Exploring the relationship between domestic violence perpetration and suicide risk in male prisoners

by

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Declaration

This work has not been accepted in substance for any degree and is not being concurrently submitted for candidature in any degree. The work submitted is a result of my own independent work and investigations unless explicitly stated. Other sources are acknowledged and referenced, and a bibliography is appended to the thesis.

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Abstract

Suicide in prisons remains a critical issue for frontline staff and policy makers, however there are gaps in understanding who, of an already vulnerable population, is at increased risk and why. This thesis explores the relationship between domestic violence perpetration and suicide risk in prisoners, as although such a link has been suggested it has not been investigated in custodial populations. The first study uses template analysis to identify what is known and gaps in knowledge about domestically violent men who died by suicide in prison by analysing Prison and Probation Ombudsman Fatal Incident Reports (FIRs). Drawing from qualitative interviews, the second study uses thematic analysis to explore the experiences of domestically violent prisoners who have attempted suicide in prison.

Overall the two studies demonstrate that a relationship between domestic violence perpetration and suicide risk exists in a prison population. The first study identified two overarching aspects to FIRs; individual factors and situational and management factors. A key finding was the limited knowledge and understanding of the histories and backgrounds of the men studied within FIRs. However, the study identified potentially important areas of further exploration including how the men experienced relationships, coping skills and their emotional experience. The second study identified five key themes that illustrate the experiences of domestically violent men who have attempted suicide in custody through a sequence or pathway of experiences; Trauma, victimisation and life struggles, Relationship ideals versus relationship reality, Explaining domestic violence, The impact of prison and Suicide as a coping strategy.

This thesis concludes that the relationship between domestic violence and suicide risk in prisoners may be better understood by consideration of underlying features of domestic violence perpetrators, such as experiences of trauma, personality psychopathology and attachment. Further exploring pathways to suicide in this population may provide useful insight in the future.
Chapter 1: Introduction

1.1 Background to thesis

Suicide is a leading cause of death in correctional settings (World Health Organisation, 2007) and has remained so for many years. While deaths by suicide in UK prisons had begun decreasing over several years, recent statistics indicate that rates have been steadily increasing since 2012 (Ministry of Justice, 2016), raising continued concerns about the safety of prisoners. Prisons have introduced methods and processes designed to aid both the assessment and management of suicide risk (Ministry of Justice, 2013). However, while suicide is a major cause of deaths in custody it is still a relatively rare event, making it difficult to accurately predict who will go on to complete suicide; Chapter 2 explores the rates of suicide in prison settings versus the community.

A recent investigation into risk factors in self-inflicted deaths in custody (Prison and Probation Ombudsman, 2014a) highlighted that a particular vulnerability for suicide was the commission of offences against family members or others close to them. This was based on their review of deaths in custody over a number of years, where they found that 26% of those who had died by suicide in custody had committed their main offence against someone they were intimate with or a member of their families. This was also highlighted in Welsh prisons, where in clinical practice concerns were raised that across four suicides in custody in a short space of time, three were identified to have an index charge or conviction of domestic violence. These are small numbers, but each death in custody is a serious issue for both criminal justice professionals and the families of those who have died. As Webb et al. (2012) point out, the research into the perpetration of specific types
of violence and relevance to suicide risk has not been explored thoroughly. While domestic violence perpetration has been identified as a vulnerability for suicide there is limited information about why this is the case and the mechanisms by which this may occur.

Some studies have explored the link between domestic violence perpetration and suicide in offenders (for example, Wolford-Clevenger et al., 2014) however none have done so for incarcerated populations. Given that those in prison are around six to seven times more likely to die by suicide than those in the general population (World Health Organisation, 2007), it is of vital importance that specific factors that may make prisoners more likely to die by suicide are understood. Difficulties have been identified with developing robust screening tools for suicide risk in custody (Gould, McGeorge, & Slade, 2017) and predicting risk of suicide in individuals (Goldney, 2012). It has been suggested that the focus should move away from identifying broad risk factors that may be applicable to many in the prison population who do not go on to die by suicide, to investigating suicidal processes and prisoners from groups with specific vulnerabilities (Forrester & Slade, 2014). Therefore, exploration of the suggested vulnerability to suicide that comes with being in prison for an offence against a partner or family member may provide information that could improve suicide risk assessment and management in custody.

1.2 Research aims

As stated, while there is evidence that a relationship between domestic violence perpetration and suicide risk exists there are no studies to date that have investigated this in prisoners. Of the research that has been completed, it has been noted that there are
difficulties in identifying the temporal nature of the relationship (Nahapetyan, Orpinas, Song, & Holland, 2014) and some researchers have suggested that there are common underlying factors which may explain the link (Starr & Fawcett, 2006; Swahn et al, 2008). However, whether the relationship can be explained by these factors in a prison population has not been explored, and which factors are most relevant is unclear. In addition, the available research has tended to focus on the broad risk factors for suicide with little attention paid to individual psychological factors, triggers or motivations within this population.

The overarching objective of the present thesis is to fill a gap in the wider literature by exploring the relationship between domestic violence perpetration and suicidal behaviour in male prisoners. There are three specific aims that fulfil this:

1. To explore what is known, and identify gaps in knowledge, about why domestically violent prisoners have died by suicide in custody.
2. To gain an account of the experiences of domestically violent prisoners who have attempted suicide in custody to understand their background and histories.
3. To investigate further the factors that may underpin why and how domestic violence perpetration is related to suicide risk in prisoners attempting suicide.

These aims are achieved through two studies. While both provide information to answer the overarching objective of the thesis, the first study focuses on Aim 1 by analysing Prison and Probation Ombudsman (PPO) Fatal Incident Reports, which are written after every death in custody and involve an investigation into the circumstances of the death. Therefore, this study offers insight into the relationship between domestic violence perpetration and completed suicide. The second study fulfils Aims 2 and 3 by building on
this knowledge and investigating relevant factors through interviewing domestically violent prisoners who have made a near-fatal suicide attempt. This population has been identified as a useful proxy for completed suicides to help understand suicidal behaviour (Marzano, Rivlin, Fazel, & Hawton, 2009). As the aims of both studies involve exploration and investigation, a qualitative approach is used, which allows a researcher to describe and understand the experiences, behaviours and perceptions of individuals, and can address the ‘what, when and how?’ questions of research (Fischer, 2006).

The two studies presented in this thesis focus on suicide and attempted suicide in male prisoners. Self-harm is a risk factor for subsequent suicide (Fazel, Cartwright, Norman-Nott & Hawton, 2008) however is a specific and separate problem in custodial settings, and the patterns and rates of self-harm behaviours differ substantially from suicides in custody, and between males and females (Hawton, Linsell, Adeniji, Sariaslan, & Fazel, 2014). Therefore, broader self-harm issues and self-harm or suicide in female prisoners are not included in the scope of this study. Issues around domestic violence perpetration by women are also not explicitly covered, except for within the context of understanding that the domestic violence perpetrators that form the participants for the two studies may also have been victims (Lamis, Leenaars, Jahn, & Lester, 2013).

1.3 Overview of thesis

This chapter has provided context and background for the present thesis. Chapter 2 will explore more thoroughly the prevalence of suicide in custody and relevant definitions, issues in identifying domestic violence perpetration, review the risk factors and motivations for suicide in prisoners more generally, and will go on to review the available
literature on domestic violence and suicide risk. Chapter 3 introduces the qualitative methodologies used within the two studies and considers issues around data saturation, rigour and reflexivity in qualitative research. Chapter 4 contains the methodology and findings of the first study; a qualitative analysis of Fatal Incident Reports on the suicides of domestically violent men in custody. Chapter 5 contains the methodology and findings of the second study; the experiences of domestically violent men who have attempted suicide in custody. Chapter 6 examines and discusses the findings of the two studies and how they contribute to our understanding of the factors underpinning the link between domestic violence and suicide in prisoners. This chapter will also consider the implications for future research and practice. Overall the thesis will seek to address the aims and objective outlined in section 1.2 and add to the limited understanding of how domestic violence perpetration and suicide risk are related.
Chapter 2: Review of relevant literature

2.1 Introduction

2.1.1 Overview

This chapter will first provide some context and introduction to the areas of suicide and domestic violence. This will outline the prevalence of suicidal behaviour in prisoners, definitions of suicidal behaviours, definitions and prevalence of domestic violence perpetration, and typologies of domestic violence perpetrators. Consideration will then be given to what is known about risk factors, motivations and triggers for suicide in prisoners. Research on the relationship between general violence and suicide will be reviewed before focusing on the available studies that suggest a link between domestic violence perpetration and suicide across different samples. While the focus is on suicide in prisoners, as no studies to date have explored domestic violence as a risk factor or vulnerability in prisoners, the wider literature on offenders and other populations will be explored. A particular problem with this topic is that the focus of most research is on the effects of domestic violence victimisation only, despite a wealth of evidence that perpetrators of domestic violence can also be victims and vice versa (Lamis et al., 2013). Therefore, many studies could not be included as they did not identify rates of perpetration among the participants. Those that have been included are studies where perpetration of domestic violence was specifically measured, either in conjunction with or separately from victimisation.
2.1.2 The prison population

To provide some context when discussing the problems and psychopathology present within suicidal and/or domestically violent prisoners, it is useful to know the rates of such issues in prisoners overall. Reported rates vary among studies, likely due to the specific populations studied and the methods of collecting data. A systematic review of substance abuse and dependence in prisoners suggested rates of between 18% to 30% for alcohol abuse or dependence, and 10% to 48% for drug abuse or dependence (Fazel, Bains, & Doll, 2006). A review of mental health needs identified on reception into custody indicated that for males, 50% reported drug problems and in a more recent longitudinal study, further problematic patterns of substance issues were found; 19% reporting that they needed help with their alcohol use and 81% reporting having ever used drugs, although drug dependence and current issues with drug use were not reported (Light, Grant, & Hopkins, 2013).

