s when I didn’t feel right and I done the whole, on my phone I done the check... whatever it is. Diagnostic. I done that and then and it was everything for depression. I was like, me sort of thing, so I was like doctors, go to the doctors and he gave me them (antidepressants).” (Dan)

The examples outlined above emphasize the complications faced by probation staff in being able to identify whether or not a client is vulnerable to suicidal behaviour or likely to carry out suicidal behaviours. Lack of communication from the client to the offender manager can limit the offender manager’s ability to spot signs or indicators of their client’s risk, even when both parties perceive there to be an effective professional relationship. In this sense the client’s unwillingness or incapacity to disclose their feelings to staff created a barrier for potential sources of support.

9.3.2 Change in engagement with Probation

A significant sign of the client’s spiral into the suicidal state, referred to by both clients and staff, was their increased or decreased engagement with different aspects of the probation process. For example, Dave increased his engagement with probation prior to his near-lethal incident by attending extra contact hours with his offender manager to gain emotional support.

“...but for the last say six months or so, because I haven’t been having a great time I asked her if I could come in again weekly and she said that that is not a problem.” (Dave)

Dave’s increase in contact reflected his need for support at a time when his depressive state had worsened, spiralling into a suicidal decline. By not directly expressing these concerns to Sarah and instead asking for increased contact meant that Sarah was unaware of Dave’s deeper concerns and worries regarding his emotional state. Sarah felt that Dave was vulnerable but also felt that he had the capacity to offload and unburden himself through talking.

“He was always quite vulnerable but he was always sort of able to talk enough to sort of you know, get through as much as possible until this incident.” (Sarah)

In contrast to Dave who wanted increased contact with probation staff as a means of support, other clients spoke of their reduced engagement with probation prior to their near-lethal behaviour. For instance Dan stopped attending his probation meetings and unpaid work. Kevin said that during the period of time prior to Dan's attempt he did not recognise this as being a sign that Dan was depressed, however in retrospect he recognised the underlying problems linked to these missed appointments. Arguably Kevin was unable to identify these signs prior to the near-lethal incident because he did not view Dan as being at risk of carrying out suicidal behaviour because of his lack of suicidal history.

“In terms of coming to appointments that was the only thing that kind of, in hindsight in looking at things that's the kind of things that was leading up. Missing appointments and at times when he was in interviews he would say that he forgets stuff as well. Those are the only little things that came up. Yeah. Yeah, not going to the unpaid work, yeah.” (Kevin)

Interestingly, during a later follow up interview, Dan stressed that missing his appointments were a sign of his depression and that probation's reaction to his missed appointments fuelled his depression further, later developing into suicidal feelings. In this sense missing his probation appointments was Dan's initial cry for help prior to his near-lethal behaviour.

“Obviously yeah some people miss appointments... on purpose, but maybe they (probation) should try to get to the bottom of it before they assume that they are just not coming.” (Dan)

Summary: Overall both staff and clients identified signs and indicators of near-lethal behaviour, however this identification often occurred retrospectively after the incident. Staff sometimes were unable to pick up on warning signs due to having little knowledge about their client's 'normal' behaviour, feeling that their client was not at risk of suicidal behaviour or feeling that their client would talk to them about suicidal feelings rather than acting on them. Similarly clients expressed confusion over being able to identify signs of their near-lethal behaviour, with some feeling that the behaviour was linked to their on-going depression, whilst at the same time feeling that their behaviour was unpredictable. Some clients said that their depressive state prior

to their near-lethal act, was reflected in their change in engagement with their probation process.

9.4 Causes and triggers

Causes and triggers of the near-lethal incident were viewed by participants as being complex, however there were some common causes and triggers identified by both staff and their clients. These included issues related to the probation process as well as perceived inadequate support for the client's depression and mental health problems.

9.4.1 Vulnerable Stages in the Probation process

Participants often associated their near-lethal behaviour with core stages of the probation process including; receiving a court sentence; awaiting a court sentence; going into breach; finishing probation. The breach process in particular was commented on by a number of clients as being a contributing factor towards their suicidal behaviour, provoking feelings of uncertainty, fear, concern and panic over the possibility of receiving a prison sentence. As mentioned in the previous theme Dan's depression led him to miss his probation appointment which resulted in him breaching the terms of his probation sentence.

“It actually started when Kevin (offender manager) sent me back to the court. That's when I thought I'm definitely going prison, so I think from that, that's when I just started noticing that I was feeling down and different and all... I was worried about going to prison basically.” (Dan)

A prominent aspect of Dan's account was the lack of concern that he felt Probation had into the underlying causes for his missed appointments.

“...anxiety and things like that... Like there were things worrying me. And then straight away they just take me back to court... I'm here worrying thinking fxxking hell it's even worse, I might be going prison now. So that's what caused me all this stress and that. I wanted to kill myself because I didn't want to have to go through that... Probation didn't cause me to do it but it just put something on top that made it worse for me... So I think they could have understood a little bit...I told them that the reason that I missed the appointment is because I've been depressed, I've been to the doctors, but they

didn't do absolutely nothing, still sent me to court.” (Dan follow-up)

Dan's already existing depressive state was worsened by the breach process which acted as the trigger to his suicidal behaviour, fuelling feelings of entrapment. In comparison Kevin agreed with Dan that the breach process had contributed towards his suicidal behaviour, however did not view it as the singular cause.

“Yeah it was the breach process I guess, because the fact that he hadn't been complying so I guess that was the build up to it. And the fact that he was missing several appointments as well, so I guess if anything that's kind of a build-up factor. Because I'm sure he had other things going on outside of probation as well.” And “He was fed up with his situation, I don't think that he was where he wanted to be and erm, with everything else that had been going on as well, especially with the sentence as well.” (Kevin)

This example demonstrates how the experience of the breach process and its possible consequences and outcomes can cause concern, worry and fear, and in some cases lead to suicidal feelings. Furthermore, in many instances feelings which are experienced by the client are not necessarily recognised by the probation staff supervising them. However this was not the case for all probation staff. In contrast Harry was concerned that his client Freddie would become suicidal prior to receiving his sentence, and may attempt suicide if he were to receive a prison sentence. These concerns may have stemmed from Harry's knowledge as a mental health support worker.

“...his whole persona was around his failure, his inability to move forward. The fact that, although he is a very personable character and I think most people seem to agree with that... he doesn't agree with that he thinks he is a blight on society and other people... And I think, although one could suggest by going into custody there would be an element of supervision, you know we know from other information that people do continue to self-harm and indeed suicide in custody. And I think given the fact that he has tried so hard before, he has made really significant attempt... it would be quite likely I think that actually in custody he would try again... in the community he had access to his mother, to his dog and to probation... So there is far more support for him there than perhaps there would have been perhaps in prison.” (Harry)

Harry's account demonstrates his concern in relation to the potential negative impact the prison environment could have on Freddie who he already perceived as being vulnerable. Interestingly Freddie did not mention going to prison as worrying or concerning him, however he made a suicide attempt after receiving his community sentence, suggesting that although Harry felt that prison could escalate Freddie's suicidal feelings, Freddie was still at risk in the community.

"They gave me a month on tag... I tried to commit suicide, I opened up my wrists and ended up in hospital for three days." (Freddie)

Similar to Freddie, Kathy's suicide attempt occurred shortly after receiving her probation sentence. Kathy frequently commented on her lack of trust in authorities, as well as feeling let down by the justice system, however she did not say that her probation sentence had caused or triggered her suicide attempt. Jane on the other hand felt that Kathy's feelings of injustice about being on probation contributed towards her low mood and suicidal behaviour.

"I think probation was a contributing factor, but I don't think it was necessarily the way she was dealt with on probation, it's just the nature, the contact with the criminal justice system." (Jane)

In contrast, and unlike other clients Dave's suicidal behaviour was linked to the loss of support that he anticipated when finishing probation. Interestingly Sarah also felt that coming to the end of probation contributed towards Dave's suicidal feelings because this meant that he would be losing the support provided to him by probation.

"You know but in terms of actually finishing with me, you know he didn't actually say I'm worried that I'm not going to see you anymore or anything like that... I mean he was, I think maybe because he wouldn't have had that support around his drinking and there was a lot of stuff to do with his partner and arguments they were having and all the rest of it. You know, so, so there was a lot of other stuff going on and I think in a way he was anxious that that support that we offered him was going to totally disappear and he wouldn't have anyone to talk to." (Sarah)

These concerns were not mentioned by Dave during his initial interview. However,

during his follow up interview Dave said that he could now identify the anxiety and worry he experienced in relation to the loss of support that probation had offered him.

“I had finished probation before I started my day groups and yeah I suppose in a sense finishing probation was a bit scary in that, erm, yeah I thought that my help was backing away from me and I was a bit, well to be honest with you I was scared about that.” (Dave: follow up interview)

Overall these key stages in the probation process evoked fear, anxiety and stress for many clients. This was also recognised by the staff supervising them. Commonly mentioned time points included beginning their community sentence, awaiting a court sentence or going through the breach process, and for Dave, finishing his probation sentence.

9.4.2 Inadequate professional support

Feeling unsupported was commonly referred to by participants as contributing towards and triggering their suicidal behaviour. Issues that clients needed support with included mental health problems, alcohol, depression, and domestic violence. For example, both Mike and his offender manager viewed the inadequate support that he received prior to the incident as a triggering point for his suicidal act.

“He wanted to be admitted... he said he couldn't go on and he needed help... and that's why he, I'm guessing that's why he self-harmed so he could go, so... the police would have to take him back to the hospital and then I think he was admitted then.” (Christine)

“I wanted them to help me... what I was telling them was pretty full-frontal, what I was like tempted to do... And they were like no. You're discharged. See you later.” And “I was so pxxsed off with the outcome of the meeting, my CPA meeting, so I set myself on fire in front of them.” (Mike)

Lack of support regarding a mental health condition was frequently referred to by clients and staff as being a potential cause of near-lethal behaviour. A further example comes from the accounts of Dave and Sarah who both felt that the frequent changes to Dave's bipolar medication and changes in his psychiatrists had led to him experience unstable moods, uncertainty in relation to who he could talk to about his condition, as well as apprehension and anxiety regarding having to get to know a new psychiatrist.

“Yeah, it’s just so many things all rolled into one. It’s not just that day it’s the fact that I have got bipolar, it’s the fact that my medication wasn’t working therefore the little that it was doing for me has been halved and I’m being taken off of it.” And “That will be the fourth different psychiatrist that I have had in a year and it’s tough. It sort of, there are so many issues going on here that there is a lot of trust issues... it takes me a while to get to trust people anyway... then I get four different psychiatrists, it’s really not going as well as it could.”

(Dave)

“So yeah I think it was a combination of things on the day and also swapping GP’s and psychiatrists and you know changing his medication. Erm, but it’s strange though because before that things were actually going quite well.”

(Sarah)

Overall both client and staff felt that this inconsistent support had contributed towards Dave’s suicidal behaviour and feelings. However, the contrast in perceived build-up time to the incident was apparent from Sarah and Dave’s account, with Sarah feeling that the change in mood was sudden, in comparison to Dave who felt that his suicidal feelings had been building up over a longer period of time. These subtle differences in staff-client accounts were particularly insightful in some cases. For example Kathy felt that there was little help available to her with regards to her depression, alcoholism and domestic violence, feeling let down and rejected by those who she felt were meant to help her. In contrast Jane felt that support was available but Kathy was unwilling to accept this support.

“It was like being frustrated, like I’m trying to get help. The trouble is, when you are trying to get help no one wants to help ya. When you don’t want anyone to help you they all want to help ya. The same as, because I was crying out so I cried out that way (makes a cutting sign on wrist).” (Kathy follow up)

In contrast:

“She has had some sort of counselling before in relation to domestic violence, but she found it very backward looking... she said that that wasn’t helpful. Erm, but mainly I think it’s that, you know I tried discussing with her that it

could be different this time around but she just sort of said I can deal with it myself, I can look after myself and I don't need you know. I think it's a suspicion I think of agencies and outside intervention that kind of thing..." and "It's not through not knowing what support is out there it is through an unwillingness to seek that support unfortunately." (Jane)

Kathy felt let down by other professionals and said that her near-lethal incident, as well as suicidal and self-injurious behaviours in general, might not have happened if she had got the appropriate help at the right time. In contrast Jane felt that Kathy was unprepared to accept the support offered to her because of her difficulties with being able to open up and trust others, as well as her previous unhelpful experience of counselling. The current dyad draws attention to the notion that Kathy appears to want help, but in the same light is perceived by others as not wanting help. These accounts lead to further questions regarding how to provide someone with support when they do not appear to want help, and perhaps more importantly how clients could be encouraged to share their feelings with probation staff and to signify to staff when they do feel like they need extra support.

Summary: Overall the participants' accounts provided important focus on specific points of the probation process when a client might be particularly vulnerable to suicidal behaviour, and how increased vigilance by staff at these moments can be vital in preventing potential suicide attempts. Furthermore, lack of perceived support for clients who needed help was often damaging, leading to feelings of isolation, rejection and contributing towards suicidal behaviour. However, in some cases clients appeared not to want help, making it difficult for staff to identify if their client would be willing receive extra support if provided.

9.5 Prevention: Talking, Confiding, Listening

Talking as a form of prevention was viewed by participants as being particularly effective. Talking was viewed as a mechanism for offloading feelings, emotions and concerns, and provided clients with an outlet when they felt suicidal. Both talking and being listened to helped to increase a client's sense of belonging, and often helped to reduce feelings of loneliness and isolation. In contrast times when there was perceived to be no one to talk to, or times when clients felt that there was no one to listen to them, often resulted in a build-up of suicidal feelings and eventual suicidal behaviour.