In terms of mental health problems, 14% of men during reception screening reported previous treatment for mental health issues, 22% being on medication in the community and over 50% of men were assessed as having clinical needs in relation to their wellbeing (HM Inspectorate of Prisons, 2007). Using psychological health screening surveys, 33% of newly sentenced male prisoners were assessed at being at risk of experiencing anxiety, 37% depression, 23% of being at risk for both and 15% reporting psychotic symptoms (Light et al, 2013). Thirty-four percent of prisoners have been identified as meeting the criteria for a personality disorder, primarily related to antisocial and borderline personality disorder (Bebbington et al., 2017).
High levels of traumatic brain injury (TBI) have also been identified within prison populations; a systematic review calculated that while there was significant variation, a mean of 46% of participants reported TBI which is much higher than prevalence in the general population (Durand et al., 2017). This review also noted evidence of comorbidity in prisoners with TBI, including anxiety, substance misuse and hospitalisation. Childhood and family experiences have also been investigated in prison populations. Williams, Papadopoulou and Booth (2012) looked at data from newly sentenced prisoners and identified that 24% reported that they had been in care at some point, 29% experienced abuse in the home and 41% observed violence in the home. Lower rates of secure attachments with primary caregivers have been found in prisoners compared to controls (37% vs 56%), indicating a greater prevalence of insecure attachments in this population (Timmerman & Emmelkamp, 2006).

A full review of the profiles of prison populations is out of scope of the present research, however the above summary identifies some of the key issues present in a prison population such as TBI, substance misuse, mental health problems and personality disorder. Much of the research into psychopathology involves self-report and screening questionnaires, therefore may well represent an underestimation of the true levels of such difficulties. In addition, the distribution of these difficulties among prisoners incarcerated for different offences is not reported in such research.

2.1.3 Definitions of suicide

Researchers into suicide have acknowledged that while the dictionary definition of suicide is clear, defining instances of behaviour as suicide can be more complex due to the difficulties in assigning intent to an act that results in a person’s death (Joiner, 2005). In
addition, there are a range of cognitions and behaviours that may manifest as suicidal thoughts or behaviours, but may not result in actual suicide (Van Heeringen, 2001). Given the challenges in researching suicide, studies have measured and investigated a range of different suicidal behaviours as well as completed suicide, therefore it can be useful to provide clear definitions of each. Logan (2013) defined the range of suicidal behaviours as follows:

*Suicidal behaviour* refers to a range of behaviours that indicate self-inflicted harm, including completed suicide as well as self-harm acts that do not have a fatal outcome.

*Completed suicide* is a death resulting from an intentional self-inflicted act where there is evidence of an intention to die.

*Attempted suicide* is self-harming behaviour that does not have a fatal outcome however, where there is evidence that the person intended to die.

*Self-harm* refers to an intentional act of inflicting self-injury, but where there is generally not the intention to die.

*Suicidal ideation* refers to thoughts of causing one’s own death and may occur with or without associated plans or suicidal behaviours.

While there are debates about the terms used for suicidal and self-harming behaviours, there tends to be consensus that attempted or completed suicide involves the intent to die, although this can be of different degrees (Lester & Fleck, 2010) while self-harming behaviours can encompass a much wider range of harmful behaviour (Logan, 2013). These are not the only terms used within suicide literature, for example “suicidality” is used to encompass the range of cognitive and behavioural characteristics that may later manifest in suicidal ideation or behaviour (Van Heeringen, 2001). Self-harm has been defined as “parasuicide” or “self-injury” (Logan, 2013) and in the Ministry of Justice, the term “self-
inflicted death" is used to refer to all known or suspected deaths by suicide among prisoners (Ministry of Justice, 2017b). The Ministry of Justice definition of self-inflicted deaths categorises all deaths by their apparent cause in order to capture likely suicides as widely as possible, and therefore does not require intent to die to be explicitly apparent (Ministry of Justice, 2016).

A particular terminology used within the present thesis is that of ‘near lethal’ suicide attempts. While some research suggests that those who have died by suicide have some overlapping or similar characteristics with those who have attempted suicide (DeJong, Overholser, & Stockmeier, 2010) other studies indicate a number of differences such as personality disorder characteristics or rates of alcohol misuse (Giner et al., 2013). It has been suggested that ‘near lethal’ or ‘serious’ suicide attempters may be most similar to those who actually die by suicide (Marzano et al, 2009). Near-lethal suicide attempts in prisoners have been defined as those which could have been lethal if not for the intervention of others and involve methods which are associated with a reasonably high chance of death (Rivlin, Fazel, Marzano & Hawton, 2012), although other studies have used the definition of medically serious attempts that required hospitalisation or surgery (Horesh, Levi, & Apter, 2012).

2.1.4 Rates of suicidal thoughts and behaviours in prison

Suicide is one of the most common causes of death in prisons (World Health Organisation, 2007) and is more common in prisoners than people in the community of similar age and gender (Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016). In the general population in the UK, the rate of suicides per 100,000 of population in 2015 was reported as 10.9 overall, 16.6 for males and 5.4 for females (Samaritans, 2017). In comparison, the rate of self-
inflicted deaths of men in custody in the 12 months prior to March 2016 was 120 per 100,000 (Ministry of Justice, 2016); this indicates that men in prison were more than seven times more likely to die by suicide than men in the community. Figure 1 shows the changes in self-inflicted deaths of men in prisons over the last 20 years according to official government statistics (Ministry of Justice, 2016).

The data indicates that after peaks in the late 1990s self-inflicted deaths had overall been decreasing steadily and remained somewhat stable until 2012, when they began increasing again, with somewhat alarming rapidity.

Figure 1: Number and rates of self-inflicted deaths of males in custody 1996-2016

Rates in prison do appear to be decreasing according to the most recent data, with the most recent prevalence being reported as 90 self-inflicted deaths per 100,000 (Ministry of Justice, 2017b), although a high number of deaths are still awaiting classification. Given the small numbers involved, it is worth noting that these recent changes could be due to random variation rather than signifying a new trend. Even at the lowest levels seen in the
past 20 years in 2011 however, prevalence of self-inflicted deaths in custody was still 68 deaths per 100,000 for males, many times the rates in the community.

In terms of other suicidal behaviours, approximately 20% of the general population have reported ever experiencing suicidal thoughts, and suicide attempts were found in approximately 7% (McManus, Bebbington, Jenkins, & Brugha, 2016). Again, rates among prisoners are higher than in the general population; in a sample of UK local prisoners (local prisons are designated to house individuals awaiting trial or sentencing, and those on shorter sentences), 12% had current suicidal ideation and 25% reported attempting suicide at some point in their lives (Senior et al., 2007). Data from other countries also supports that there are higher rates of suicidal ideation and attempts in custodial populations in Canada (Bland, Newman, Dyck, & Orn, 1990), Australia (Larney, Topp, Indig, O’Driscoll, & Greenberg, 2012) and Italy (Roy, Carli, Sarchiapone, & Branchey, 2014).

Overall it is clear that prisoners are at increased risk of a range of suicidal behaviours including completed suicide. While this has been known for some years and prisons have continued to develop suicide prevention programmes and guidelines, self-inflicted deaths in custody remain problematic.

2.1.5 Domestic violence definitions and prevalence

The present thesis is concerned with how perpetration of violence towards those close to someone may relate to a vulnerability to attempting or completing suicide. Domestic violence may be variously referred to as domestic abuse (Evans, Scourfield, & Moore, 2014), intimate partner violence (IPV) (Dutton & White, 2012), dating partner violence (Chan, Straus, Brownridge, Tiwari, & Leung, 2008) battering (Cameranesi, 2016) and family violence (Durose et al., 2005) within the literature. These terms can overlap or can
represent a slightly different definition or focus. The UK cross-government definition of domestic violence is:

“Our incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial or emotional harm” (Home Office, 2016).

This is a broad definition of domestic violence, which is inclusive of abuse towards family members as well as intimate partners, although much of the data on domestic violence is focused on the latter. For example, in a review of 42 papers examining domestic violence among psychiatric patients, only seven included violence involving family members other than a partner (Oram, Trevillion, Feder, & Howard, 2013). All of the studies exploring domestic violence and suicide risk presented in this chapter use the narrower concept of IPV which has been defined as the “experience of one or more acts of physical and/or sexual violence by a current or former partner” (World Health Organization, 2013). IPV is traditionally defined as involving actual physical violence or threatened weapon use, and this is often measured using the Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). There still remain some issues with this definition however, as IPV can be measured in other ways for example by researcher developed scales that may also include questions about controlling, aggressive or coercive behaviour (Rhodes et al., 2009). The inclusion of psychological or emotional abuse within the concept of IPV fits more closely with the UK Government definition of domestic violence (Home Office, 2016), however the differing concepts and measurement can make comparing and integrating
research findings challenging. For example, it is difficult to know whether the factors underpinning types of domestic violence (for a brief overview see 2.1.6) are relevant to relationships where there is coercive and controlling behaviour but not physical violence.

Prevalence estimates of domestic violence in the UK have generally focused on those who report victimisation rather than those who report perpetration. In national crime surveys, 26.3% of women and 13.6% of men have reported experiencing domestic abuse since the age of 16 (Office for National Statistics, 2017); this survey used the wider definition of abuse by a partner or family member. By comparison, statistics on the number of men in prison for perpetrating domestic violence are not available, as such offences are grouped within the category of violence against the person. This category comprises around 25% of offences by sentenced prisoners and 23% of offences by prisoners on remand (Ministry of Justice, 2017a). Information about domestic violence arrests and recorded crimes has started to be collected by police forces however, and indicate that 11% of all offences recorded by the police are flagged as domestic abuse related (Office for National Statistics, 2017). This included a range of different types of offences including violence against the person, criminal damage, arson, public order and sexual offences. It is unclear how many of these go on to attract a custodial sentence, and how accurate detection rates are.

Measuring domestic violence can be difficult due to the under-reporting of such abuse by victims, how to quantify continuous or frequent domestic violence, and the lack of a specifically defined conviction of domestic violence (Dar, 2013). This is a problem across many countries, where offence codes cannot provide reliable estimates of domestic violence and those arrested for domestically violent behaviour are often given low level charges or cautions (Day, Richardson, Bowen, & Bernardi, 2014). Therefore, wherever
research reports prevalence of domestic violence it is likely that this under-represents violence, much of which may not be captured by narrower IPV definitions, is not acknowledged by victims or perpetrators, not reported to police, or does not result in a charge or conviction.