For example Sarah felt that Dave's inability to share his feelings with another person on the day of his near-lethal behaviour contributed towards his actions, whereas if he had an opportunity to express his feelings his suicidal thoughts would have reduced, making a suicide attempt less likely.

"Everything kind of came on top of him and he couldn't really verbalise it or cope with it." (Sarah)

Dave also felt this way, and said that Sarah herself could have been an outlet to share his thoughts, feelings and emotions with. Being listened to was viewed by both Dave and Sarah as a mechanism to reflect on thoughts and feelings which were difficult to make sense of alone, and was also perceived as an alternative form of release compared to self-injury.

"It's just if I had realised what was happening earlier and caught the signs and then got myself here to just have a chat with Sarah, that would have been her part played. Because she would have listened." (Dave)

Talking and listening was not only referred to in relation to the clients most recent near-lethal incident, but also as something that could have been useful at various stages in their life when they had felt suicidal, depressed or felt like self-harming. For example retrospectively Kathy felt that her continuous suicidal behaviour could have been prevented if she had been provided with the right support after the death of her father.

"I'll be honest with ya, I should have gone to counselling when my daddy died... But I didn't pick up. And where they kept throwing me nut nut tablets down my throat before I was self-harming. I think maybe if I, say I had somebody like you obviously to talk to I think that probably would have, because you are sitting there and you're listening. You're not throwing me with pills which makes people feel even worse, do you know what I mean, well in my case it does." (Kathy)

Kathy's emphasis on wanting someone there to listen to her rather than providing her with medication, demonstrates how powerful listening can be in terms of suicide prevention. Furthermore demonstrating the importance of dealing with these types of emotional issues when they arise. As mentioned in the previous theme Kathy's

offender manager Jane also felt that talking and listening could be a key form of support, but that Kathy would be unwilling to accept this help. However during her later follow up interview, after she had gone into detox, Kathy reflected on her previous unwillingness to seek help, even from trained professionals such as the Samaritans.

“I didn’t want to admit that I wanted help, I’m a tough cookie. But you do need help sometimes. It’s that picking up the phone call, do you know what I mean. I nearly phoned (Samaritans). And I thought, no... don’t, because if they had said something silly I would have took it as no you don’t want to help me. So I thought don’t even phone them. I know that that is mad because I know that I should phone.” (Kathy follow-up)

Not only has Kathy grown aware of her previous unwillingness to accept help, she also now emphasizes the possible role that talking can have in suicide prevention. Her use of the phrase ‘I know I should,’ indicates that she knew that talking may have helped to prevent her suicidal behaviour but at the time she felt too scared to talk out of fear of receiving a negative reaction from the listener. Similarly Harry felt that Freddie’s emotional wellbeing would be improved if he had an outlet for expressing his feelings. Harry felt that, for Freddie in particular, having the opportunity to talk through his feelings could reduce his suicidal feelings and encourage a more positive self-perspective.

“My main aim was obviously to listen to what he had to say about what he thought was paramount in his life, it was trying to convince in a sense, looking at the positive things that he was telling me and building on those. And offering him support more than perhaps he had in the past...” (Harry)

Freddie felt that probation had provided him with support by offering him the chance to talk with people that understood some of his problems.

“Being able to talk to someone, and someone who knows what they’re talking about as well is really.” And *“Just for the support yeah. Probation in itself not a great thing to be part of is it, sort thing. But the help that I’ve had has been fantastic.”* (Freddie follow-up)

However what was particularly striking about Freddie's account, and echoed comments made by other clients, was his feelings surrounding the end of his probation sentence, when he anticipated losing the support that probation had been providing him with. These concerns highlight the need for having access to continued support once the client has finished their probation sentence.

Interviewer: "How do you feel about coming to the end of probation?"

Freddie: "It's a losing, it's a loss, isn't it, its losing something, losing that stability if that's the word. Stability. But yeah I'm not, yeah losing that crutch will be quite hard for me, for the short term yeah. I won't have anyone else to talk to apart from the doctors." (Freddie follow-up)

All participants agreed that talking and listening could be used as a form of support and could help to prevent suicidal behaviours, and often both staff and clients commented on the importance of talking in relation to building trusting working relationships. While, two members of staff did not comment on this, their clients (Dan and Mike) did. For example during Mike's follow-up interview he said that he now felt able to talk to Christine about his depressive and suicidal feelings;

"When I you know, I do have my problems I speak to Christine a lot you know. I'm always on the phone to them if I've got a problem or things like that..." (Mike follow-up)

Similarly Dan felt that being able to talk and confide in someone may have prevented his near-lethal attempt, but that trust and non-judgemental listening were a crucial part of this process. When discussing this in relation to his offender manager Dan said that he could talk to Kevin, but that this would not be the same type of talking that he is able to do with people who he feels close to.

"Yeah I could that I could tell him (Kevin), I could come in and tell him. But, to talk to him, but I don't think it would really, do you know. It's different than talking to family... So I could just come and tell him, I feel bad, you know. But that would be about it. Nothing else."

Dan's distinction between 'telling' and 'talking' demonstrates that he would be able to 'tell' Kevin if he were feeling suicidal, but he does not feel that he could 'talk' to

him about the feelings and emotions that coincide with his suicidal state. This suggests that for Dan talking is more than just explaining how he feels, it represents being able to go beyond description of feelings and feeling able to express himself in more depth. Although, Dan's feeling of being unable to discuss these types of issue with Kevin may relate to his previous experience of feeling that probation were not concerned about his emotional state prior to his near-lethal attempt. Furthermore, Dan's reluctance to open up to Kevin about these personal feelings arguably relates to Kevin's professional role which Dan may not perceive to include discussions about these issues.

Summary: Having the outlet to express feelings through positive means such as talking, was viewed by the participants as playing a crucial role in suicide prevention. Being able to talk about feelings, concerns and worries enabled the client to unburden themselves and explore alternative methods for coping with these feelings, rather than through self-harm or suicide. However, having the capacity and willingness defined whether or not a client was likely to disclose and discuss their suicidal feelings. Some clients felt unable to share their feelings through fear of receiving negative reactions, or from feeling that the person listening would not take their feelings seriously. Being able to talk was often reliant on having a non-judgemental and trusted listener. Furthermore if a client and staff member were able to communicate with one another, both parties reported having a stronger working relationship which enabled honest discussions about both problems in general as well as suicide.

9.6 Discussion:

The focus of the current study was to explore suicidal behaviours by offenders serving community based sentences from dual perspectives, and to compare the accounts of the client who carried out the near-lethal incident with the account of the member of probation staff supervising them at the time. The findings of the current study extend the findings from the previous studies and broaden the knowledge on suicide by probation clients. Findings suggest that clients and staff are able to recognise signs and indicators of suicidal behaviour prior to the act, however there are barriers which prevent staff in particular from picking up on signs, including lack of disclosure by the client about previous suicide attempts. A second finding is centred on the

perceived causes and triggers for suicidal behaviour which include key stages in the probation process, as well as perceived lack of support. Lastly both clients and staff spoke of their views about what can be done to prevent suicide and how those who feel suicidal can be helped. The most useful form of prevention was seen to be through listening and talking. A summary of these findings can be found in Figure 8.

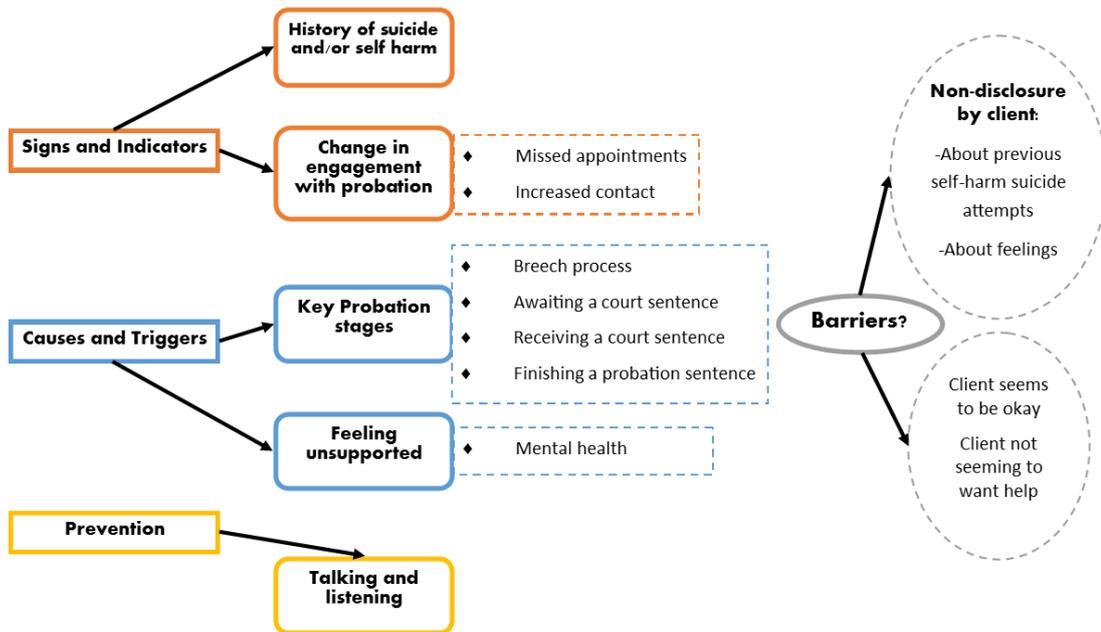


Figure 8: Study 4 findings summary diagram

Signs and/or indicators that the client was vulnerable to, or had intentions to carry out near-lethal behaviour were identified by participants but often varied between staff and client, thus highlighting the importance of multiple perspective research. Staff were often unable to pick up on some of the signs that the clients themselves had recognised, such as: feeling low leading up to the incident; not feeling able to carry out normal day-to-day behaviours and routines; missing probation appointments. The ability to recognise these signs before the incident, to some extent, related to how well the member of staff knew their client prior to the incident, and how willing the client was to disclose their feelings to that member of staff. However, this was not always the case, for example Sarah and Dave, who have a strong relationship, still revealed subtle differences in their perspectives regarding indication of risk. Dave felt that his increased contact with Sarah was a sign that he was feeling low, however, Sarah viewed this increased contact in a positive light as it provided Dave with more support. This example demonstrates that having a good professional relationship is important,

but that this must be also reinforced by having open discussions from both parties in respect to any concerns that they may have in relation to feelings and problems. Furthermore, where staff were trained to assess suicide risk, they were more able to identify vulnerable clients and pick up on potential signs.

NICE guidelines suggest that professionals working with vulnerable people who self-harm should aim to ‘develop a trusting, supportive and engaging relationship with the client’ (NICE, 2011). Although these guidelines are focused on self-harm, professionals who work with individuals who are vulnerable to suicide should also attempt to develop such relationships. The current study demonstrates that clients did not always share their feelings/concerns with staff, whether through lack of trust in the Criminal Justice System or because they did not feel that this was appropriate. Previous studies demonstrate that suicidal individuals find it difficult to disclose their suicidal feelings, and those that do disclose are more likely to speak to trusted individuals such as family members (Freedenthal & Stiffman, 2007; Robins, 1981). Furthermore it is argued that a lack of disclosure distinguishes between those who make serious attempts and suicidal ideators (Apter, Horesh, Gothelf, Graffi, & Lepkifker, 2001). Together with the current findings this highlights the need for professional relationship building techniques between clients and probation staff to aid suicide prevention.

The qualitative method used in the current study has allowed broader understanding to be gained in relation to the barriers that prevent people from disclosing to professionals, such as lacking trust and not perceiving this to be the role of probation. Additionally the current findings draw attention to the need to ask all clients about their feelings regardless of whether or not they have history of suicide attempts. For example, several participants commented on their past self-harm and previous suicide attempts yet had not disclosed these issues to staff, and having made these previous attempts may have provided them with the capacity to be able to put their suicidal thoughts into action (Joiner, 2005; O’Connor, 2011). Having transparency about issues such as suicide, self-harm, and depression are important, and are key to enabling staff to pick up on indications of suicide risk, providing the client with the confidence to disclose their suicidal feelings, and enabling both staff and clients to work together to reduce suicide risk.

Furthermore, most participants spoke of the perceived causes of the near-lethal incident. Commonly identified causes and triggers included key stressful stages in the probation process, as well as receiving little support for problems such as mental illness. Key stages which clients and staff considered to be most stressful and most likely to contribute to suicidal behaviour included: going through the breach process; awaiting a court sentence; the period shortly after receiving a community sentence; finishing and coming to the end of a community sentence. Reaching the end of a probation sentence in particular meant the loss of support that probation provided to the client. This was discussed by clients and staff, and needs to be considered when clients are reaching the end of their sentence. Support (and lack of) were discussed by both staff and clients, and were also found to be themes in studies 1, 2b & 3. These findings are comparable to the findings from studies on suicides of recently released prisoners, which suggest that recently released prisoners are often at an increased risk of suicide because they have lost the support and structure which the prison environment had previously provided them with (Binswanger et al., 2011; Pratt et al., 2006; Zlodre & Fazel, 2012). When offenders leave prison they are sometimes losing their only source of support, whereas offenders in the community should have access to multiple channels of support which are not solely focused around the Criminal Justice process. However, the current study indicates that despite having other channels of support, probation is a dominant provision for clients and often relied upon. Thus staff should endeavour to draw attention to external sources of support, which will also help clients to overcome barriers such as trust, and could help their transition period when finishing their probation sentence, in turn helping to reduce the risk of further attempts.

It is evident from the current study that signs and causes of suicidal behaviour are often complex and difficult to pinpoint. However, both clients and staff felt that support via talking and listening is likely to decrease the risk of suicide, as well as help staff to identify those clients who may be vulnerable to carrying out these types of behaviour. Whereas having no one to talk to about their feelings was viewed by clients as making their situation and emotional state worse, with many referring to 'bottling up' their feelings or reaching the 'boiling point.' A recent survey (MIND, 2014) of individuals waiting for access to talking therapies (N=2000) found that 40% of these individuals harmed themselves whilst on the waiting lists, and 1 in 6 people attempted suicide.

The outcomes of this research, along with the findings from the current study demonstrate the urgent need for vulnerable people to have access to forms of listening, an issue already recognised in prison settings (Snow & Biggar, 2006). Forms of listening support, such as the Samaritans, are available in the community to clients whilst serving their Probation sentence, but also, and importantly, are still available when they have finished their sentence. It is therefore essential that staff encourage their clients to access these forms of support whilst they are still serving their community sentence in order to overcome barriers regarding trust, and potentially increase the likelihood that they will continue to use this support in the future.

A dual perspective form of qualitative analysis has not previously been used to understand the experience of a suicide attempt or a near-lethal incident, therefore the findings from the current study are helpful in highlighting how this type incident is experienced by different individuals involved. This study is however limited to the experiences of the client and the member of staff supervising them, and does not include all parties experiences of the incident such as family, friends, work colleagues who all may hold important information about the suicide attempt. Further studies may wish to include the follow-up interviews of both the client and the staff, and/or other parties involved such as family members.

This type of methodology enables researchers to not only learn about a set behaviour but also about the relationships between the parties who experience the behaviour, and could be employed by other qualitative researchers who are interested in experiences that involve relationships between a number of different individuals. This study for example, demonstrates that building strong professional relationships is key to suicide prevention, as strong relationships can help to increase trust and confidence, and give both parties the ability to voice their feelings and concerns with one another. Furthermore, it is clear from the three previous studies, that probation clients are vulnerable to suicidal behaviours, however the current study highlights how being in the community exposes clients to a range of factors which may make them even more vulnerable to suicide, and the short amount of contact staff have with probationers can restrict their ability to recognise the signs that clients are vulnerable. Therefore clients having access to a range of sources of support should be encouraged by staff, and these forms of support should be also be accessible when a client finishes their Probation sentence.

10 Chapter Ten: General Discussion

10.1 Introduction

Suicide is a complex and multifaceted problem which effects individuals from all backgrounds, making prevention a global focus. However, some populations are more at risk of completing suicide than others. Offenders that have received community based sentences are one such group, although to date, little research exists in relation this problem (see Chapter 2). The current work sought to bridge this gap in knowledge by employing a qualitative approach to understand the perceptions and experiences of those who have carried out a near-lethal suicide attempt whilst serving a community based sentence. The overall aims of the present research were:

- To explore the suicidal experience from the perspective of offenders serving community sentences using an in-depth qualitative approach.
- To understand how their perceptions of these experiences may have changed once given time to reflect and discuss their experience.
- To explore the perspectives of staff managing these offenders and to gain their insight into issues such as suicide risk, management and training.
- To gain new insights into the problem of suicide by offenders serving community sentences by employing a dyad approach for exploring the experiences of those who have made near-lethal attempts and the staff supervising them at the time.

The studies presented in this thesis should be considered as elements of an overall research programme. Therefore the current chapter will integrate the findings of the five presented studies. An overview of the five studies and their main findings is first provided. The key findings of the overall research and its limitations are then discussed, drawing attention to the novel aspects of the research. Lastly, implications and recommendations are presented, with final concluding points.

10.2 Overview of Study 1 and key findings

Study 1 consisted of interviews with probation staff working in London who had direct contact with probation clients. This is the first study to be carried out with probation

staff in England which sought to understand experiences of managing clients who have carried out suicide, attempted suicide and self-harmed (Mackenzie, Cartwright, Beck, & Borrill, 2015). The interviews focused on how staff felt about managing these behaviours, what they perceived to cause these types of behaviour, if they felt adequately trained to deal with these issues, and their views regarding staff support. Findings suggest that staff sought to understand their clients' behaviour and tried to make sense of it by referring to their knowledge about mental health in general or knowledge from their training. Occasionally lack of training resulted in negative stereotypes. Yet, a number of barriers existed for taking part in training such as having limited time to engage. For staff, the nature of suicide was viewed as being unpredictable and as having multiple causes. The unpredictable nature of suicide often presented staff with a sense of helplessness. Some staff felt able to support their clients through listening or through referrals for specialist help, although those who lacked training and experience felt less equipped to provide support. Staff felt emotionally affected by these issues and referred to being able to gain support from their managers or through a telephone counselling service. However, this support was not always perceived to be immediately accessible and therefore they reported primarily relying on peers to offload and unburden themselves.

Overall Study 1 fills the gap in knowledge regarding UK probation staff experiences of dealing with suicidal probation clients. Findings indicate that staff want to understand suicide in order to provide the best support to their clients, but a lack of training and knowledge hindered their ability to do this. This led to negative effects on staff who often required support from colleagues after an incident.

10.3 Overview of Study 2a & 2b and key findings

Study 2a & 2b focused on seven probation clients who had made a near-lethal suicide attempt whilst serving a probation sentence in London. Data for Study 2a was gathered through psychological measures and a psychiatric interview with an aim to gain a more in-depth understanding of client individual differences, especially in relation to their feelings and behaviour. Key findings suggest that all but one participant may have a psychiatric illness and, these participants require further investigation into personality disorder, have impulsive tendencies and may find it difficult to identify and express their feelings.

For Study 2b clients took part in in-depth interviews about their near-lethal experience, with particular focus on how their behaviour was perceived to relate to their probation sentence. Findings indicate that clients' suicidal states were experienced in relation to a number of traumatic losses, including the loss of their loved ones through bereavement. Moreover at the time of their attempts clients felt that they had lost control over their lives and in many cases their mental state. These experiences were accompanied by struggle and confusion about their identity. When clients felt suicidal they often struggled to open up to others about their feelings, despite discussing how talking about their problems would have helped them think more clearly about alternatives to suicide and helped them to unburden their feelings. The potential difficulty they faced with trying to explain and describe their feelings to others was an issue highlighted by their high alexithymia levels. Furthermore, clients found it difficult to share their feelings with authority figures which frequently related to their lack of trust in others and the criminal justice system. However, when trusting relationships were established this enabled clients to speak more openly about their concerns which eased their suicidal feelings. Additionally, clients also spoke of the importance of having a meaningful life. If clients felt a sense of meaning and purpose in their lives, such as being valued by their family, then they were less likely to feel suicidal, whereas near-lethal acts occurred at times when they lacked meaning and purpose.

Overall Study 2b suggests that participants experienced a lack of control over their mental state and life situation during the period prior to their attempts. Clients were struggling with a number of issues but having the opportunity to talk about their feelings and concerns was perceived as being helpful. However, the clients' ability to share their feelings was often hindered by their lack of trust in other people and concern about judgements from others.

10.4 Overview Study 3 and key findings

Study 3 sought to understand how participants felt about their near-lethal attempts once given time to reflect and whether or not they went on to make further attempts, and if so, the reasons for this. Follow-up interviews were carried out with participants approximately three months after their initial interviews. Of particular interest was whether participants' perspectives about their suicide attempts had changed since their original interviews and the reasons why. Additionally, the study explored differences

between the accounts of those who had gone on to make further attempts and those who had not. Findings demonstrate that the suicidal state was experienced as part of an on-going process which continued after the participants' initial interviews. The period of time prior to their attempts was characterised by a slow build-up of negative feelings and problems. Frequently during these times clients would turn to maladaptive coping mechanisms to block out or manage their stressful and often traumatic experiences and feelings. In contrast, the suicidal act itself was perceived as quick, impulsive and unpredictable. The period after the suicidal act then began to slow down giving participants time to process their emotions. Significantly, clients who did not go on to make further attempts described feeling supported and having someone to listen to them. Whereas clients who made further attempts were still struggling to share their feelings with others, often out of lack of trust and fear of judgement.

Overall findings suggest that the suicidal act was quick and impulsive, whereas the descent into suicide was slow and gradual presenting opportunities for early intervention. The use of maladaptive coping mechanisms and maladaptive ways of expressing emotions amplified their difficulties. In contrast receiving support from friends and professionals for negative coping mechanisms and suicidal feelings helped to prevent further attempts. Furthermore, this support provided clients with positive social experiences and an opportunity to share their thoughts.

10.5 Overview of Study 4 and key findings

Study 4 sought to draw out the potential differences and similarities between probation staff and probation clients perspectives about near-lethal attempts. A dyad approach was used, drawing together understanding of the clients' near-lethal acts from the accounts of both the client and a member of probation staff supervising them at the time. Key findings demonstrate that having strong client-staff relationships are helpful in suicide prevention, but are not always possible. Participants identified a number of barriers that stopped clients from disclosing their suicidal feelings and prevented them from seeking help, such as lack of trust. Lack of disclosure made it difficult for staff to identify their client's suicidal state, even when they had prior knowledge about a client's history of suicidal behaviours. Particularly significant about these findings was the group of individuals who were not deemed to be at risk by staff due to having no prior history of suicide or self-harm, and non-disclosure of their suicidal feelings.

This group appeared to be a ‘hidden at risk group’ who went unnoticed and whose suicidal acts were perceived as the most shocking. Additionally, it is clear that certain stages in the probation process are particularly stressful for clients and are perceived as being linked to triggering suicidal behaviour. These stages include: shortly after starting their probation sentence; awaiting a court sentence; during the breach process; and at the end of their probation sentence. Furthermore, supporting the findings of all studies in the current research was the finding that talking and listening were viewed to be a vital form of support and prevention.

Overall, findings suggest that it can be difficult for staff to identify those at risk of suicide, frequently due to lack of disclosure by clients. However, there are key stages in the probation process where clients may be at an increased risk of suicide which staff should be aware of if suicide is to be prevented. Furthermore, confirming findings of studies 1, 2b, & 3, talking and non-judgemental listening, as well as having support, were perceived to be vital forms of prevention. A markedly important implication of this study is how potential barriers can be overcome (see section 10.8) in order to provide this support.

10.6 Overall key findings of research

The following section draws on the key and novel findings from the research overall. These findings are discussed in relation to prior research with comments on how the current research has developed the literature, added to what is already known about suicide by probation clients, and contributed to new understandings of this issue.

10.6.1 The unpredictable nature of suicide

Suicide was understood as being largely unpredictable by both staff and by clients. Paradoxically both clients and staff spoke of how to prevent it. In this sense it was the suicidal act that was thought to be unpredictable and impulsive (Study 2a & 2b), rather than the build up to suicide which was instead characterised by a perceived slowing down of time (Study 3) (Neuringer & Levenson, 1972). Importantly these findings suggest that a slow build-up period does present opportunity for interventions, such as providing a source of non-judgemental listening or help with maladaptive forms of coping, if clients are able to overcome barriers regarding disclosure. Overall, suicide was characterised as being part of a process of on-going events and traumas rather than being attributed to just one factor, reiterating the complex nature of suicide and

falling in line with process theories of suicide (O'Connor, 2011). However, what was novel about the current research was the identification of key stages of the probation process where clients appeared most vulnerable to stress, anxiety and depression, and consequently more likely to attempt suicide. These stages included: the beginning of a probation sentence; the end of a probation sentence; whilst awaiting a court sentence; during the breach process.

The beginning of a probation sentence: This time point reflects the vulnerability also demonstrated in prisoners who have just entered into their prison sentence (Sattar, 2001). However, the current research highlights the unique perceived causes for this vulnerability specific to probation clients. Unlike prisoners who may be concerned about issues such as adjusting to prison life and losing contact with their families (Borrill, 2005; Marzano et al., 2009; Sattar, 2001), probation clients were primarily concerned with loss of control over their social situation and emotional state. For many clients starting their probation sentence confirmed a loss of control over their life, reaffirmed their negative self-doubts or invoked feelings of failure. Overall the beginning of a probation sentence was a distinctly distressing time for clients, and a time when support from probation and other agencies is vital (see section 10.8).

During the breach process and awaiting a court sentence: The breach process and awaiting a court sentence is, according to the current research, a particularly stressful time for clients. The main concern for clients during these stages were their fears regarding sentencing. Frequently clients were worried that they would receive a prison sentence. Fears regarding prison included the anticipation of the prison environment changing their identity and losing contact with loved ones. Previous research has demonstrated that prisoners and those on remand also have these concerns (Borrill, 2005; Marzano et al., 2011; Rivlin, Fazel, Marzano, & Hawton, 2011; Towl, McHugh, & Snow, 2000), however the current research adds to this literature by demonstrating that probation clients concerns can contribute towards suicidal feelings. Furthermore, prior research on suicide by probation clients has tended to focus on establishing prevalence rates rather than understanding what clients perceive to cause suicidal behaviour. The current research has therefore provided novel insights into the perceptions of clients regarding their suicidal behaviour. In particular, how the breach process and awaiting a court sentence causes worry, concern and anxiety, increasing the risk of suicidal feelings and behaviours.