2.1.6 Types and typologies of domestic violence perpetration

Research has also sought to understand domestic violence through exploring heterogeneity related to the features of the violence and the perpetrators involved. In terms of the nature of IPV, studies have investigated the directionality and nature of domestic violence; that is whether those involved are victims only, perpetrators only, or perpetrators and victims. Johnson (2006) proposed four types of IPV based on several variables, focusing on the presence of violence and controlling behaviour. “Intimate terrorism” describes IPV where one of the partners is violent and controlling, whereas the other is nonviolent and/or non-controlling. “Violent resistance” refers to IPV where one partner responds to violent and controlling behaviour with their own violence. “Situational couple violence” involves mutual IPV behaviours but where neither partner is both violent and controlling. Finally, “Mutual violent control” refers to IPV where both partners are violent and controlling towards each other. Many studies have explored these different types of IPV and indicated that they can be perpetrated by both genders, although some researchers have suggested that certain types of IPV may be more commonly perpetrated by men and others by women (Kelly & Johnson, 2008). This stance has been criticised by some researchers for conflating gender and violence, and seeing IPV in a stereotypical way as triggered by the male desire for power and control (Dutton, Hamel, & Aaronson, 2010). Dutton (2012) argues that bidirectional IPV is the most common form of domestic violence.
given the range of literature indicating that women can be perpetrators of IPV behaviours as frequently, and sometimes more so, than men (Archer, 2002). While the debate about the role of gender continues, it can still be useful to recognise that IPV is not homogenous and that men may also be victims of IPV, either with or without being perpetrators.

The second approach to understanding IPV has been the development of typologies of IPV perpetrator. A number of studies have identified sub-types of IPV perpetrators across dimensions of severity of marital violence, generality of violence and psychopathology or personality disorder (Cavanaugh & Gelles, 2005; Holtzworth-Munroe & Stuart, 1994) as well as using other methods such as psychometric testing (Fowler & Westen, 2011; Johnson et al, 2006). Table 1 presents a summary of some of the key typologies identified in the IPV literature.

While there are differences in the methods used to identify typologies, the definitions and the focus placed on different behaviours or pathologies, there are clear similarities across the typologies presented in Table 1. In particular, IPV perpetrators who engage in violence largely within their relationships and with lower severity or frequency are distinguished from those with a variety of problematic personality psychopathologies, and those who engage in a range of criminal and violent behaviour. It has been suggested that a range of distal and proximal factors account for the development of the different subtypes of IPV behaviour, such as experience of childhood abuse, attitudes to violence or women, social skills or attachment style (Dixon & Browne, 2003). The heterogeneity of domestically violent men has been supported in several studies, with much of the literature focusing on the typologies presented by Holtzworth-Munroe and Stuart (1994).
### Table 1

**Summary of subtypes and typologies of IPV perpetrator**

<table>
<thead>
<tr>
<th>Study</th>
<th>Typologies</th>
<th>Definition/description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holtzworth-Munroe and Stuart (1994)</td>
<td>Family only batterer</td>
<td>Low severity of marital violence, low extrafamilial violence or other criminality, little psychopathology, moderate anger</td>
</tr>
<tr>
<td><strong>Subtypes based on literature review</strong></td>
<td>Dysphoric or borderline batterer</td>
<td>Moderate to high severity of marital violence, low to moderate extrafamilial violence or other criminality, borderline or schizoid personality disorder, moderate drug abuse, high levels of depression and anger</td>
</tr>
<tr>
<td></td>
<td>Generally violent or antisocial batterer</td>
<td>Moderate to high severity of marital violence, high levels of extrafamilial violence or criminality, antisocial/psychopathic personality disorder, high levels of drug abuse, moderate anger</td>
</tr>
<tr>
<td>Cavanaugh and Gelles, (2005)</td>
<td>Low risk batterer</td>
<td>Low severity and frequency of violence, little or no psychopathology, usually no criminal history</td>
</tr>
<tr>
<td><strong>Synthesis of batterer typologies</strong></td>
<td>Moderate risk batterer</td>
<td>Moderate severity and frequency of violence, moderate to high psychopathology</td>
</tr>
<tr>
<td></td>
<td>High risk batterer</td>
<td>High severity and frequency of violence, high levels of psychopathology, usually have a criminal history</td>
</tr>
<tr>
<td>Johnson et al (2006)</td>
<td>Low pathology</td>
<td>Low interpersonal dependency, moderate macho attitudes and levels of narcissism and low levels of childhood abuse experiences</td>
</tr>
<tr>
<td>psychometric measures</td>
<td>Borderline</td>
<td>High levels of psychopathology such as depression and alcohol dependence, fearful or preoccupied attachment styles, high levels of physical and sexual abuse as children, high levels of suicidal ideation, low self-esteem and anger</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Narcissistic</td>
<td>High narcissistic and paranoid traits, low macho attitudes, less fearful or preoccupied and high on impression management</td>
</tr>
<tr>
<td></td>
<td>Antisocial</td>
<td>High antisociality scores, high substance dependence, high levels of macho attitudes, poor school behaviour and most likely to have previous convictions</td>
</tr>
<tr>
<td>Fowler and Westen (2011)</td>
<td>Psychopathic partner-violent men</td>
<td>Violence used instrumentally, generally violent, violence and other externalising behaviour begins in childhood</td>
</tr>
<tr>
<td>Subtypes based on assessment of personality characteristics</td>
<td>Hostile/controlling partner-violent men</td>
<td>Angry and controlling, poor impulse control, reactive to perceived slights.</td>
</tr>
<tr>
<td></td>
<td>Borderline/dependent men</td>
<td>Higher negative affect, features associated with Borderline Personality Disorder</td>
</tr>
</tbody>
</table>
These typologies have been validated in a range of studies involving different contexts and populations, for example in court-referred IPV perpetrators the original typologies were supported and found to predict programme attendance, completion and recidivism (Carbajosa, Catalá-Miñana, Lila, & Gracia, 2017). More support across studies has been found for antisocial and borderline typologies, although there is limited agreement on the individual features and proportions of perpetrators fitting into each group (Cameranesi, 2016). There remain criticisms of the use of typologies, such as the difficulties in using rigid classification systems, and the lack of attention paid to the environmental and contextual factors (Dixon & Browne, 2003). Nonetheless, distinguishing between types of IPV perpetrator and their profiles is proposed to be useful to aid effective assessment and intervention (Cavanaugh & Gelles, 2005). As with much research on this topic, the focus has largely been on male perpetrators of abuse towards their female partners, therefore the relevance to the wider issue of family violence is unclear.

2.2 Understanding suicide in prisoners

2.2.1 Risk factors for suicide in prisoners

In the general population, individual risk factors for suicide have been identified to include a previous suicide attempt, mental disorders, harmful alcohol use, job loss, hopelessness, chronic pain, family history of suicide and genetic factors (World Health Organisation, 2014). The WHO have identified that males between the ages of 17-49, persons with mental illness and persons with substance misuse issues are at increased risk; all of whom are over-represented in custodial populations (Allen & Watson, 2017; HM Inspectorate of Prisons, 2007; Singleton, Farrell, & Meltzer, 1997). Investigations into suicide in prisons
have sought to identify whether the pertinent risk factors are similar to those in the general population, or whether additional issues regarding this vulnerable group are relevant. Consistent with the general issues experienced by prisoners, key characteristics of prisoners who have completed suicide include high levels of mental disorder, particularly depressive and bipolar disorder, substance misuse histories or drug dependence, previous self-harm, being within seven days of reception into prison and being alone or in a single cell (Humber, Piper, Appleby, & Shaw, 2011; Shaw et al., 2004). Studies such as these have clear limitations due to the high levels of some of these characteristics found generally in prisoners. For example when reviewing mental health provision in custody, HM Inspectorate of Prisons (2007) found that half of those entering custody reported drug or alcohol misuse problems, 17% had a mental health history and 16% reported a history of self-harm. Given that this information, which was obtained upon reception into prison, relied on the relevant questions being asked and self-disclosures being made it is likely an underestimation. However, as these characteristics are prevalent within a prison population as outlined in section 2.1.2, studies focusing on characteristics are unable to explain why some prisoners have died by suicide and others with similar characteristics have not.

Despite the limitations of these descriptive studies, many of the characteristics identified have been supported by more robust studies that compared rates of these characteristics in those engaged in suicidal behaviours with control groups. Compared with controls, those who completed suicide in prison have been found more likely to have a history of self-harm, to occupy a single cell, be on remand and have previous mental health contact or psychiatric diagnosis (Frühwald et al., 2004; Humber, Webb, Piper, Appleby, & Shaw, 2013). A systematic review of the literature also provided support for many of these
factors increasing risk of suicide including single cell occupancy, suicidal ideation and a history of attempted suicide, current psychiatric diagnosis and being on psychotropic medication (Fazel et al., 2008). These factors all had odds ratios of four or greater indicating that individuals with these factors were at least four times more at risk of suicide than controls; for suicidal ideation, completed suicide was 15 times more likely. Fazel and colleagues also identified further factors including being on remand, receiving a sentence of over 18 months or a life sentence, being male and being white as risk factors for prison suicides. These factors were all found to have an odds ratio of 1.5 or greater, and were also significantly associated with suicide in prisoners. While this systematic review used only studies that had a matched or random control group, they reveal only that if these factors are present in someone’s history they may increase risk of suicide. The findings do not reveal how these factors may change over time or which combinations of risk factors may be most critical to understanding suicide risk. The authors note that many of these risk factors are likely to co-occur in individuals who complete suicide, however it is unclear what number and/or combination of risk factors may predict completed suicide in prisoners and whether this is different for those attempting suicide or engaging in other suicidal behaviours.