The end of a probation sentence: Reaching the end of a probation sentence was an experience that was viewed by clients and staff as linked to their suicidal behaviour, and has not previously been discussed in the literature. Whilst similar to findings of prison studies which highlight the increased risk of suicide in recently released prisoners (Binswanger et al., 2011; Kariminia et al., 2007; Pratt et al., 2006), the current research shows that probationers who have recently completed their probation sentence could be at an increased risk of suicide. Coming to the end of a probation sentence was experienced as challenging and anxiety provoking. Instead of providing clients with freedom as might be expected, clients were worried about losing the support provided by probation. Particularly striking were clients' fears about losing the relationships that they had built with probation staff; which were deemed particularly important because they were one of only a few sources of support in the clients' life at that time. These findings have important implications in terms of providing care to clients who are reaching the end of their probation sentence, an issue that is discussed further in section 10.8.2.

10.6.2 Relationships and support

It is clear from the current research that staff-client relationships play an important role in suicide prevention. Having someone to confide in and share feelings with was viewed as important. However, strong professional relationships between staff and clients did not necessarily mean that clients would disclose their suicidal feelings. Instead a number of barriers prevented clients from disclosing their feelings.

Barriers: The overall research findings indicate that staff capabilities of picking up on client risks of suicide are often hindered by their client's inability to or unwillingness to disclose their feelings. Findings suggest that certain barriers prevent client disclosure. One barrier included the client's lack of trust in authority figures and concerns regarding being judged negatively by others, also found in previous research (Ganzini et al., 2013; Howerton et al., 2007). However, a novel aspect of the current research is how these barriers can be overcome and trust can be built specifically in probation settings. For example, if clients felt cared for by staff and felt that staff were concerned for them, clients were more likely to open up and disclose. Yet, this is not always practical given staff resources, discussed further in section 10.8.2. Additionally, a second barrier included staff perceptions of their client's risk. Previous research indicates that probation staff are more likely to consider individuals who have

made past attempts to be at risk of making further attempts (Cook & Borrill, 2013). This perception was confirmed in the current research. However, the use of a qualitative approach has widened the understanding about what this means in practice for those managing potentially suicidal clients. A ‘hidden group’ of individuals who failed to disclose their suicidal feelings and had no history of past suicide attempts, self-harm or suicidal feelings were often missed in risk assessments and staff were unlikely to ask about possible suicidal feelings. A further compounding barrier for clients disclosing their suicidal feelings was their potential inability to identify and express their feelings, as indicated by their high alexithymia levels. These findings have important implications for probation staff working with clients and suicide prevention strategies (see section 10.8).

Talking, listening and support: Unlike previous research on suicide by probation clients (Clark et al., 2013; Gilbert & Allan, 1998; Herbert, 2010; Paton & Jenkins, 2005; Wessely et al., 1996) the qualitative approach used in the current research, was able to shed light on what can be done to prevent suicide by probation clients. A key form of prevention involves providing clients with support and an opportunity to talk through their feelings, enabling them to consider alternative solutions to their problems rather than suicide and maladaptive coping (Joiner, 2005; O'Connor, 2011; Shneidman, 1993). Furthermore it was demonstrated from the follow-up interviews that those who received professional support, and support from friends and family, were less likely to go onto make further attempts. Having a source of support enabled clients to re-evaluate meaningfulness and purpose (Study 2b), as well as developing a sense of belonging and acceptance rather than judgment. Having access to non-judgmental forms of listening is an important suicide prevention strategy in the general population. However, the current findings highlight the difficulties of providing this support specifically to probation clients. The barriers outlined above prevented clients from obtaining support, and this was further complicated by the clients’ complex characteristics, such as possible personality disorders and an increased likelihood to act impulsively. An important issue to be noted here was the high alexithymia scores of the clients, which may have initially prevented them from identifying and discussing their feelings with others. However, the current findings suggest that this can be overcome if appropriate non-judgmental forms of support exist. Non-judgmental listening has been demonstrated to be an important way of preventing and

reducing suicide in prisons. The prison listener scheme was introduced in Wales in 1991 and continued to grow, eventually being initiated across England (Davies, 1994; Dhaliwal & Harrower, 2009). This has yet to be explored in a probation sample, despite probation clients having more access to already existing listening services such as the Samaritans. This is an important finding, as it demonstrates for the first time the difficulties that probation staff might face when trying to provide support to their clients, thus having important implications for suicide prevention strategies in probation settings (discussed further in section 10.8).

10.6.3 Staff training

The current research has for the first time enabled the identification of concerns that probation staff have about training for managing suicide and self-harm. Participants primarily felt that they had not received sufficient training to deal with these types of issues. Furthermore, it was felt that training should be mandatory for all probation staff with a specific focus on suicide and self-harm rather than mental health in general. Staff also reported barriers to attending the non-mandatory training course run by LPT, including having to prioritise other training and having heavy caseloads making time off for training difficult. These findings support comments made by the Howard League of Penal reform who highlight the need for probation staff to be sufficiently supported in their management of suicidal offenders and those with mental health needs (Gelsthorpe et al., 2012). A lack of training hindered staff in two main ways; 1) staff did not have the confidence to deal with these types of behaviours and often questioned whether their actions were appropriate, correct or could cause further stress to the individual; 2) staff were unaware of when a person might be at an increased risk of suicide and therefore unlikely to pick up on the signals that a client was feeling suicidal.

Lack of confidence: When staff had not taken part in suicide and self-harm training they lacked confidence in supervising those who attempt suicide and self-harm. These findings also reflect the concerns of prison staff who have reported a lack of confidence in knowing how to manage suicide and self-harm by offenders (Short et al., 2009). Changes to the training that prison staff receive regarding suicide and self-harm have been implemented to ensure that all staff are adequately able to deal with these types of issue (Ministry of Justice, 2013a), yet this is still to be implemented in probation settings. If, as suggested from the current findings, probation staff also have

similar concerns about training and lack confidence in dealing with these types of behaviour then it is imperative that mandatory training be a high priority for both the NPS and CRC's. Implications are discussed further in 10.8. Previous research has found that training on suicide and self-harm can increase confidence and reduce stereotypical attitudes (Daniel, 2006). Furthermore, a training course set up to provide staff with knowledge about mental health in general has proven to be successful (Brooker & Sirdifield, 2009), suggesting that a suicide and self-harm only course is also likely to be viable.

Inability to recognise risk: The current research findings suggest that staff struggled with identifying who might be at risk of suicide, which frequently related to a lack of training. The Offender Assessment System (OASys), an assessment tool used to inform sentences and management of risk, is designed to aid staff in the assessment of risk to self by suicide or self-injury (Mair, Burke, & Taylor, 2006). However, very few staff in the current research mentioned this assessment, this may be due to issues highlighted by prior research in relation to ease of use (Mair et al., 2006), although future research should consider the reasons for not using in more detail. Consistent with findings from studies with prison staff (Kenning et al., 2010; Short et al., 2009), probation staff were likely to refer to inconsistent and stereotypical explanations for their clients behaviour. These findings offer an explanation as to why staff may find it difficult to pick up on signals that their client is at risk of suicide. A unique finding of the current research lies with the difficulty staff experienced in identifying their client's risk. The use of a dual perspective approach allowed for the perspective of both staff and clients to be considered. Staff often struggled to identify a client's negative and maladaptive forms of coping as risk factors for suicide, instead attributing these forms of coping to negative stereotypes. Clients on the other hand felt that these maladaptive strategies, such as alcohol use, were related to and fuelled their suicidal spirals. These findings provide support for prior research carried out with probation staff, which also found that staff do not predict client suicide risk through their use of alcohol or their lack of social support (Cook & Borrill, 2013). Conversely these issues were perceived by clients as being linked to their near-lethal incidents. The use of the client perspective in current research provides new insights into what can cause, trigger or contribute towards suicidal behaviours, and how staff-client views may differ.

10.7 Methodological strengths and limitations

Despite the current research shedding new light on the issue of suicide by probation clients, the findings must be considered in the context of a number of limitations. Therefore, the current section outlines limitations and strengths of the research for consideration of the reader, as well as considerations for future research.

IPA: The use of IPA developed a detailed and rich understanding (Smith et al., 2009) of probation clients experiences of near-lethal suicide. A key strength of employing an IPA methodology was its appropriateness for the client sample. IPA endorsed a focused analysis of the accounts of the clients, drawing on their experiences and feelings on a number of levels, and led to a deeper understanding of how they perceived their suicidal actions to relate to their probation process. Furthermore, IPA was particularly fruitful for gaining knowledge from the client sample, which is often difficult to gain access to and recruit (see section 4.3). IPA involves subjective interpretation on the part of the researcher, therefore the findings are only one possible explanation and other interpretations may exist. A strength of the current research is that themes were checked for consistency, accuracy and representation by two other researchers (Dr Jo Borrill and Dr Tina Cartwright). Furthermore, the researcher provides a reflective account (see chapter 3) where personal views about the research are acknowledged, enabling the reader to understand the potential impact of the researcher's position on the research findings.

Dual perspectives: A further strength of the current methodology was the employment of a dual perspective approach which strengthens the analysis by providing a richer more detailed account of the event (Ciclitira et al., 2012; Kenning et al., 2010). Probation clients are a difficult to recruit sample, thus considering only one perspective could lead to some information being missed. It is therefore interesting to consider how different subjective accounts about the same event may interact or differ to one another (Harden et al., 2010). For example, the use of dual perspective analysis in the current research enabled the identification of how staff misinterpret clients' behaviours and how staff accounts differ to those of their clients. IPA researchers suggest the use of multiple perspectives can lead to a more comprehensive understanding of an experience and can help to triangulate the analysis (Guion et al., 2011; Larkin et al., 2006; Reid, Flowers, & Larkin, 2005). The use of follow-up interviews added another perspective to the research, which developed the

understanding of why probation clients attempt suicide. Follow-up interviews are particularly helpful for understanding complex behaviours such as suicide (Kleschinsky et al., 2009) and in the current research have allowed for the identification of important findings such as what can be done to prevent suicide.

Near-lethal suicide: Arguably a limitation of the current study is its analysis of suicide using participants who have not completed suicide, and may not have the same motivation or intentions as those who have completed suicide. However, a study of near-lethal attempts enabled information to be gathered that would not be possible if employing autopsy methods or focusing retrospectively on completed suicide (Hawton, 2002; Rivlin et al., 2012a). For example, it would be impossible to gather information about how clients understand their experience of feeling suicidal and how they perceived this to relate to their probation process. Information such as barriers for support and vulnerable stages in the probation process may have been missed. Despite being a distinct behaviour near-lethal methods are characteristically close to completed suicide therefore are useful and viable for investigation into suicide (Hawton, 2002; Klonsky & May, 2014; Marzano et al., 2009).

The use of Psychological and Psychiatric measures: A notable limitation of the current research is the small sample size, making inferential testing in relation to the psychological and psychiatric measures unfeasible. Thus these measures can only provide an understanding of this particular group and cannot be generalised to wider populations. However, a strength of the current research is that the use of these psychological and psychiatric measures provided a deeper understanding of individual differences in the client sample, as well as insights into each individual case and why they felt or behaved in particular ways. For example, clients screened as having high levels of alexithymia, suggesting that they may face difficulty in identifying and describing their feelings (Bagby, Parker, & Taylor, 1994) which may cause them difficulty in disclosing their suicidal feelings to probation staff. Arguably these difficulties may have affected the participant's ability to express and talk about their feelings to the researcher. However, the use of in-depth interviews helped to draw out their key experiences and feelings. Furthermore, a number of techniques were used by the researcher to ensure that participants were able to express their feelings accurately. Participants were not put under pressure to talk quickly – giving them time

to relax and think about what they wanted to say. Furthermore, the researcher used prompts where necessary to probe clients about supplementary details if appropriate.

The use of measures revealed that the client cohort also met the threshold for needing further investigation into personality disorder (Pluck et al., 2012). PD can contribute towards both suicidal and self-harming behaviours, can present challenges for staff working with them (Hayward, Moran, Hayward, & Moran, 2007; Shaw, Minoudis, Hamilton, & Craissati, 2012), and thus may affect the way in which these clients are managed by staff. Additionally, given the number of participants in the current client sample that screened for PD, as well as in previous research populations (Pluck et al., 2012), it is clear that personality disorders are an important issue which staff should be aware of when supervising probation clients, particularly in relation to suicidal behaviours. Although not the focus of the current research programme, it would be helpful for future research to focus on personality disorders in probation samples and to establish how these relate to suicidal behaviours.

Due to the lack of previous research with probation populations very few measures have been validated for use with this group, therefore the current research used measures which have previously been used with other offender groups. For example, the TAS has been used in prison settings (Kroner & Forth, 1995) and with juvenile probation clients in the USA (Donenberg, Emerson, Mackesy-Amiti, & Udell, 2014), but is yet to be validated for use within a UK probation population. Thus, further research could seek to validate the effectiveness for the TAS in accurately assessing alexithymia in probation clients, as well as establishing the links between alexithymia and suicide in probation clients. On the other hand both the SAPAS (Pluck et al., 2012) and the MINI (Brooker et al., 2011) have previously been used in UK probation samples. Additionally, the BDI has not previously been validated within a probation sample, which may account for the discrepancy between the BDI and MINI with regards to depression. Yet it has previously been suggested that the MINI may be oversensitive in terms of assessing depression (Rivlin et al., 2010).

Recruitment & generalisability: A potential limitation of the current research was the location of the interviews. Most interviews, apart from telephone interviews, took place in probation facilities which may have influenced the participants' willingness to disclose. However, all interviews took place in quiet rooms without any

disturbances and clients were assured that their accounts would remain anonymous. Furthermore, in terms of the small number of telephone interviews employed, prior research indicates that telephone interviews are just as reliable for qualitative interviewing as traditional face-to-face methods (Burke & Miller, 2001; Carr & Worth, 2001).