While these studies have investigated factors associated with completed suicides in prisoners, others have explored characteristics linked to future suicide risk in prisoners, usually measured using self-report or clinician rated scales. While such studies have limitations in the conclusions that can be drawn about those who will go on to complete suicide, an advantage is that they allow more in-depth exploration of psychological and individual factors. Prisoners identified to be at increased risk of suicide have been found to report at least twice as many traumatic life events across their lives than non-suicidal
prisoners (Blaauw, Arensman, Kraaij, Winkel, & Bout, 2002), and the authors suggest that it is the accumulation of such traumatic events over the lifespan that is associated with increased suicide risk. When investigating psychological characteristics as predictors of suicide probability, moderate positive correlations were found between feelings of hopelessness, entrapment, and defeat and suicide probability (Gooding et al., 2017), although further analysis in this study indicated that it was primarily defeat and hopelessness that contributed to suicide probability over and above entrapment. This study is limited by the lack of control group and the specific sample; participants were from a high-security prison and had already been identified as at risk of suicide using ACCT (Assessment, Care in Custody and Teamwork: the framework used to manage suicide risk in prison). However, the findings are consistent with other research, for example the finding that over time those who self-harm and are assessed as experiencing hopelessness are 2.5 times more likely to complete suicide (Steeg et al., 2016). In a large Italian study, prisoners engaging in suicide attempts were found to be 1.6 times as likely to have experienced childhood trauma, emotional lability and have problems with substance abuse than those who had not (Sarchiapone et al., 2009). Similar findings were found by Sarchiapone et al. (2009) for those who reported suicidal ideation; these prisoners were over twice as likely than non-suicidal prisoners to experience emotional lability or childhood trauma. These studies exploring the psychological characteristics have their limitations as they are largely based on self-report data, however offer suggestions for variables that may be helpful to include when assessing suicide risk over and above the generic questions regarding previous history.

Past suicide attempts are associated with completed suicide in prisoners (Fazel et al., 2008) and medically serious suicide attempters have been found to be a strongly overlapping
population with suicide completers in terms of their characteristics and risk factors (Beautrais, 2002). It is of note however, that despite many similar characteristics Beautrais (2002) found that over 70% of the suicide attempters had a history of previous suicide attempts compared to only 42% of suicide completers. As there are those that will complete suicide on their first attempt, further research may be needed to identify whether it is possible to identify these individuals. Nonetheless, examination of prisoners making near-lethal suicide attempts has been suggested to provide a useful proxy to those dying by suicide (Rivlin et al., 2012), as it allows detailed investigation and discussion with those who have come close to completed suicide. Compared to controls, prisoners making near-lethal attempts reported increased levels of problematic psychological characteristics such as depression, impulsivity and hopelessness, and increased rates of both childhood trauma and adverse life events (Rivlin, Hawton, Marzano, & Fazel, 2013). However, it was noted that such issues were common among all the prisoners in the study, although those making a near-lethal suicide attempt had experienced significantly more types of adverse life events than controls. In a systematic review of articles that researched near-lethal suicides, a range of factors were found to be associated with such attempts (Marzano et al., 2016). These included historical factors such as prior self-harm and psychiatric treatment, prison related factors such as nature of prior convictions and negative experiences of incarceration, and clinical factors such as mental health problems, aggression, and childhood trauma. The similarities to those identified for prisoners completing suicide suggest that individuals making near-lethal attempts are likely to experience comparable issues that make them vulnerable to suicide. A limitation of such studies is the reliance on self-report through questionnaires and interviews, which may be affected by what participants are willing to disclose.
In summary, the research indicates that many factors linked to suicides in prison are similar to those linked to suicides in the general population. Importation models of prison suicides suggest that the reason rates of suicide in custody are substantially higher is due to prisoners ‘importing’ the demographic, social and psychological characteristics associated with suicide risk generally and that these predate imprisonment (Adams, 1992). In contrast, the deprivation model holds that prison suicide is an artefact of the restrictive prison environment and that it is being deprived of human needs such as security, liberty and goods that leads to destructive behaviour towards the self or others (Dye, 2010). Evidence to support the deprivation model comes from the factors around location and time in custody being relevant; more restrictive environments are associated with increased rates of suicide (Daniel & Fleming, 2006) as is being in a single cell (Fazel et al., 2008). The consensus among researchers appears to be that prison suicides can best be explained by a combination of both models; prisoners have higher rates of the characteristics associated with risk of suicide generally and experience an isolating, often difficult environment that further increases their risk (Dye, 2010; Hochstetler & DeLisi, 2005; Rivlin et. al., 2013). Marzano et al., (2016) have also suggested that the combination of factors lends support to diathesis-stress models of suicidal behaviour being relevant to prisoners. Diathesis-stress, or vulnerability-stress, models describe psychopathologies as an interaction between stress levels and the biological, genetic or environmental factors that predispose someone to experience that problem (Ingram & Luxton, 2005). In relation to suicidal behaviour, diathesis-stress models suggest that environmental adversity, genetic and neurobiological factors and personality traits contribute significantly to suicide risk (Brodsky & Stanley, 2012; Brodsky, 2016; Mann, 2003). Therefore, prisoners may
experience higher levels of the predisposing risk factors of suicide, a vulnerability to stressors, and the environment further adds to this by increasing their stress.

2.2.2 Motivations and explanations for suicide in prisoners

Further to the exploration of risk factors, other studies have explored the motivations and triggers for suicide in prisoners. It has widely been identified that there is not a single definition or profile of a ‘suicidal prisoner’ (or suicidal person), therefore researchers have sought to identify typologies of suicidal individuals by looking at their motivations, explanations and reasons for suicide. One theme that has come from these studies is that of the prisoner who is unable to cope (Liebling, 1999; Rivlin, Ferris, Marzano, Fazel, & Hawton, 2013; Snow, 2002). Liebling (1999) linked suicide attempts for this group to coping with emotions such as fear, helplessness, distress or isolation. Snow (2002) distinguished between suicide attempters and those engaging in self-harm, and identified that those who had self-harmed largely gave explanations for their behaviour focusing on their experience of emotions and coping. Those attempting suicide linked their behaviour to dealing with a wider range of motivations, including dealing with grief or bereavement and interpersonal problems. This suggests that coping deficits were relevant for those attempting suicide. Rivlin, Fazel, Marzano and Hawton (2011) explored the reasons given by prisoners for their near-lethal suicide attempts when exploring the suicidal process in this group. These were grouped into four main areas including adverse life events. The most common adverse life events were linked to interpersonal issues; relationship breakdown or conflicts, bereavement or illness in the family and missing family, indicating that the ability to cope with life stressors or those linked to the prison environment was an important factor for many.
A second pattern within suicidal prisoners relates to environmental or situational motivations. Liebling (1999) specifically identified those serving or facing life sentences as being a distinct type of suicidal prisoner, which she linked to the experience of guilt or the prospect of ‘no future’. Snow (2002) also identified a lengthy sentence and offence related motivations as being an explanation that prisoners gave for attempting suicide, and that adult male offenders were most likely to describe situational factors which related to a negative emotional reaction to being in custody and experiences of being in prison including drug withdrawal. Similarly, Rivlin et al. (2011) found that some prisoners gave reasons linked to criminal justice or prisons for their suicide attempts, such as anxiety about sentencing, segregation and conflict with staff or the ‘system’. Two of Rivlin et al’s (2013) sub groups of suicide attempters relate to the environment or situation; those with instrumental motives and those attributing their suicide attempts to their withdrawal from drugs in custody.

Another proposed type of prison suicide is that of the psychiatrically ill offender (Liebling, 1999; Rivlin et al., 2011; Rivlin et al., 2013), where psychotic or other psychiatric symptoms motivate the suicide attempt. Liebling (1999) suggested that these prisoners can experience high levels of alienation, loss of control and fear that contributes to their risk of suicide. While this is the third main type of suicidal prisoner that is apparent across the literature, some other motivations and explanations have been postulated. Rivlin et al (2013) noted that there was an ‘unexpected’ group of suicide attempters, where the attempt was impulsive and difficult to pin down to a specific motivation. This is concerning in terms of suicide risk assessment as the presence of this group suggests that for some prisoners there may be little warning of a suicide attempt.
There is clear overlap between the typologies and explanations for suicide in prisoners. The range of motivations for suicide in prisoners indicates that there is unlikely to be one profile of a suicidal prisoner, and there may be different risk factors that are relevant for different subgroups of prisoners (Rivlin et al., 2013). There are limitations to the available data on motivations for suicide in prisoners. Snow (2002) noted that 478 different explanations were given by 123 participants, indicating that there may be substantial overlap between different typologies of suicidal prisoners. Leibling (1999) used data collected by prisons to identify different types of suicidal prisoner, but it was unclear where the information on what motivated the suicides came from, and this was not empirically tested. The largely qualitative nature of these studies means that there are limitations in terms of applicability across different times and locations. However, they provide valuable additional information about the various processes and factors important in understanding suicidal behaviour. It is not yet clear how the research on risk factors and typologies of suicidal prisoners may work together; for example, what combinations of stable and acute risk factors, characteristics and motivations may explain suicide in this population.

2.3 Violent behaviour and suicide risk

A common finding in many of the studies regarding risk of suicide in prisoners is the contribution of a violent history, although the evidence is somewhat mixed. Early studies found that in psychiatric populations, risk of violence and suicide was correlated (Kotler et al., 1993; Plutchik, van Praag, & Conte, 1989; Plutchik, van Praag, Conte, & Picard, 1989) although these studies are limited in explaining why this link may have occurred. In prison
samples, an index violent offence or history of violent offending has been associated with suicide (Fazel et al., 2008; Frühwald et al., 2004; Humber et al., 2013; Webb et al., 2012), with odds ratios ranging from 1.63 to 12. The highest increase in risk of suicides was found for an index offence of homicide or attempted homicide when comparing completed suicides in adults with criminal justice contact in Denmark with controls (Webb et al., 2012). The lowest was found for UK prisoner deaths for those charged with a violent offence other than murder or manslaughter (Humber et al., 2013). A study exploring the characteristics of prison suicides without a control group also found that a history of violence was significantly associated with suicide (Humber et al., 2011). No such relationship was found when investigating prisoners with a near-lethal suicide attempt versus matched controls who had never made such an attempt in prison (Rivlin et al., 2013). A further exception to this finding was an early study of deaths in the Scottish Prison Service, which reported that ‘most’ of the 33 completed suicides between 1970 and 1982 were of men who were serving short sentences for non-violent crimes such as theft (Backett, 1987), although the specific types of crimes and histories were not reported. In contrast, a similarly timed study of prison suicides in England and Wales found that a significantly higher proportion had been charged or convicted of a violent or sexual offence compared to the general sentenced population (Dooley, 1990). This suggests that there may have been specific differences between the populations and characteristics of the Scottish sample.