The sensitive nature of the current research, as well as the population of interest made the recruitment process very difficult (see 4.3). Staff acted as gatekeepers for recruitment of the client participants therefore these individuals who took part may have staff supervising them who are understanding and interested in suicide prevention. In which case caution should be taken with generalising the results, particularly in terms of findings regarding relationships, as staff willingness to refer clients may reflect their positive relationship with their client and feeling comfortable enough to approach them about the study. Secondly, due to recruitment issues all studies consisted of small numbers of participants. However, qualitative research, in particular IPA, commands the use of small samples in order to dedicate time to grasping the true nature of an experience (Baker & Edwards, 2012; Smith, 2004). Although it is difficult to generalise the findings of a study that employs such methods, the aim of this study was not to generalise but instead to focus on the accounts of staff affected by the near-lethal behaviour of the probation client and the client themselves (Smith, 2004; Wilstrand et al., 2007).

The current research concentrated on one probation area (London) therefore future research could consider expanding to focus on different probation areas. The focus on London makes it difficult to generalise to other probation areas particularly rural locations where differences in environment may impact on suicidal behaviours and/or the probation process. For example, there may be a greater distance to travel to a probation office and this may cause difficulties for clients to fit their appointments around employment. Moreover the client sample used in the current research consisted mainly of male participants; given the differences in suicidal experiences of males and females, a direction for future research would be to consider how male and female probation clients experience near-lethal attempts and whether there are differences between these experiences. Having said that, the current sample is likely to represent near-lethal suicide in probation settings, as more males are serving community sentences compared with females (Ministry of Justice, 2014) and males in

general, are more likely to make more severe attempts than females (Varnik et al., 2008).

Lastly, an important issue to note is that the data collection for the current research took place before the changes to the probation system, therefore allowing the researcher access to high, medium and low risk offenders (rather than just the high risk offenders now supervised by the NPS). Having access to all types of risk group has led to some important implications which are discussed in section 10.8.

10.8 Implications and recommendations

The current section outlines the implications of the research findings, as well as drawing on recommendations for future best practice. Implications for research and practice are discussed.

10.8.1 Implications for research

Implications for researchers focusing on suicide: Findings from the current research have significant implications for other researchers investigating attempted suicide and near-lethal attempts. Some researchers are concerned that talking about suicide so openly may be too emotional distressing for participants (Lakeman & Fitzgerald, 2009). However, the current research adds to the relatively new approach to suicide research which encourages researchers to monitor the emotional wellbeing of their participants (Biddle et al., 2013; Rivlin et al., 2012b). Participants rated their emotional state using a visual analogue scale prior to and after the interview. All participants mood ratings increased (see appendix 5). A number of participants also commented on the positive experience of taking part in the study and how this provided a non-judgmental form of listening, comparable to that mentioned in their interviews as being important for suicide prevention. These findings are consistent with the growing body of evidence that suggests that if suicide research is carried out in an ethically sensitive manner then participants are likely to have positive experiences (Biddle et al., 2013; Rivlin et al., 2012b). Thus, it is encouraged that research on this topic continue, providing that it is carried out sensitively, and future research of this nature should also seek to monitor participant wellbeing.

Implications regarding offence type: Little research has made a link between low risk offenders and suicide. Research that has been carried out on offenders has traditionally focused on high risk offenders, particularly their risk of violence (Conner

et al., 2001; Gvion & Apter, 2011; Webb et al., 2011; Webb et al., 2013). However, all but one participant in the current sample were charged with low risk offences. This is consistent with the ongoing analysis of deaths in one probation area that indicates that suicide by probation clients is not linked to the severity of their index offence (Borrill & Cook, 2015). This has significant implications as it is now the responsibility of the community rehabilitation companies to manage these low risk offenders. Therefore it is essential that community rehabilitation companies make training for staff a priority and suicide prevention is a key policy issue. The suicide training that currently exists is run by the NPS London and therefore it is unclear whether this training will be extended to those working for the community rehabilitation companies, and therefore the staff managing clients with lower index offences.

10.8.2 Practical implications for probation

Figure 9 and Figure 10 provide an overview of the key implications for suicide prevention in probation settings. Key findings of the research suggest that prevention can be achieved through non-judgemental listening and by providing clients with support for their maladaptive ways of coping and expressing emotions. However, three main barriers exist that limit the likelihood that these prevention techniques can be achieved. Firstly, clients were unlikely to disclose their suicidal feelings to probation staff because of their lack of trust in authority and their fear of being judged. Secondly, staff occasionally struggled to identify clients at risk of suicide, due to clients' non-disclosure and lack of prior suicide attempts. Thirdly, staff have limited time and resources to ask all clients about suicidal feelings, particularly if they have not screened as at risk during their initial risk assessment. It would be impractical to suggest that staff spend time asking all clients about risk of suicide. However, a number of recommendations can be made from the current research to overcome these barriers:

- ***Collaboration with external agencies:*** Having trusting relationships with staff and having someone able to offer non-judgmental listening appears to be a key way to help alleviate suicidal feelings. Although, often staff do not have the capacity/resources to offer this support and clients do not always feel that they can trust 'the system.' Further research would be helpful for tailoring and assessing new ways to support these clients. However it is recommended to overcome these issues that probation make use of already existing resources,

drawing up partnerships where possible with agencies such as the Samaritans, Mind, May tree, and community mental health nurses. Community mental health nurses may be of particular importance for those individuals with psychiatric conditions and psychological conditions (Brooker & Sirdifield, 2007), such as personality disorders and depression (as highlighted by the interviews and measures). In addition community nurses may be able to support those clients using maladaptive coping strategies, such as alcohol to repress negative emotions. It may also be appropriate to refer clients to bereavement support agencies, such as Cruse, given the difficulty that this group faced with managing loss. Furthermore it is recommended that the development of a listener scheme similar to the one offered in prisons, but tailored to suit the needs of a probation population be considered. The Samaritans already have outreach teams who have set up partnerships with specific agencies such as prisons, schools and hospitals (Hurtig, Bullitt, & Kates, 2011). Therefore it is likely that this type of outreach service would also be applicable to probation settings. The service that the Samaritans provide is non-judgemental and confidential, which could help to alleviate the concerns that clients have in relation to trust and feeling judged. Additionally providing face-to-face support has been demonstrated as a key way to prevent suicide and therefore has implications for some community rehabilitation companies who plan to replace client-staff appointments with electronic monitoring (Napo, 2015). Although, it is important to note that despite non-judgemental listening being a useful source of support for the general population (Mishara & Daigle, 1997), schemes do need to be designed specifically to meet the needs of probation clients. For instance such schemes need to tackle the barriers outlined above, as well as ensure that those who are providing the support are aware of the problems that this specific group face.

- ***Providing support details to all clients:*** Some participants had not experienced suicidal feelings prior to their probation sentence and staff often referred to their suicide attempts as unexpected and out of character. This 'hidden' group of clients are therefore arguably most at risk, as their suicidal decline is less likely to be spotted and this leaves less time for intervention. However, findings from the follow-up interviews also suggest that the suicidal

state is experienced in relation to a perceived slowing down of time and a gradual build-up of tension, concern and worry. It is therefore essential that during this time frame staff intervene by providing sources of support before the client acts impulsively to make a suicide attempt. Therefore, it is recommended that all clients are signposted to sources of support such as those outlined above, rather than only those individuals deemed at risk of suicide. Even if a client does not disclose any information about suicidal feelings/behaviours and/or self-harm during their initial Offender Assessment Systems (OASys) risk assessment, information should still be provided. It may also be useful to display information about sources of support in client waiting areas.

- ***Support after probation:*** The current research highlights the need to support individuals who are approaching the end of their probation sentence, as well as after their sentence is completed. Currently probation contact meetings are reduced incrementally, yet little support is offered to those who have finished their probation sentence. Due to limited resources and financial costs it would be impractical to provide every ex-probation client with individual support after sentence completion. However, a possible solution could be to provide clients with opportunities for ‘touch point’ contacts, such as being able to make telephone contact with a probation mental health worker for support if needed after sentence completion. Staff will then be able to refer these ex-clients to appropriate external agencies. Furthermore, as outlined above, if staff encourage clients to access these external sources of support during their probation sentence, it is likely that clients will also make use of them once their sentence is completed.
- ***Raising awareness of vulnerable stages:*** It is clear from the current research that clients’ experiences of specific time points during their probation process induced feelings of stress and depression, and caused concern, worry and fear. Staff should be made aware that these key time points may induce these feelings in clients. Furthermore, this presents another opportunity for staff to provide clients with details of sources of support, as well as to ask clients directly how they are feeling about this stage in their probation process.

Moreover, clients can be encouraged to access the sources of support outlined above when coming to the end of their probation sentence. Therefore, the support that is being provided by probation can be replaced by more specialist agencies and continue once the client ends the sentence.

- ***A need for consistent training:*** Staff consistently mentioned not feeling qualified to deal with these types of behaviour. Staff should be given consistent non-optional training in both community rehabilitation companies and the NPS. Training helps to increase confidence and prepares staff with accurate knowledge for dealing with self-harm and suicidal behaviours. Therefore it should be consistent for all professionals working within probation settings. A prominent issue found in the current research was the difficulty that staff faced in identifying individuals at risk of suicide. Training should therefore focus on how to identify someone who may be at an increased risk of suicide, as well as how to manage someone who reports suicidal feelings. Additionally, training should focus on both suicide, attempted suicide, and self-harm, as well as highlight maladaptive forms of coping that these individuals often employ. Many clients in the current research described their use of maladaptive coping to block out memories and painful experiences. However, these maladaptive coping mechanisms often made their situations worse and fuelled their suicidal spiral. Additionally, the need for training on other mental health issues (Brooker & Sirdifield, 2009) such as the ones outlined in the current research (personality disorders and depression to state a few) is vital if staff are to understand and manage these individuals effectively. Information about these magnifying issues also needs to be incorporated into training. Lastly, the developments that have taken place in relation to training and suicide prevention, including the use of ligature knives in approved premises (Beck, 2014a) should continue to develop.
- ***Support for staff:*** A final implication of the current research is for probation staff working with suicidal clients. Staff reported feeling emotionally affected by their clients' suicidal behaviours. However, whilst staff felt that support was available it was not always perceived to be immediately accessible, therefore staff tended to rely on colleagues to offload their concerns. It is therefore recommended that staff sources of support should be made visible,

widely advertised and easily accessible. Furthermore, some members of staff could receive further training to act as specialists to support their colleagues.

10.8.3 Considerations for future research into suicide prevention

There is a growing body of evidence to suggest that mindfulness can increase psychological wellbeing (Keng, Smoski, & Robins, 2011). Research suggests that mindfulness based cognitive interventions can be helpful for preventing relapse into depressive episodes (Teasdale et al., 2000). Furthermore mindfulness has been shown to be helpful for treating anxiety, personality disorder, depression, suicide, self-harm and substance abuse (Ivanovski & Malhi, 2007). The current research demonstrated that clients suffer from high levels of depression, anxiety, personality disorders and used maladaptive coping mechanism such as alcohol, therefore mindfulness may be helpful to these clients. These types of intervention have proven effective in prison settings (Liehr et al., 2010; Samuelson, Carmody, Kabat-Zinn, & Bratt, 2007; Shonin, Van Gordon, Slade, & Griffiths, 2013) yet little is known about how this type of programme might work in a community setting. Currently some approved premises run mindfulness courses (Beck, 2014b), although these are aimed at clients in general rather than specifically for depressed and suicidal clients. Therefore future research may wish to explore the effectiveness of this type of intervention in a probation setting.

Furthermore, a significant issue highlighted by the current research is the importance of having meaning and purpose in life. Research suggests that interventions that target life meaningfulness can prevent suicide (Kleiman & Beaver, 2013), such as positive psychological interventions including goal setting (Huffman et al., 2014; Lapierre, Dubé, Bouffard, & Alain, 2007). There are currently some schemes that seek to restore meaning to the lives of offenders and ex-offenders. For instance, the May Day trust is currently piloting a project that aims to restore meaning to offenders' lives through employment (The May Day Trust, 2015). Other examples which have proved effective include prison based schemes which aim to restore meaning through animal training schemes, such as paws for progress in Polmont Youth Offending Institute (Mercer, Gibson, Clayton, & Ireland, 2015). It would therefore be beneficial if these types of schemes were evaluated for use in community settings, and those that do currently exist be utilised by probation services.

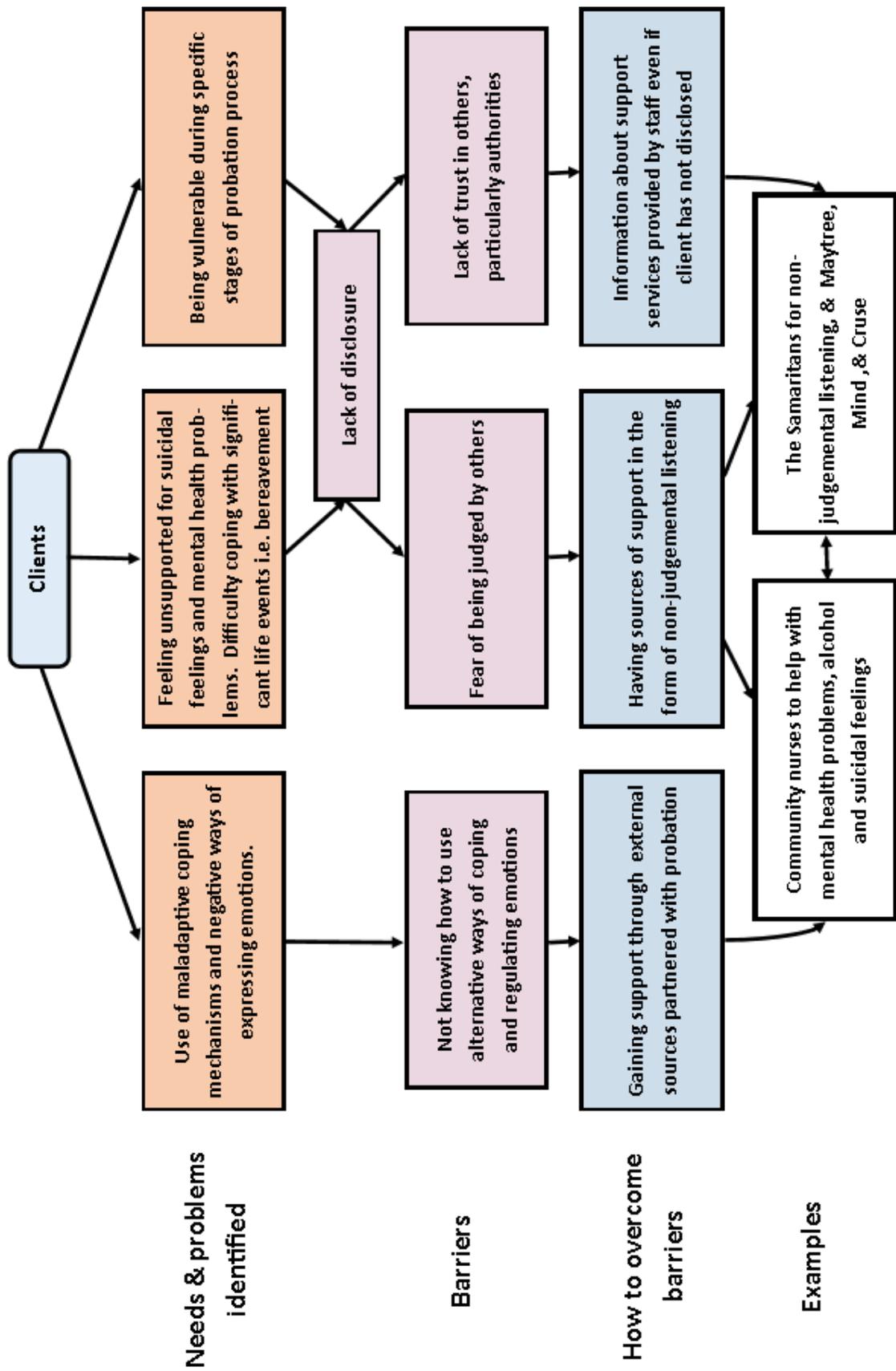


Figure 9: Overall findings - clients

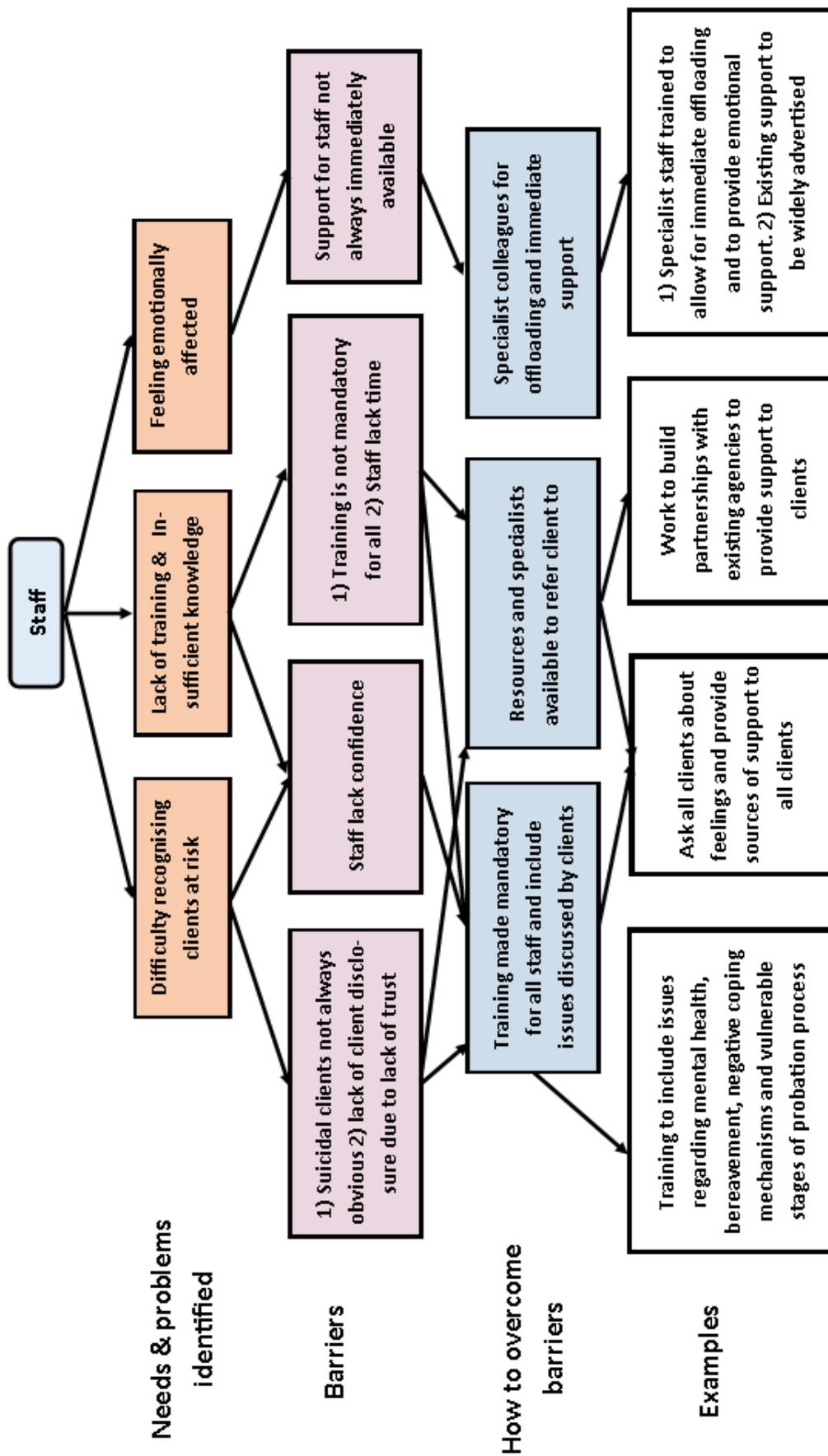


Figure 10: Overall findings - staff

10.9 Final conclusions

Offenders in the community are often a marginalised group who face a number of struggles, including suicide, suicidal feelings and self-harm. The limited research into suicide by this group makes intervention and prevention difficult. Previous research has been helpful in identifying the degree of risk that this population face. However Hjelmeland and Knizek (2011) in their chapter ‘What kind of research do we need in suicidology today?’ propose that we need to ‘*change our focus from explanation to understanding*’ (pg 596), and this was a key and overriding aim of the current research programme.

The use of an in-depth qualitative approach has expanded previous findings and provided novel insights into the problems that this population face and the barriers that prevent them from getting help. Multiple problems are perceived to be linked to their suicidal behaviour, some of which have also been found in the general population. But what is novel about the current research is the specific way that these problems are encountered and experienced by probation clients, and how suicide prevention techniques should be tailored to meet their particular needs. For example, although suicide can be considered largely unpredictable, having knowledge about stages of probation where clients are at an increased risk could help staff to be more vigilant, to ask clients about their feelings and provide them with sources of support. Thus, staff training is key to suicide prevention. Of course, as the current research has demonstrated, clients will not always be willing to disclose their feelings or engage with support from staff due to their perceptions of the justice system and lack of trust in others. Furthermore, with increasing probation caseloads, staff do not always have the time to talk to their clients about these issues. However probation engagement with external sources may be a useful way of overcoming these barriers.

There is still a lot of work to be done if suicide is to be reduced in this vulnerable population, however this programme of research has provided new insights into the problem, helped to develop what is known from previous research, and draws attention to the problems that probation client’s face in the community. Moreover, the current research has proposed possible prevention techniques, identified risk stages of the probation process and identified barriers that may stop clients from receiving support that could prevent suicidal behaviour. These outcomes now provide new directions for future research and suicide prevention strategies.

11 References

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12 Appendices

Appendix 1. Consent and information forms

Research on Community Sentences: Participant Information

We are carrying out research with the London Probation Trust to find out about people's experiences while serving a sentence in the community. In particular we are interested in why some people on community sentences become very distressed at times, and may harm themselves or attempt suicide, whereas other people do not harm themselves at all. This research will consist of an interview during which you will also be asked to complete some confidential questionnaires. It will take about an hour and can be arranged at a time convenient to you.

You have been invited to take part in this study because:

EITHER

a) We understand that you recently tried to hurt or harm yourself and we would like to understand what led up to this incident and how you think incidents like this might be prevented in future.

OR

b) We have no record of you having harmed yourself, so we would like to compare your experiences of community sentences with those of people who have recently harmed themselves to see what they could learn from your experiences.

Your involvement in this research would be very valuable to us and to the London Probation Trust and we hope that it would contribute to preventing self-harm and suicide in the future. BUT you do not have to take part in this study – it is entirely up to you to decide.

- If you decide not to take part, your decision will not affect your progress or supervision in any way. You can just say no and you do not have to give an explanation.
- If you decide to take part we will arrange an interview that is convenient for you and will provide you with a £20 to reimburse your travel expenses and time.
- If you agree to take part and then change your mind later that is OK – you can stop at any time.
- If you decide to withdraw from the study at any point then any existing information that you may have provided will be destroyed as long as this has not already been included into a report.

The information you give us will be kept confidential and anonymous - the findings from the study will not identify anyone by name. However there is one exception to confidentiality: if you tell the interviewer that you are about to harm yourself (or someone

else) we would have to pass on that information to your offender manager or to someone else who could ensure your safety.

If you would like further information about the research please contact the researchers by writing to the address below:

Jay Mackenzie / Dr Jo Borrill

Dept of Psychology, University of Westminster,

309 Regent Street,

London W1B 2UW

CONSENT TO RESEARCH FORM (clients)

Title of project: Research on Community Sentences

Name of Researcher: Miss Jay Mackenzie

Please tick box

1. I confirm that I have read and understood the information sheet datedfor the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I agree to the tape recording of part of the interview, and that words that I use during the interview can be used anonymously, in the presentation of the research.

4. I agree to take part in the above study.

5. I am willing to be contacted in approximately 6 months time to discuss the possibility of doing a short follow-up interview Y N

If Yes, please provide contact details (e.g. phone number or email address)

For further details please contact Jay Mackenzie Department of Psychology, University of Westminster, 309 Regent Street, London W1B 2UW.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

Research on Community Sentences: Participant Information (staff)

We are carrying out research with the London Probation Trust to find out about people's experiences while serving a sentence in the community. In particular we are interested in why some people on community sentences become very distressed at times, and may harm themselves or attempt suicide, whereas other people do not harm themselves at all. We are also interested in the views of London Probation Trust staff in relation to suicide and self-harm. This research will consist of a short telephone interview during which you will also be asked about your experiences whilst working for the LPT of suicidal and self-harming behaviour amongst clients. You will either be asked about a specific client that you have previously referred to us or you will be asked about your experiences in general.

Your involvement in this research would be very valuable to us and to the London Probation Trust and we hope that it would contribute to preventing self-harm and suicide in the future. BUT you do not have to take part in this study – it is entirely up to you to decide.

The information you give us will be kept confidential and anonymous - the findings from the study will not identify anyone by name. If you decide not to take part you do not have to give an explanation.

- If you decide to take part we will arrange an interview via telephone that is convenient for you.
- If you agree to take part and then change your mind later that is OK – you can stop at any time.
- If you decide to withdraw from the study at any point then any existing information that you may have provided will be destroyed as long as this has not already been included into a report.

If you would like further information about the research please contact the researchers by writing to the address below:

Jay Mackenzie / Dr Jo Borrill

Dept of Psychology, University of Westminster,

309 Regent Street,

London W1B 2UW

Or please contact Jay Mackenzie at Jay-marie.mackenzie@my.westminster.ac.uk

CONSENT TO RESEARCH FORM (staff)

Title of project: Risk factors for suicide in individuals on probation.

Name of Researcher: Jay Mackenzie

Please tick box

1. I confirm that I have read or have had read to me, the information sheet datedfor the above study.

2. I have had the opportunity to ask questions and I confirm that I understand the purpose of the study, limits of confidentiality and how my information will be used.

3. I understand that my participation is voluntary and attendance will not be enforceable and that I am free to withdraw at any time, without giving any reason. If I withdraw from the study, all information from this interview will be deleted.

4. I agree to the tape recording of the interview, and that words that I use during the interview can be used anonymously, in the presentation of the research.

5. I agree to take part in the above study.

.....
For further details please contact Jay Mackenzie Department of Psychology, University of Westminster, 309 Regent Street, London W1B 2UW.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

Appendix 2. Information about follow-up interview

Research on Community Sentences: Participant Information follow up

We are carrying out research with the London Probation Trust to find out about people's experiences while serving a sentence in the community. In particular we are interested in why some people on community sentences become very distressed at times, and may harm themselves or attempt suicide, whereas other people do not harm themselves at all. You previously took part in an interview and agreed to be contacted at a later date to do another interview.

Your involvement in this research would be very valuable to us and to the London Probation Trust and we hope that it would contribute to preventing self-harm and suicide in the future. BUT you do not have to take part in this study – it is entirely up to you to decide.