Self-reported violence has also been linked with increased suicidal ideation in those treated for substance use disorders (Ilgen et al., 2010) and high levels of aggression were found among a forensic psychiatric sample of suicide attempters (Gunilla Stålenheim, 2001). It is of note that this study did not find a relationship between suicide attempts and
violent criminality. It may be that the differing samples explain the inconsistencies among findings of a relationship between violence and suicide risk. For example, it may be that prisoners in custody with a history of more serious violence have increased risk of completing suicide, rather than those in psychiatric populations or where suicide is attempted but not completed. The reason for this discrepancy is not clear, although differences between those who attempt and completed suicides have been found, such as increased substance use prior to the suicidal act, and increased problems with finances and employment (DeJong et al., 2010). Despite some inconsistencies in the literature, overall there is evidence that prisoners with a history of violence are a risk both to themselves and others (Humber, Piper, Appleby, & Shaw, 2011).

2.4 Domestic violence and suicide risk

There has been limited research into whether the perpetration of specific types of violence is associated with risk of suicide, and this has not been quantified accurately or precisely in the literature (Webb et al., 2012). One important point to note is that all the research into domestic violence and suicide has investigated Intimate Partner Violence (IPV) rather than the wider definition of domestic violence. Therefore, the applicability of any of the research presented in this section to violence against parents, siblings or other close family members is unclear. Tentative links have been made between perpetration of IPV and suicide risk, although the types of suicidal behaviour and populations studied have varied considerably. Given the limited range of studies on this topic, the following represents a review of the available literature on the relationship between IPV and suicidal thoughts or behaviours.
2.4.1 Offenders

No available studies have specifically looked at the relationship between domestic violence and suicide in incarcerated offenders. In fact, few studies have explored this relationship in those officially charged with domestic violence or serving community sentences, and all those available use American samples. One area of related study is that of homicide-suicides; where a perpetrator of a murder subsequently commits suicide usually within a very short time span. Liem (2010) conducted a thorough review of the literature into homicide-suicide, identifying that the most common type of homicide-suicide involves intimate partners and is predominantly committed by men, although can occasionally include parents or siblings. She identified that perpetrators are often found to have suffered from mental illness, have controlling and emotionally dependent characteristics, and are characterised by aggression and jealousy when the relationship is threatened. While this literature reinforces the link between domestic violence and suicide, it is important to note that suicides in this context generally occur in the community and are a rare event (Flynn et al., 2009).

Of the research into the link between IPV and suicide in offending populations, studies have focused on men in the community rather than custody, and the main aims of these have often been on other issues such as IPV perpetration. One study looked at rates of IPV in males who completed suicide in the community as part of investigations into all domestic violence fatalities in Washington State. Although the focus was primarily on victims, the numbers of perpetrators who also died were examined. The researchers found that almost 20% of men who died in the state in one year had a court documented history of perpetrating domestic violence, which the authors highlight as a likely
underestimation (Starr & Fawcett, 2006). Data collected in the USA indicates that 15% of those in state prisons and 22% in local jails were convicted of family violence (Durose et al., 2005) although this includes crimes perpetrated by women and offences against children, which comprised up to half of family violence crimes in state prisons. The same statistics indicate that around 17% of violent crimes recorded by police were domestic violence between spouses. Given that only half of recorded crimes resulted in arrest, these statistics indicate that men with a court documented history of domestic violence are over-represented in terms of completed suicide.

Conner, Cerulli and Caine (2002) recognised a gap in the understanding of IPV perpetrators and suicide risk, and gathered information on suicide attempts and threats of suicide by men who had been asked to attend a domestic violence intensive intervention court. They found that 45% of the men had a history of threatened suicide and 13% had a history of suicide attempts. Of the perpetrators who made threats to harm themselves, 26% had also attempted suicide. The authors noted that most suicide threats occurred within the previous six months, however suicide attempts tended to be more historic, suggesting that there may be differing patterns of suicidal threats and behaviour in this group. However, this information was gathered from female petitioners at the court rather than the male perpetrators directly which presents concerns about the accuracy of the information and reporting. This is not the only study to use this technique, and others have identified female victims’ perception of perpetrator suicidality to be linked with IPV injury (Walton-Moss, Manganello, Frye, & Campbell, 2005), and victim reports of perpetrator threats of suicide to be associated with an ‘intimate terrorism’ style of IPV (Frye, Manganello, Campbell, Walton-Moss, & Wilt, 2006). There are clear limitations in these studies as they rely on victim perceptions and are descriptive in nature, meaning that few conclusions can
be drawn about the nature of the relationship between IPV and suicide. Additionally, while the rates of threatened suicide appear high, rates of attempted suicide seem to be comparable with prisoners generally (see 2.1.4).

More recently, Wolford-Clevenger et al. (2014) studied suicidal ideation in male IPV perpetrators who were attending a community intervention programme. In contrast to the previous studies, they obtained information about suicidal ideation directly from the perpetrators, and found that 22% of participants experienced suicidal ideation in the two weeks prior to starting the intervention, and suicidal ideation was positively correlated with physical IPV perpetration. However, when controlling for IPV, symptoms of Borderline Personality Disorder (BPD) and depression accounted for significant variance in suicidal ideation. This suggests that it may not be IPV specifically, but interpersonal difficulties, aggression or impulsive responses that underpin suicidal ideation in this group. While this is the only study of IPV and suicide in offenders to attempt to distinguish the contribution of IPV from other factors, the authors measured suicidal ideation through a depression measure rather than one validated to measure suicidal ideation, and did not use formal diagnoses of BPD. These limitations, as well as the potential differences between those with suicide ideation versus those who attempt or complete suicide, may have impacted on the results.

A further study compared male and female perpetrators of IPV to identify and compare their respective treatment needs (Henning, Jones, & Holdford, 2003). They completed a psychological assessment of the participants after their conviction, and identified those who had previously attempted suicide. While their findings focused on exploring differences between male and female perpetrators of IPV, they reported that 3.8% of
males in the sample reported a past suicide attempt. This is similar to the rates found across countries in the general population (Weissman et al., 1999) and lower than recent rates found in the UK (McManus et al., 2016). This result calls into question the relationship between domestic violence and suicide in offending populations, however it is possible that the methods may have impacted on the results. A single question was asked regarding suicide attempts, and the authors note that some of the data for their study was collected in groups (although they do not specify which data); either of these factors may have limited the information self-reported by participants.

2.4.2 Other populations

While there is limited research using those with formal charges for IPV, studies using self-reported IPV perpetration have provided evidence for a link with suicide risk. In student and adolescent populations, those who had considered, planned or attempted suicide reported significantly higher perpetration of a range of dating violence behaviours (Else, Goebert, Bell, Carlton, & Fukuda, 2009), and a history of suicide attempts was found to predict bidirectional IPV in young adults, with young males with a suicide attempt being over three times more likely to be involved in IPV (Renner & Whitney, 2012). Similarly, adolescents and public school students who reported dating violence perpetration were more likely to report suicidal ideation (Nahapetyan et al., 2014) or suicide attempts (Swahn et al., 2008). These studies suggest that IPV increases risk of suicidal behaviour but also that suicidal behaviour increases risk of IPV. Kerr and Capaldi (2012) found that suicide attempt history in adolescents predicted relationship instability and causing injury to a partner, although not domestic abuse arrests, which the authors suggested may be due to the generally low levels of serious injury in their sample. This supports a suggestion that
suicide risk may be increased in those with more serious domestically violent behaviour. Investigation of adult inpatients presenting with suicidal ideation as their main difficulty identified extremely high proportions of both self-reported IPV perpetration and victimisation; 91% reported perpetrating IPV and 93% reported experiencing IPV (Heru, Stuart, Rainey, Eyre, & Recupero, 2006). This is substantially higher than estimates of the general prevalence of domestic violence (see 2.1.5). Heru, Stuart and Recupero, (2007) further explored this finding and suggested two potential hypotheses; that family functioning may have deteriorated in this group due to their suicidal thoughts or that interpersonal violence may have resulted in suicidal thoughts. However, there was no clear evidence about which hypothesis was more likely, or why such high levels of IPV were found among this sample. It may be that there are some common underlying factors, for example as Wolford-Clevenger et al. (2014) suggest, the relationship may be explained by depression or borderline personality features.

In community samples, studies have identified increased suicidal ideation in men presenting in emergency departments who reported involvement in IPV compared to those who reported no involvement (Houry et al., 2008; Rhodes et al., 2009). The ‘involved in IPV’ groups in these studies included those who were perpetrator-victims as well as those who were purely victims however, making it difficult to apply the findings to perpetrators of IPV. A further population studied in relation to domestic violence and suicide have been those with alcohol or drug related problems. Conner, Duberstein and Conwell (2000) found that domestic violence histories were reported in 50% of alcoholic men who died by suicide in an analysis of psychological autopsy data. Psychological autopsy, a retrospective investigation into the motivations and experiences of the deceased that takes place by interviewing close relatives (“The Psychological Autopsy,”
1981) has been highlighted as a useful method to understand prison suicides (Spellman & Heyne, 1989), however it has been rarely applied. In another study, outpatients in a substance misuse support service reported relatively high levels of both partner and non-partner aggression, and physical partner aggression was associated with increased suicidal ideation (Ilgen et al., 2009). However, the association became non-significant when adjusting for measures of negative affect, although depressive symptoms and suicidal ideation were collected from the same measure which may have impacted on the results.

There is generally consistent evidence of veterans having increased rates of both domestic violence and suicide (Jones, 2012; Kirsch, 2014; Marshall, Panuzio, & Taft, 2005; Rozanov & Carli, 2012), however only two studies have explored the link between these issues. Male veterans who reported involvement in IPV were identified to be more likely to also report suicidal thoughts than those who had no involvement (Cerulli, Stephens, & Bossarte, 2014). However, while the authors note that only one individual reported perpetration in isolation of victimisation, it was not clear whether the remaining participants who reported IPV involvement were purely victims, or both victims and perpetrators. While the findings are limited by a cross-sectional design, they are supported by the results of a wider longitudinal study. In this, Ursano and colleagues (2017) found that veterans with a history of perpetrating family violence were more likely to make a suicide attempt than victims, or those without any history of family violence. This finding was after controlling for variables such as mental health diagnoses, indicating that family violence was an independent predictor of suicide attempts. Interestingly, while not exploring the link between domestic violence and suicide specifically, one study found that after a community wide intervention designed to reduce suicide risk among US Air Force veterans was implemented, moderate and severe family violence reduced (Knox, 2003). This suggests that there may be similar
underlying characteristics or risk factors for suicide and family violence in this group, although causal inference is not possible and the paper does not specify perpetration or victimisation of the violence.