The information you give us will be kept confidential and anonymous - the findings from the study will not identify anyone by name. However there is one exception to confidentiality: if you tell the interviewer that you are about to harm yourself (or someone else) we would have to pass on that information to your offender manager or to someone else who could ensure your safety.

- If you decide not to take part, your decision will not affect your progress or supervision in any way. You can just say no and you do not have to give an explanation.
- If you decide to take part we will arrange a telephone interview that is convenient for you.
- If you agree to take part and then change your mind later that is OK – you can stop at any time.
- If you decide to withdraw from the study at any point then any existing information that you may have provided will be destroyed as long as this has not already been included into a report.

If you would like further information about the research please contact the researchers by writing to the address below:

Jay Mackenzie / Dr Jo Borrill

Dept of Psychology, University of Westminster,

309 Regent Street,

London W1B 2UW

Appendix 3. Appropriate person confidentiality statement

Confidentiality statement for appropriate person

By signing this document you agree to and understand the following:

You have been provided with a copy of the participant information form and understand that the research being carried out is on near lethal suicide attempts/self harm in offenders doing community sentences. Sensitive and possibly upsetting information may be discussed by the participant and the researcher. All information that you hear whilst the participant is being interviewed is to be kept confidential – by this it is meant that you will not discuss any information outside the interview that is talked about during the interview by the client or the researcher with anyone other than the client or researcher. It is essential that all the participants details are kept confidential.

Signature of appropriate person: X.....

Date

Signature of participant: X.....

Date

Researcher's signature : X.....

Date

Appendix 4. Information for participants to take away

If you are feeling suicidal, are having thoughts of self harm or you would just like some emotional support then you may find the following organisations helpful;

Samaritans: The Samaritans provides confidential non-judgemental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair, including those which could lead to suicide.

Contact details: Telephone number: 08457 90 90 90. Or 116 123, Email jo@samaritans.org, Website www.samaritans.org Or write to Chris, P.O. Box 90, Stirling, FK8 2SA Or you can visit any branch and talk to someone face to face. You can find the address of any branch from the website or by calling the Samaritans. Your nearest branch is COMPLETE AS APPROPRIATE

Mind: Mind informs and supports people with mental health issues. They provide information through: Mindinfoline which offers callers confidential help for the price of a local call; their Legal Advice Service which provides information on mental health related law to the public, service users, family members/carers, mental health professionals and mental health advocates; and their publications and website.

Contact details: Mind info line: 0845 766 0163 Website: www.mind.org.uk

SANE: SANE exists to provide emotional support and information to anyone affected by mental illness. There are 3 main ways to reach them: Phone, Email and via the Support Forum.

Contact details: Telephone: 0845 767 8000, Website: www.sane.org.uk, You can also write to them at SANE Services, 1st Floor, Cityside House, 40 Adler Street, London E1 1EE.

National self harm support network: Supports people who self harm.

Contact details: Telephone Number: 0800 622 6000, Opening hours – Open every day 7pm-11pm (including public holidays) Website: www.nshn.co.uk

You can also contact you offender manager who can refer you to relevant services within the probation trust.

Appendix 5. Visual Analogue scale results

A Wilcoxon signed-rank test showed that taking part in an interview about a near-lethal suicide attempt did elicit a statistically significant change in perceived emotional wellbeing ($Z = -2.214$, $p = 0.027$, two tailed) with emotional wellbeing being rated more highly after ($M=87$) the interview than before ($M=63$).

Descriptive Statistics

	N	Mean	Std. Deviation	Minimum	Maximum
before	7	62.86	25.797	20	100
after	7	85.71	12.392	70	100

Wilcoxon Signed Ranks Test

Ranks

		N	Mean Rank	Sum of Ranks
after - before	Negative Ranks	0 ^a	.00	.00
	Positive Ranks	6 ^b	3.50	21.00
	Ties	1 ^c		
	Total	7		

a. after < before

b. after > before

c. after = before

Test Statistics^a

	after - before
Z	-2.214 ^b
Asymp. Sig. (2-tailed)	.027

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

Appendix 6. Interview agenda 1 – staff who have made referral

The interview shouldn't be too long. I am just going to ask you a few questions about the client that you referred to me for the suicide and self harm study.

1. Thinking back to the incident can you describe to me how you came to be aware of it? Prompt: were you the client's offender manager, supporting a colleague whose client had self harmed, etc.
2. How did he/she describe the incident to you?
3. (if appropriate) How would you describe what happened?
4. Had he/she ever talked to you about self harm or suicide before?
5. Did you notice any changes in his/her behaviour leading up to the incident?
6. Were there any signs that you can think of that may have indicated that he/she was going to harm themselves?
7. Had any changes occurred before the incident in relation to your clients probation process or were any changes about to occur (prompt; were they ending their probation, changed OM, changed or finished a programme).
8. When you became aware of the incident did you feel that you had adequate knowledge and training of how to deal with the incident? (Prompt: report incident, support the individual, knowledge of Delius and ACCT)
9. How did you go about reporting the incident?
10. (If appropriate) How did you deal with and support the client? (Prompt: referring to support services, etc)
11. Looking back on the incident is there anything that you would have done differently?

12. How do you feel about the incident, has it effected you in anyway (Prompt: personally, professionally)?

13. Is there anything that you think LPT could do to improve their training and procedures for staff on how to handle suicide and self harm in clients?

14. Is there anything else that we haven't talked about that you would like to mention?

Appendix 7. Interview agenda 2 & 3 – staff who have not referred

General staff Interview

1. Whilst working within the LPT have you encountered a client who has talked about or carried out suicide and/or self harm? y/n

If Yes

15. Can you describe to me how you came to be aware of this incident? Prompt: were you the client's offender manager, supporting a colleague whose client had self harmed, etc.
16. When this occurred did you feel that you had adequate knowledge and training of how to deal with the incident? (Prompt: report incident, support the individual, knowledge of Delius and ACCT)
17. How did you go about reporting the incident?
18. (If appropriate) How did you deal with and support the client? (Prompt: referring to support services, etc)
19. Looking back on the incident is there anything that you would have done differently?
20. How do you feel about the incident, has it effected you in anyway (Prompt: personally, professionally)?
21. Is there anything that you think LPT could do to improve their training and procedures in place for LPT staff on how to handle suicide and self harm in clients?
22. Is there anything else that we haven't talked about that you would like to mention?

If No

1. What do you think you would do if an incident of suicide or self harm occurred in a client or if an offender talked to you about it?

2. If an incident of self harm or suicide were to occur do you feel that you have adequate knowledge and training in order to deal with this incident? (Reporting, supporting client, delius)?
3. Is there anything else that you think LPT could do to improve their training and procedures in place for LPT staff on how to handle suicide and self harm in clients?
4. Do you have any other concerns about this? Is there enough support for LPT staff?
5. Is there anything else that we haven't talked about that you would like to mention?

Appendix 8. Client interview agenda

Interview agenda

Introductory questions

1. What is the sentence that you are currently serving?
2. Is this your first sentence - Prison or community? (If no – what other sentences have you been given?)
3. Can you tell me a bit about the structure of your sentence – for example supervision, any programmes that you received?
4. How far into completing your sentence are you? (If relevant) have you completed any of the components of your sentence i.e. programmes?
5. What was life like for you before you received your sentence? (Prompts; employment, finances, relationships, family, health).
6. Can you describe what it was like for you when you first found out about your MOST RECENT sentence? (prompts) concerns and thoughts about family, friends, job , feelings of remorse etc
7. (only for those on licence and been in prison) What was it like when you got given your sentence and new that you were facing prison? (prompts regime of prison, bullying, length of sentence)
8. How do you feel about doing community payback/living in an AP etc?
9. What is community payback / living in an AP like?
10. Is this different to what you thought that it would be like? (if so in what way)
11. (Only for those in approved premise) do you get on with the people that you live within the hostel?
12. (Only for those on community payback) do you get on well with anyone else who is doing community payback?
13. (Only for probation) do you know and get on well with anyone else who is currently on probation?
14. (only for those who have been in prison) How was it when you came out of prison and had to adjust to life outside prison? (prompts; finding a job, place to live etc)
15. How do you feel about any targets and objectives given to you by your offender manager (prompts: too many, too little, good, bad)?
16. Did your offender manager or other staff who you spent time with change whilst you were on probation?
17. If yes how many and what was the reason for this change?
18. (If appropriate) how did this affect you?
19. How often did you see your OM/payback supervisor/programme tutors/AP staff up until the incident?
20. How well do you get on with your OM/payback supervisor/programme tutors/ AP staff?
21. Has anyone previously raised concerns with you about your potential risk? **E.G friend or professional**

22. (If in prison before) were any ACCT forms opened and if so how did you respond to this?

Prior to the incident (we are just going to talk about your feelings and thoughts before your recent self harm).

1. Did you talk to anyone about any thoughts or feelings that you were having about suicide or self harm or both with anyone before the recent incident?
2. (If applicable) who?
3. And was this helpful or not? How was it helpful?
Prompts; did you receive any support
4. (If applicable) why did you not share your thoughts and feelings with anyone?
5. (If applicable) If you felt like this again do you feel able to discuss these types of thoughts and feelings with your offender manager or another Ipt staff member; if not then why?
6. What would enable you to share these thoughts and feelings with your OM or other probation staff?
7. Were you taking any medication/drugs or alcohol **before** the event? If so what?
8. (If so) was this an ongoing issue or a change in your normal behaviour?
9. Have you had or have a history of intentional self harm which may or may not have been attempts on your life? (if yes ask for details)

The incident

1. Was this your first suicide attempt/most serious time that you have self harmed? If not then when did you do this before? Was it whilst on probation?
2. Could you describe your intentions; suicide or self harm? (prompt or unsure)
3. Can you describe the incident to me?
4. Can you tell me what was going through your mind on the day that you (took an over dose/ self harmed/ etc)
5. Can you think of anything that happened that caused you to carry out this act? (Prompt) events, thoughts etc. (what led up to the event)
6. Was there any particular event/s or experience/s which you were thinking of at the time of the incident?
7. When was the last time that you had contact with the probation staff before the near miss?
8. Did you inform your OM about your attempt either before or after the incident?
9. Did you seek medical attention before or after the attempt?
10. If not – why? If yes then please describe what happened?
11. Can you tell me about what led you to choose the method that you used?
12. Were there any other methods that you thought of?
13. If previous attempts – do you tend to use the same method?

14. Were you being prescribed any medication, taking drugs, alcohol or coming off of drugs, alcohol or medication **at the time** of your... overdose, self harm etc?
15. Where you in contact with other agencies at the time?
16. Did you tell them about your intentions?
17. How long did you spend planning this incident? Was there a time gap between your first thoughts of self harm/suicide and the event?
18. Can you describe the events and your mood in the days leading up to the incident?

19. (if applicable) When thinking about the event did you feel that you wanted to end your life or did you want to end the situation that you were in?
20. Did you leave a suicide note?
21. If situation, what was it about the situation that you wanted to end?
22. What prevented the near miss from succeeding? (prompts – change mind, outside intervention)
23. Has anyone close to you ended their life through suicide or self harm????
24. Has anyone close to you **SERIOUSLY** self harmed or attempted suicide? **WHO, WHEN, WHY?**
25. (If applicable) How did this affect you?
26. Do you feel that this had a role to play in your **RECENT SUICIDE ATTEMPT?? SELF** harming behaviour?
27. Is there anything that you think could have prevented you from carrying out this act?
28. Has there been anything previous to this that has stopped you from carrying out this type of behaviour? I.e. thoughts of family, friends, religion

Post incident

1. Has anything at all positive come out of the incident/ has the incident changed anything in your life?
2. How do you feel about the incident now?
3. Do you feel that you might attempt suicide and/or self harm in the future?
4. If yes please describe your feelings about this?
5. Is there anything in particular that you think might trigger this?
6. (If not) Has anything changed in your life to make you feel that you will not attempt suicide /self harm / carry out behaviour like this again? (If yes) what do you think could prevent you from doing this?
7. Is there any support that you think the probation service could have provided you with before the event that would have helped you not make an attempt on your life in anyway?
8. Are you aware of confidential emotional support services such as the Samaritans?
9. Did you use them – if not why not?
10. Did you receive any support after the incident? If so in what form (i.e. GP)
11. Do you feel that a call from the Samaritans when you returned from the hospital would have helped in anyway?

12. (may have covered) How long do you have left of your sentence/probation period?

HOW FAR INTO IT ARE YOU?

13. What are your plans for the future? Like employment, accommodation, etc?

14. If the probation service could do one thing to make it less likely that you would harm yourself again, what would it be? Prior to and leading up to incident

15. Is there anything that you would like me to pass onto your OM?

Tell them of information you intend to pass on re imminent risk.

Collect contact details for those who consent to a follow up.

Appendix 9. Follow-up interview agenda

Follow Up Interview Agenda

I Spoke to you before about an incident that happened whilst you were on probation which resulted in you harming yourself. I am just going to ask you a few questions about how things are since that incident.

- 1) Are you still under the supervision of probation? (when did you finish, how long do you have left?)
- 2) Do you feel life has changed for you since the incident that we talked about in the last interview? (jobs, accommodation, relationships)
- 3) **If yes** – in what way?
- 4) **If still on probation** – has probation provided you with any on-going support since you harmed yourself? (what sort, has this been helpful)
- 5) Have you received any other support? (other organisations, family, friends etc)
- 6) Have you harmed yourself since the last incident that we spoke about in the interview?
- 7) **If yes** – why do you think this happened?