Other studies investigating IPV perpetration and suicide have yielded mixed results. In college students, some studies have not found consistent links between self-reported IPV and suicidal ideation that could not be accounted for by other factors such as depression or hopelessness (Chan, Straus, Brownridge, Tiwari, & Leung, 2008; Chan, Tiwari, Leung, Ho, & Cerulli, 2007; Lamis et al., 2013). However, these results may be an artefact of the low reported prevalence of physical assault, the measure being of suicidal ideation rather than attempts, and may be specific to the international samples used. As Lamis et al (2013) suggested, such results could still indicate that IPV perpetration does have a role to play in suicide but is mediated through other variables rather than being an independent predictor. Another study in fact found the opposite relationship; that men who had reported suicidal thoughts or actions were less likely to have engaged in IPV behaviours (Peek-Asa et al., 2005). This may be related to the specific rural US population used, or as the authors suggest, the lower overall severity of abuse included within this study. This could provide further support for the relationship being stronger when the associated behaviours are more serious.

2.4.3 Limitations of the literature

There are several limitations with the research in this area. Most studies used a cross-sectional design, which means that their ability to define the nature or direction of the relationship between IPV and suicide, when found, is limited. Where longitudinal methods have been used, a relationship has been found in both directions; that IPV perpetration
predicts suicidal behaviours (Nahapetyan et al., 2014), and that suicidal behaviours predict IPV (Renner & Whitney, 2012), which makes it difficult to define the temporal nature of the relationship. While the varied methods and populations used can be an advantage in terms of the relationship between IPV and suicide being seen across a range of samples, it also means that given the small number of studies, replication and confirmation of the association is limited. Some of the studies investigated those ‘involved in IPV’ but did not always separately report outcomes for those who were either only perpetrators or perpetrator-victims, rather than victims only. As IPV victimisation has been widely linked to increased risk of suicides in female victims, and tentatively for male victims (Devries et al., 2013) this means that identifying the specific role of IPV perpetration in suicide risk in these studies is challenging.

Studies have variously measured suicidal ideation or thoughts, suicide attempts or more rarely, completed suicide. It appears that the studies that found no association between IPV and suicide risk tended to use suicidal ideation measures, suggesting that it may be that IPV perpetration is associated with more serious forms of suicidal behaviour. Similarly, there is suggestion that the relationship is more pronounced for more serious IPV perpetration. Additionally, most of the studies used self-report measures, with many using single items to identify concepts such as suicidal ideation, suicide attempts or IPV perpetration. While self-report can be considered an essential part of behavioural research, bias and uniformity of collection procedures are among the limitations of this method of obtaining information (Baldwin, 2009).
2.5 Summary

This chapter has introduced the nature of suicide in prisoners and provided context to defining and identifying domestic violence. Despite the limitations noted within the current research, there is generally consistent evidence of a relationship between IPV and risk of suicide, particularly for those involved in more serious violent or suicidal behaviours. However, there are clear difficulties in clarifying this relationship given the different methodologies and samples used, and no studies have explored this issue in prisoners. Whether domestic violence perpetration influences suicide risk or vice versa is unclear, as both associations have been found in different studies but there is limited temporal information. There is also suggestion that the relationship in offenders may be mediated or moderated by other factors such as depression or borderline personality traits (Wolford-Clevenger et al., 2014). Other papers have noted that there are common underlying risk factors to domestic violence and suicide such as problem solving and coping deficits, environmental characteristics, substance misuse, child maltreatment, personality difficulties and mental illness (Else et al., 2009; Nahapetyan et al., 2014; Swahn et al., 2008). However, the applicability to offenders is unclear and has not been explored. The two studies presented within this thesis aim to explore domestic violence and suicide risk in men in prison to add to the limited knowledge about the relationship between these behaviours in this group.
Chapter 3: Qualitative methodology

3.1 Introduction

As outlined in Chapter 2, much of the current knowledge about the link between domestic violence perpetration and suicide risk suggests a relationship exists. However, these findings do not establish how or why such a link is present, and little attention has been paid to this link in convicted prisoners where there is already a substantial increased risk of suicide (Fazel et al., 2016). The available literature has established the relationship based on statistical analysis of rates of IPV among those completing or at risk of suicide (e.g. Conner, Cerulli, & Caine, 2002) however this provides limited insight into why those who engage in IPV are at increased risk of suicide. In addition, some of the research has found a temporal link between suicide risk and later IPV (Renner & Whitney, 2012), indicating complexities in the nature of the relationship.

Given that prior research has focused on quantitative and statistical methodologies, a detailed understanding based on the views of individuals involved in IPV and suicide behaviours has not been undertaken. The aims of this thesis are investigative and seek to explore the relationship between domestic violence perpetration and suicidal behaviour in male prisoners rather than testing a specific theory or hypothesis. Qualitative methodology is used to explore open research questions where there is no claim to be tested (Braun & Clarke, 2006; Willig, 2013). It allows for the exploration of the ‘reality’ of an issue, as well as the perspectives of participants and everyday knowledge and practice (Flick, 2007), which is relevant to the present research aims. Therefore, this chapter will
review qualitative methodologies and issues of rigour and reflexivity in qualitative research.

3.2 Choosing qualitative methodologies

Qualitative research methods share a number of features, such as involving naturalistic data, being led by the participant, being open and flexible enough to allow new or unexpected findings and meanings to be included and involving a need for personal and epistemological reflexivity (Willig, 2013). There are several specific methodologies that can be applied to qualitative analysis, and the methods chosen may depend on the epistemological orientation of the researcher or the nature of the research questions asked (Willig, 2013). Grounded Theory (GT) provides an analytic framework and set of systematic procedures for handling qualitative data (Charmaz, 1996), however this approach focuses on the development of theory from the data. The two studies contained within this thesis aim to explore factors relevant to and the relationship between domestic violence and suicide in prisoners rather than develop a specific theory, therefore GT was not considered a suitable approach. Interpretative Phenomenological Analysis (IPA) aims to explore in depth a person’s lived experience and how they make sense of that experience (Smith, 2004). This approach focuses on a person’s perceptions of objects, ideas or events but also the researcher’s role in analysing such perceptions, making it particularly suitable for exploration of sensitive topics. Smith suggests that the detailed, individual focused analysis required of IPA works best with small sample sizes (5-10 cases) and even single case studies have value when analysed in this way. While IPA may have had some application to the second study which involves qualitative interviews, the data source in the first study was textual data regarding prison suicides, written by the Prison and
Probation Ombudsman (PPO) and based on investigations into the deaths conducted by a team of investigators. As such this written data was not a ‘first person’ account of the experiences of those who died by suicide, and IPA was not appropriate as it is not possible to gain true insight into the lived or perceived experiences of the men who committed suicide via third party perspectives. Furthermore, the aims of the studies were to explore current knowledge and potential factors explaining a link between domestic violence perpetration and suicide risk rather than focus on lived experience.

The present thesis is comprised of two separate but related studies, each contributing to the overarching objective of exploring the relationship between domestic violence and suicide in prisoners. The research aims, while concerned with this specific topic, seek to allow for a broad range of findings from the data that may establish connections to previous literature or provide new meaning and interpretation. As such, neither study is confined to focusing on lived experience and instead aim to critically understand what the data in each study can tell us about the world.

3.2.1 Thematic Analysis

To provide coherence across the two studies, allow for differences that may occur and provide flexible ways of understanding and analysing the data (Willig, 2013) Thematic Analysis (TA) was used as a basis for both studies. TA has been distinguished from content analysis, which generally results in a numerical description of the features of textual data, by being more focused on the qualitative and contextual features of the information (Joffe & Yardley, 2004). This approach allows for recognising and organising patterns in qualitative data, and identifying common threads of meaning (Willig, 2013). While there has been an argument that TA is not a qualitative method and is instead a tool that can be
used across qualitative methods (Willig, 2013) some have argued that TA can be seen as a method in its own right that allows flexibility and theoretical freedom to the researcher (Braun & Clarke, 2006) and offers a transparent and systematic approach (Joffe, 2012).

A number of authors have offered guidance about how to apply TA in a structured and methodologically sound way (Braun & Clarke, 2013; Fereday & Muir-Cochrane, 2006; Joffe, 2012). Fereday and Muir-Cochrane (2006) outline a hybrid approach between inductive and deductive methods that uses a ‘codebook’ to organise the text based on prior theory, while Joffe (2012) outlines a general approach of examining the dataset to develop a coding frame, checking reliability, coding the entire dataset based on the frame, and analysing the categorised data. Braun and Clarke (2006; 2013) offer a flexible but detailed phased approach to TA, outlined in Table 2, that does not require codes to be developed from prior research or theoretical concepts. They note that analysis is not necessarily linear, and a researcher may move back and forth between phases of analysis over time.

Table 2

<table>
<thead>
<tr>
<th>Phases of Thematic Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase</td>
</tr>
<tr>
<td>1. Familiarising yourself</td>
</tr>
<tr>
<td>with the data</td>
</tr>
<tr>
<td>2. Generating initial codes</td>
</tr>
<tr>
<td>3. Searching for themes</td>
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<tr>
<td>4. Reviewing themes</td>
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<tr>
<td></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td><strong>5. Defining and naming themes</strong></td>
</tr>
<tr>
<td><strong>6. Producing the report</strong></td>
</tr>
</tbody>
</table>

*Note: Table adapted from Braun & Clarke (2006, p87)*

### 3.2.2 Template analysis

Template analysis is a form of Thematic Analysis (TA) that uses a set of techniques for thematically organising and analysing textual data (Brooks, Mccluskey, Turley, & King, 2015; King 2004). It has close similarities to TA methods that use the ‘codebook’ approach, as outlined by Fereday and Muir-Cochrane (2006) and Joffe (2012). In this approach, rather than coding each data item separately before then collating codes into themes, a list of codes is developed as a template representing themes within the data. This can happen using theoretically derived codes as well as inductive codes that are grounded in the content of the data. This list of codes is then applied to further data to check reliability and can be revised and refined as analysis proceeds. It is similar to TA both in process and not being tied to a specific philosophical assumption or epistemological position, and allows
flexible identification of themes and patterns across the dataset. Brooks et al (2015) outline the procedural steps of template analysis as involving the following:

1. Become familiar with the accounts to be analysed through full or partial readings of the data
2. Carry out preliminary coding of the data, this may include \textit{a priori} themes that have been identified as potentially relevant to the research
3. Organise emerging themes into clusters and begin to define how they relate to each other
4. Define an initial coding template; this is usually completed from analysis of a subset of the data
5. Apply the initial template to further data and modify as necessary. New themes may be inserted and existed themes redefined or deleted. New versions of the template may be developed, normally after application to a few additional data sets.
6. Finalise the template and apply it to the full data set. Continued engagement with the data may continue to suggest refinements. A sufficient template should allow most relevant data to be coded within it.

This differs somewhat from the phases of TA as outlined in Table 2. While there are some similarities such as the importance of reading and becoming familiar with the data, development of themes happens after coding of a small subset of data rather than waiting until all data has been independently coded. The advantages of this approach are that it can handle larger sets of data and information. Brooks et al (2015) acknowledge that a disadvantage of template analysis techniques is the focus on cross case analysis rather than a detailed and holistic within-case understanding.

3.2.3 Application to the present studies

Template analysis was the method used for the first study, described further in Chapter 4. The aim of this study was to explore what is known, and not well understood, about domestically violent prisoners who have died by suicide. The data involved 32 lengthy independent reports, and therefore template analysis as a mechanism to manage
potentially large amounts of data was deemed appropriate. In addition, the focus was on
developing an overview of relevant factors rather than detailed understanding of individual
cases, therefore the focus on cross case analysis that can come from template analysis was
viewed as a strength rather than a disadvantage for this study. Thematic analysis guided by
the phases outlined by Braun and Clarke (2006; 2013) was the methodology used within
the second study, and application of this is discussed in more detail in Chapter 5. This
enabled flexible, data driven and inductive coding of the data. As the second study
involved a smaller number of participants and ‘richer’ data than with the first study due to
data being gathered from qualitative interviews, this approach rather than one using a
codebook or template was appropriate.

3.3 Data saturation: how many participants is enough?

Identifying the ‘correct’ sample size for a qualitative study can be complex, and advice
regarding how many sources are appropriate for thematic analysis provide a wide scope.
For example for secondary sources (sources already in existence rather than being
generated by the researcher, as in the first study) this could be anywhere between 1 and
400 (Braun & Clarke, 2013). Hammersley (2015) points out that sampling decisions do not
have to be taken at the beginning of research, rather this can be a process that occurs
throughout data collection, as data begins to be obtained and analysed and relevant
themes identified. Data saturation is often considered within qualitative research, that is
the point where additional data does not necessarily provide more useful information
(Mason, 2010). Qualitative researchers tend to agree that there is not a ‘one size fits all’
strategy for identifying when enough data has been collected, and the quality of the data
should be a primary consideration rather than a set number (Fusch & Ness, 2015). However most of the attention to data saturation has been placed on studies involving qualitative interviews. There is far less guidance regarding sufficient sampling for secondary or other written data sources. The general principles suggested for qualitative interview sampling are still likely to be applicable to other types of qualitative inquiry; such as stopping when no new themes or patterns are generated (O’Reilly & Parker, 2012).

For qualitative research involving participant interviews, sample size can be dependent on the purpose of the study, complexity of the issue and the range of experiences or views being collected (Francis et al., 2010). Samples of between 15 and 30 are common in interview based qualitative studies (Braun & Clarke, 2013), although where there is a narrow scope and specific questions are asked, a smaller sample size may be appropriate (Morse, 2000). Investigations into data saturation within qualitative interviews have suggested that this may occur between six and twelve interviews (Guest, Bunce, & Johnson, 2006), and others have argued that it is the depth of data and ability to engage with analytic arguments that are important rather than number of interviews undertaken (Hammersley, 2015).

3.4 Rigour and reflexivity in qualitative research

The question of how to determine whether a piece of qualitative research is of a high standard is not always easy, as there are no absolute criteria on which to judge this (Braun & Clarke, 2013), and there have been disagreements over whether concepts such as bias, validity and reliability should be applied (Hannes, Lockwood, & Pearson, 2010). Tracy (2010) presents a set of eight criteria that make a piece of research of ‘qualitative quality’;
worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethical and meaningful coherence. Additionally, Braun and Clarke (2006) offer a specific checklist for what is constitutes a ‘good’ thematic analysis. This includes consideration of the transcription of interview data, the coding process, ensuring analysis includes interpretation and tells a convincing story, and allowing enough time to each phase of thematic analysis.

Yardley (2000; 2008) outlines four principles which can guide the assessment of quality within qualitative research; sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. This offers a flexible approach to evaluating the quality of a piece of research, and this section will reflect on how the present research meets the principles of Yardley’s guidelines. A fuller summary of the guidelines is presented in Table 3. These principles have been applied throughout this thesis to ensure quality and rigour within the two studies. The present chapter will consider some of the general issues considered and applicable to the thesis as a whole, while specific attention will be paid to these principles in relation to the two studies presented in Chapters 4 and 5.

Table 3

<table>
<thead>
<tr>
<th>Characteristics of good qualitative research</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity to context</td>
<td>Theoretical, relevant literature, empirical data, sociocultural setting, participants’ perspective, ethical issues</td>
</tr>
<tr>
<td>Commitment and rigour</td>
<td>In-depth engagement with the topic, methodological competence/skill, thorough data collection, depth/breadth of analysis</td>
</tr>
</tbody>
</table>
Transparency and coherence

| Clarity and power of description/argument, transparent methods and data presentation, fit between theory and method, reflexivity |

Impact and importance

| Theoretical (enriching understanding), socio-cultural, practical (for example, community, policy makers, health workers) |

Note: Adapted from Yardley (2000; 2008)

Sensitivity to context, is apparent within the present thesis. For example, Chapters 1 and 2 provide a thorough review of literature that underpinned the research questions. These chapters place the research aims and the two studies within the context of current knowledge and understanding. A further aspect of the context in which this research was conducted is my own epistemological position as a researcher. Epistemology refers to the assumptions that are made about what constitutes ‘knowledge’ and what it is possible for an individual to know (Willig, 2013). The methods used within both studies are based on thematic analysis, which is a flexible approach that is not tied to one epistemological position (Braun & Clarke, 2006). However, it is still important to consider the assumptions that I personally bring. My epistemological position is that of ‘critical realism’, which is a framework that suggests that while there is a real world that we can aim to understand, some knowledge can be closer to the truth than others (Fletcher, 2017). In line with this, rather than viewing that there is one ‘truth’ that can be obtained through analysing data, I believe that knowledge gained through research is always from a specific perspective and as such there is no one truth (Braun & Clarke, 2013). This is further explored in the context of the transparency characteristic which outlines my background, experience and
positioning when conducting the present research. In addition, critical realism aims to help explain rather than purely describe phenomena (Craig & Bigby, 2015), which is consistent with the aims of the two studies. Using a critical realist perspective meant that I approached data analysis as providing a reality through the lens of the data I collected and myself as researcher and practitioner. Further evidence of sensitivity to context, particularly in relation to understanding sociocultural setting, ethical considerations and participant perspectives, will be outlined in Chapters 4 and 5.

In relation to commitment and rigour, transparency and coherence, these criteria correspond to “the usual expectations for thoroughness in data collection, analysis and reporting in any kind of research” (Yardley, 2000, p221). Commitment is demonstrated in this thesis through thorough engagement with the topic as outlined in Chapters 1 and 2, and the discussion and selection of relevant methodologies within the present chapter. The principle of rigour will be explored further within Chapters 4 and 5, as this relates to sample choice, data collection, sampling and analysis for each study. Transparency and coherence across the studies can be seen through the consideration of appropriate qualitative methodology and analytical approach to the two studies. In terms of thematic analysis there were several considerations to ensuring the overall quality across the two studies. There has been debate about whether themes are noticed or captured from the data by the researcher, or whether they are developed through active engagement and exploration by the researcher (Braun & Clarke, 2016). My perspective, as argued by Braun and Clarke, is the latter; themes within the analysis of both studies were developed through an active process of considering the data in relation to the purposive sample used,
the questions asked and the research aims. This position ensures that the context of the research and my role as researcher are explicit.

One aspect of transparency is reflexivity; within qualitative research this is the examination of how the researcher impacts on and influences the research that they are conducting (Finlay, 2003). It is important, as indicated in the guidelines above on transparency, to be clear about my position as a researcher and what I brought to the research. Within the two studies, reflexivity included consideration of my ‘day job’ as a Forensic Psychologist working for HMPPS (Her Majesty’s Prison and Probation Service). This presents something of a conflict between being an independent researcher, observing practices and experiences within prisons, and being employed by HMPPS to work within the current guidelines, practices and regulations. It was important for both studies presented in this thesis to consider how my employment may impact on my approach to the research generally as well as how I engaged with participants. For example, my knowledge of the policies and procedures of HMPPS presented an advantage in terms of understanding how suicide risk should be managed or what experiences participants may have had. However, it was vital not to allow my employment to cloud my ability to derive codes and themes from the data, or to critically evaluate the data. In addition, practicing as a forensic psychologist is a necessarily applied role and requires me to put into practice my learning quickly and effectively, therefore reflection can sometimes take a backseat. Engagement with my supervisors and the keeping of a reflexive diary, which included process, reflective and analytical notes, ensured that I could note these biases and focus on the data, as did following structured and methodologically sound guidelines for thematic and template
analysis. Appendix F provides extracts from the reflexive diaries for the two studies presented in this thesis.