- 8) **Is there anything that could have been done to prevent this?**

- 9) How, if at all, did the experience of being on probation affect you and your life?
- 10) Do you feel that anything **positive** came out of being on probation?
- 11) Do you feel that anything **negative** came out of being on probation?

- 12) What are your plans for the future?

- 13) Is there anything else that we have not talked about that you think might be important?

Appendix 10. Thematic analysis – checking for consistent and re-occurring patterns – theme development list

1. Triggers and Vulnerabilities of offenders

Direct expression of suicidal feelings, Description of SH method, method, Triggers & Possible contributing factors, Problems in clients life, Time When incident occurred, Change and anticipated change –loss of support, Instability, Past suicide/SH, Medication for mental health, No past suicide SH, Impact of sentence, Sense of injustice, Client vulnerable, Anger/violence, Alcohol (as a trigger) and other issues around alcohol, Client mental health issue (bipolar, PD etc), Re-offending

2. Can suicide or self-harm be predicted: signs but still unexpected

Signs of self-harm or suicide, Missing appointments/Breach, Visual signs of Self-harm – physical, Previous concerns for client (indicators/signs), Missing signs, No signs

3. Training (lack of & need for more, improvements, continuous)

Lack of training & need for more training, Had some general training, Differences in training depending on job role & area, Suicide training (done) (positive and negative comments, Keeping Up to date training, Training should be mandatory, Factors stopping staff from doing training, Need for Quick accessible information for staff should be available (ie flow chart)

4. Support for staff (peers, seniors and professionals)

Staff support via counselling service for staff, Need more support for staff, Support for staff via colleagues, Support for staff via managers

5. Impacts on staff and finding it hard to cope - guilt & hindsight

Cant take anything for granted, Only do so much (helpless), Cant stop/ intervene, Not affected, Affected by deaths (APS more), Personal affect, Fear –not knowing what has happened to client – what will happen to client, Staff felt they did their best, Feeling guilt – could have done more?, Worried about/for client, Other issues affecting staff, Memories of suicide/SH , Should have done something differently, Unanswered questions , Try to understand frame of mind

6. Supporting clients – referrals, support, & barriers

Contact about incident via telephone, Time elapse between first finding out and talking through, time elapse between event and talking, Referred to specialists, Importance of talking and listening, Police involvement, Clients surprised by support/ support is available, Provide support, Known by other agencies, Client not wanting support, Lack of client support & barriers for support, Communication with other agencies, Lack communication , Importance of communication, Arrange support for client (practical and other types), Close monitoring in APS, As opposed to limited monitoring in unpaid work

7. Importance of knowledge (of experts, lack of knowledge, knowledge as a tool)

Importance of knowledge – knowledge as a tool, Own personal knowledge, Lack of knowledge, Lack of knowledge – not taking suicide and S-H seriously, Importance of expert knowledge training, Importance of experts , Response type, Pre-sentence report, Knowledge of client, Working with client easier/harder because of knowledge, Feeling comfortable and confident to talk about suicide/SH, Not feeling comfortable and confident, Sometimes refer

8. Importance of experience (learning from experience, lack of experience)

Learning from experience, Staff experiences of suicide/Self-harm from previous jobs (outside of probation), Experience of suicide/SH in probation clients

9. Attitudes (mental health, helplessness, Support already in place,)

Support already in place for client – no need to refer, Staff attitudes to mental health, Cant take anything for granted, Only do so much (helpless), Cant stop/ intervene

10. Typologies

Types of suicide and self-harm (serious and not serious) – labelling types, Non-disclosers - difficulty in identifying signs, Purpose of self-harm/suicide, Unsure if client at risk – doesn't take attempts/SH serious

11. miscellaneous

Description of SH method, method, Incident needed medical intervention, Clients shame (feelings after event), Client worried after attempt about supervision (feelings after event), Finding out about clients attempt/death via 3rd party, Miscellaneous , Difficulties with client, Didn't follow procedures, Positives of interview

Appendix 11. Staff analysis thematic map



Appendix 12. Defined and narrowed themes – staff interviews

Basic themes (categories)	Organising (sub themes)	Global Themes
<p>Contact about incident via telephone, Time elapse between first finding out and talking through, time elapse between event and talking, Clients surprised by support/ support is available, Client not wanting support, Lack of client support & barriers for support,</p> <p>Importance of talking and listening (participant 1 – always importance of verbalisation), Referred to specialists,</p> <p>Arrange support for client (practical and other types), Close monitoring in APS, As opposed to limited monitoring in unpaid work</p> <p>Police involvement, Provide support, Known by other agencies, Communication with other agencies, Lack communication , Importance of communication, , Support via communication with other agencies</p>	<p>Barriers to support</p> <p>The power of listening v Making a referral</p> <p>Providing practical support</p> <p>Existing support from other agencies & not referring because of existing support</p>	<p>Providing support for suicidal/self-harming clients</p>
<p>Suicide was always unexpected, shock, disbelief,</p> <p>Only do so much (helpless), Can't stop/ intervene</p>	<p>Unexpected</p> <p>You can't stop people who want to self-harm/die</p>	

<p>Signs of self-harm or suicide, Missing appointments/Breach, Visual signs of Self-harm – physical, Previous concerns for client (indicators/signs), Missing signs, No signs</p> <p>Direct expression of suicidal feelings, Description of SH method, method, Triggers & Possible contributing factors, Problems in clients life, Time When incident occurred, Change and anticipated change –loss of support, Instability, Past suicide/SH, Medication for mental health, No past suicide SH, Impact of sentence, Sense of injustice, Client vulnerable, Anger/violence, Alcohol (as a trigger) and other issues around alcohol, Client mental health issue (bipolar, PD etc), Re-offending</p>	<p>Signals and indicators of suicide/self-harm</p> <p>Triggers & vulnerabilities to suicidal behaviours</p>	<p>Making sense of the unexpected</p>
<p>Lack of training & need for more training, Had some general training, Differences in training depending on job role & area, Surprise over lack of training, training should be mandatory, had training in previous job</p> <p>Suicide training (done) (positive and negative comments) stressful but run by experts, changed stereotypes after receiving training.</p> <p>Keeping Up to date training, Need for Quick</p>	<p>Lack of training and need for it to be mandatory</p> <p>Specific suicide training is given</p>	<p>‘Training – existence without uptake’</p>

<p>accessible information for staff should be available (i.e. flow chart)</p> <p>Factors stopping staff from doing training (time & other more important training), don't need training</p>	<p>Improvements for current training</p> <p>Barriers to training</p>	
<p>Importance of knowledge – knowledge as a tool, Response type dependent on prior knowledge, Pre-sentence report, Knowledge of client, Working with client easier/harder because of knowledge, Feeling comfortable and confident to talk about suicide/SH,</p> <p>Importance of expert knowledge training, Importance of experts, Not feeling comfortable and confident, referring clients to the experts</p> <p>Own personal knowledge, Lack of knowledge, Lack of knowledge – not taking suicide and S-H seriously, referring to an expert because don't have enough knowledge to deal with client, don't know how to do deal with client, making the situation worse, taken the wrong action because lacking knowledge</p> <p>Learning from experience, Staff experiences of suicide/Self-harm from previous jobs (outside of probation), Experience of</p>	<p>Knowledge as a tool</p> <p>Importance of experts</p> <p>Lack of knowledge & experience</p>	<p>'The importance of knowledge and experience'</p>

<p>suicide/SH in probation clients, first experience always the hardest</p>	<p>Learning from experience</p>	
<p>Quiet ones are more serious, ‘they don’t talk, they just do it,’ Unsure if client at risk – doesn’t take attempts/SH serious, repeat harmers less at risk (doing it for a reason),</p> <p>Types of suicide and self-harm (serious and not serious) – labelling types, Non-disclosers - difficulty in identifying signs, and disclosers,</p> <p>Purpose of self-harm/suicide, self-harming for a reason – going to hospital, getting attention, finding somewhere to live</p> <p>Staff attitudes to mental health in general – some mental health issues associated with self-harm PD,</p>	<p>Deciding on what is serious</p> <p>Different types of self-harm</p> <p>Clients have a purpose for their self-harm and suicide attempts</p> <p>General attitudes to mental health</p>	<p>‘Attitude and Typologies of suicide and self-harm’</p>
<p>Core care and peers & colleagues Staff support via counselling service for staff, Need more support for staff, Support for staff via colleagues, Support for staff via managers Lack of immediate support</p> <p>Unanswered questions, Try to understand frame of mind, never know if something could have been done to prevent it.</p> <p>Staff felt they did their best, Feeling guilt – could have</p>	<p>Is there enough support for staff –immediate and overtime?</p> <p>Unanswered questions</p>	<p>‘Support for staff and the Impact of Suicidal Behaviours’</p>

<p>done more? Should have done something differently, Can't take anything for granted, Only do so much (helpless), Can't stop/intervene, denial about person dying</p> <p>Not affected, Affected by deaths (APS more), Personal affect, Fear –not knowing what has happened to client – what will happen to client, Worried about/for client (after suicide attempt, self-harm, domestic violence, alcohol).</p> <p>Memories of suicide/SH, still remember the visual signs of self-harm, can't look at self-harm, talking about self-harm in a physical sense – pain.</p>	<p>Feelings of guilt & helplessness - 'I felt guilty... maybe I could have done better'</p> <p>Worrying about client</p> <p>Visual impact of self-harm and suicide</p>	
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Appendix 13. Example IPA consistency checking table

Dave	Roy	Freddie	Dan	Mike	Kathy
-use of negative coping mechanism -trust -time -talking -support -socialisation -recognition of something bad in life -mental health diagnosis -meaning -loss -injustice -independence -couldn't predict incident -control	-use of negative coping mechanisms -trust -time -talking -support -socialisation -recognised something bad -meaning -judgement -injustice -further attempts -couldn't predict attempt -control -bored of waiting	-bored waiting time control -couldn't predict attempt -further attempt -injustice -loss -meaning -recognised something bad -socialisation -support -talking -use of negative coping mechanisms	-worry -use of negative coping mechanisms -trust -talking -support -recognise something bad -mental health diagnosis -meaning -judgement -further attempts -couldn't predict incident -control	-worry -use of negative coping mechanism -talking -support -socialisation -recognise something bad -mental health diagnosis -meaning -loss -judgement -injustice -further attempts -control -boredom	-use of negative coping mechanism -trust -talking -support -recognise something bad -meaning -loss -judgement -injustice -further attempt -control

Appendix 14. Demographic information form

Check list Information about participant.

Gender: A) Male B) Female

Age

Is this their first conviction? Yes/No

If no then how many convictions do they have?

What was the most recent conviction for?

Were they given a prison sentence or were they given a community sentence without going to prison first?

Own description of ethnic group?

A) White

Any White background

B) Mixed

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed background, please write in

.....
C) Asian or Asian British

Indian

Pakistani

Bangladeshi

Any other Asian background, please write in

.....
D) Black or Black British

Caribbean

African

Any other Black background, please write in

.....
E) Chinese or other ethnic group

Chinese

Any other, please write in

.....
Own description of religion:

Are you religious? A) Not religious B) Slightly Religious C) Very religious

If religious please specify religion

Appendix 15. Research approval forms



UNCLASSIFIED



Your Ref:	
Our Ref:	
Dr Jo Borrill Department of Psychology University of Westminster 309 Regent Street London W1B 2UW	
7 May 2010	

Dear Dr Borrill

Research project – Suicide 'near misses' in community settings

This is to confirm that you have London Probation's permission to carry out this research in accordance with the research proforma submitted in April 2010. Support to this project from LP will be as described in the proforma though the detail may need to be fine tuned as the proposal is firmed up to align with practice.

We look forward to collaborating with you on this research.

Yours sincerely

Pauline Durrance
Senior Research Officer

UNCLASSIFIED

Chief Executive: Paul Wilson CBE

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71-73 Great Peter Street, London, SW1P 2BN
Tel 020 7222 5656 Fax 020 7960 1188



To: Jay Mackenzie

Cc Dr Jo Borrill

I am pleased to inform you that your PhD proposal has been approved by the University of Westminster Ethics Committee (Social Sciences, Humanities & Languages – Psychology sub-committee) on the 15/12/10.

Dr John Colwell
Chair SSSL Ethics Sub-Committee (Psychology)

A handwritten signature in black ink that reads "John Colwell". The signature is written in a cursive style with a large initial 'J'.

Signed

Date: 15 April 2011

Appendix 16. Example near-lethal criteria

Inclusion criteria for near miss

<u>Method</u>	<u>Inclusion criteria</u>
Attempted hanging Ligature use Self-strangulation	Unconscious after attempting to hang or use a ligature, or not unconscious but: (a) witnessed in suspension or using a ligature and physical evidence of asphyxiation; or (b) physical evidence of suspension or using a ligature
Self-asphyxiation Suffocation	Witnessed self-asphyxiating, or any other physical evidence of self asphyxiation
Cutting Stabbing Wound	Sustained a puncture wound penetrating body cavity or major organ, or aggravation lacerations that damaged or severed or insertion tendons, arteries or large veins, or came very close to doing so
Ingesting, inhaling, injecting (a) level of consciousness	(a) objective evidence of altered level of consciousness, or unconscious at presentation or prior to medical facility
(b) biochemical abnormalities	(b) transferred or admitted to a hospital or accident and emergency department
Jumping from a considerable height	Witnessed jumping or any physical evidence of having jumped from a considerable height, likely to have led to serious injury
Other (e.g. setting fire to self) basis	Case referral determined on a case-by case basis

Definition amended from Rivlin et al 2010