Despite the areas above that needed to be considered, there were advantages that I could bring to the research. As a forensic psychology practitioner, I have developed and demonstrated a number of proficiencies that are particularly relevant to qualitative research, such as awareness of culture, equality and diversity on practice and effective communication skills (Health and Care Professions Council, 2016). As an employee of HMPPS I have experience of the surroundings and context that men in prison find themselves in, and am familiar with the types of experiences that they may have. This allowed me to engage with the participants in interview and understand the context that they were in. Qualitative researchers are advised to ‘Bracket’ their assumptions in order to reduce the negative effects such assumptions may have and increase rigor, although exact definitions of the process remain unclear (Tufford & Newman, 2012). While there are different methods of ‘Bracketing’, within the present studies I used reflexive notes to examine my thoughts and engagement with the data. While my personal experiences and cultural perspectives have no doubt influenced the research project in some way, the aim is not to deny that this bias exists, rather to make it clear what biases may exist. Thus, the findings presented in Chapters 4 and 5 are a product both of the data and my analysis of it, and are not the only interpretation of the data that is available.

The final criteria, impact and importance will be demonstrated in depth within Chapter 6, which explores the contribution that further understanding the links between domestic violence perpetration and suicide may have on those involved in the care and support of men in prisons.
3.5 Summary

This chapter has outlined some of the important aspects of choosing appropriate qualitative methodology and how the analytical approaches to the studies in this thesis were chosen. As part of this, consideration has been given to identifying appropriate sample sizes and ensuring quality and rigour within qualitative methods. The importance of acknowledging my position as both a researcher and the influence of my personal experiences when conducting research has been outlined within this chapter. Application of the specific methods chosen and further reflections on ensuring rigour and quality will be outlined in the two following chapters, which present the two studies completed as part of this thesis.
Chapter 4: A Qualitative Analysis of Fatal Incident Reports on the Suicides of Domestically Violent Men in Prisons.

4.1 Introduction

As can be seen from the review of relevant literature in Chapter 2, there is limited and somewhat inconsistent information regarding the relationship between domestic violence perpetration and suicide risk. While the available research does indicate that such a relationship exists, it does not provide conclusions about why the relationship is present or the nature of the relationship. In addition, none of the previous research has investigated domestic violence perpetration and suicide risk in a prison population. Given that some of the research indicates that the relationship may be stronger for more severe violence and/or suicidal behaviour, investigating domestic violence and suicide within those who have completed suicide and were imprisoned due to their domestic violence appears to have utility in providing further information about this area. Previous research has focused on quantitative and statistical data and has not sought to understand the views of those involved in domestic violence and suicide.

4.1.1 Aim of the study

Given the above, the first study focused on the following aim:

- To explore what is known, and identify gaps in knowledge, about why domestically violent prisoners have died by suicide in custody.

The study investigated this by analysing Prison and Probation Ombudsman (PPO) Fatal Incident Reports that have been prepared on domestically violent men who died by suicide in prison.
4.1.2 Overview of the chapter

This chapter outlines the specific methodology, data collection and findings of the first study within the present thesis. The findings indicate two overarching aspects to the reports; themes related to individual factors, and those related to situational and management factors. Themes associated with individual factors concern those directly about the man such as their history, behaviour in custody, presentation to staff and relationships with others. Themes more related to situational and management factors are those primarily related to the prison environment and how the man was managed and assessed in custody. Given the objective of this thesis on understanding why domestically violent men may be vulnerable to suicide in prison, only the findings related to the individual factors are presented in detail in this chapter. The findings are presented alongside discussion and consideration of the wider literature.

4.2 Methodology

4.2.1 Ethical considerations

This study was approved by the Cardiff Metropolitan University ethics board, and the Code of Ethics and Conduct of the British Psychological Society (Ethics Committee of the British Psychological Society, 2009) were followed. Further ethical approval was not sought, as the study used only publicly available textual sources, and there was no human participation. There are specific ethical considerations for conducting research using sources accessed online. This includes the need for online privacy and autonomy, establishing consent, lack of control reducing scientific value and social responsibility (Hewson et al., 2013). However, the present study did not require direct contact with the
deceased individuals or their families and used only already published data. The data used within this study had already been anonymised to some degree prior to publication as names were routinely removed within the published reports. In line with guidelines on confidentiality, the data were anonymised further by removing references to specific prisons or locations.

4.2.2 Data sources and methods

Researching issues around suicide is complex, due to the limited first-hand information from those who have completed suicide. As such, the motivations and important factors leading up to their decision to commit suicide can be difficult to ascertain. This study aims to explore the known information about men who completed suicide while in prison as well as identifying any gaps in knowledge. The data source chosen for this was pre-existing textual data in the format of publicly available reports on suicides in UK prisons. While it can be more difficult to use this type of data to answer research questions around individual experiences or perceptions, Braun and Clarke (2013) suggest that secondary sources can be suitable for research identifying influencing factors, how individuals or situations are represented, accounts of practice and constructions. There are numerous examples in qualitative research of the use of secondary sources including materials such as official parliamentary proceeding Hansard reports (Ellis & Kitzinger, 2002), online forums (Coulson, 2014; Horne & Wiggins, 2009) and suicide notes (Sanger & Veach, 2008). Given the specific issue being investigated, a purposeful sampling approach was used, which specifically selects cases that will offer relevant information to the research questions being asked (Patton, 2015). For the present study, purposeful sampling was
used to generate a homogenous sample of domestically violent men who had died by suicide while in prison.

The data sources were Fatal Incident Reports (FIRs) written by the Prison and Probation Ombudsman (PPO), who conducts independent investigations into all fatal incidents as well as other complaints occurring in custody. The PPO is independent to HMPPS and other criminal justice organisations, and they are appointed by the Secretary of State to provide “fair and impartial investigations” (Prison and Probation Ombudsman, 2017). The aim of such investigations is to “understand what happened, to correct injustices and to identify learning for the organisations whose actions we oversee” (www.ppo.gov.uk, accessed 28/2/16). For each incident investigated, a Fatal Incident Report (FIR) is completed and published on the PPO website once the inquest has taken place. While each death in custody is allocated a lead investigator, the final report is produced by the PPO in post at the time; the same PPO was in post for the period covered by the present research.

The time between deaths occurring and a report being published can differ, but can often be over a year particularly if there is a police investigation into the incidents. FIRs can vary substantially in length and detail, reflecting the records and knowledge available. There is no set guidance for the content of the reports as this may be dependent on what the investigators and PPO find pertinent in each case (S. Eagle, Assistant Ombudsman, personal communication, 15/3/16). However, each FIR includes the following sections; an initial abstract, summary of the report, the investigation process, information about the prison, key events, issues and recommendations; some also include an action plan. Each FIR outlines the investigation process which is similar across investigations. This involves
inviting staff or prisoners with knowledge of the decedent to come forward, visiting the
ing wing or unit that they lived on, interviews with staff and prisoners, reviewing records and
file information, liaising with the coroner, contact with the man’s family or next of kin and
a clinical review undertaken by the NHS. The FIRs do not outline in detail the results of the
clinical review but do comment on their findings, and are not linked with medical inquests
which are undertaken by a Coroner to establish cause of death.

All FIRs for self-inflicted deaths in prisons in 2012 and 2013 that had been published by 1st
April 2016 were examined, comprising a total of 105 reports. This period was chosen to
obtain information about deaths in custody that were as recent as possible while
maintaining a relatively complete set of reports. Complex, unusual or high-profile reports
may take longer to be publicly available and the publication date of the reports analysed
ranged from October 2012 to April 2016. This time period was also consistent with the
PPO thematic report that identified prisoners with domestic violence offences as
vulnerable to suicide in custody (Prison and Probation Ombudsman, 2014a), which utilised
reports from 2007 to 2013. Government statistics indicate that there were 60 reported
self-inflicted deaths in 2012 and 74 in 2013 (Gov.uk, 2016), suggesting that 79% of such
deaths are represented within the overall sample. Two reports were unavailable due to
broken links on the website; these were reported to the PPO office however remained
unavailable during data collection. Each report was allocated a number for identification
and to aid anonymization of information.

An initial examination of the reports aimed to identify key characteristics of the men
including their charge or conviction. In total, 32 reports (30%) from the overall sample
were selected for full analysis as they had clear information that the man’s index charge or
conviction was of domestic violence, as per the cross-government definition. This meant that reports were included where the victim was reported to have been a partner, ex-partner or family member. None of the reports included in the analysed sample involved men who had been violent within a same-sex relationship. There were a small number of reports in the overall sample where there was no information about who the victim of the offence was, or where the offence itself was not clearly reported. Therefore, it is possible that some relevant reports were not included in the final analysis. A review of self-inflicted deaths in custody in 2013-14 indicated that 43% of deaths involved individuals who had committed and offence against a ‘close friend or family member’ (Prison and Probation Ombudsman, 2015). This is significantly more than the FIRs identified for this study; it may be that the slightly different (although overlapping) time period or the reports not yet published account for this difference. This may also reflect that where the victim was a friend this would not be considered domestic violence and so not captured within the present study. One report was excluded from full analysis as the individual attempted suicide prior to his arrest and his death was a direct result of ongoing medical complications from this, rather than suicidal actions in prison. While this may still represent a link between domestic violence and suicidality, the present research focuses on those who go on to commit suicide in custody and are therefore within a different environment and context.

Table 4 outlines the characteristics of men discussed with the FIRs. While data on demographics such as ethnicity is collected for general prison statistics on self-harm and suicide, this information was not included within the reports.
4.2.3 Analytical approach

As outlined in Chapter 3, template analysis was used to analyse the data in this study. This is based on TA, however Brooks et al (2005) note that template analysis can handle larger data sets, and can be appropriate where the aim is to investigate information across cases rather than in depth focus on single cases. NVivo 10 computer software was used to support coding and organisation of the data. The analysis of the data was based on the procedural guidelines suggested by Brooks et al (2015).

Table 4

Characteristics of participants in FIRs

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>DV perpetrators</th>
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<tr>
<td></td>
<td>(32 reports)</td>
</tr>
<tr>
<td>Mean age</td>
<td>34</td>
</tr>
<tr>
<td>Sentence type:</td>
<td></td>
</tr>
<tr>
<td>Sentenced (determinate)</td>
<td>9 (28%)</td>
</tr>
<tr>
<td>Sentenced (ISP)</td>
<td>4 (12%)</td>
</tr>
<tr>
<td>Recalled</td>
<td>5 (16%)</td>
</tr>
<tr>
<td>Unconvicted remand</td>
<td>14 (44%)</td>
</tr>
<tr>
<td>First time in custody:</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11 (34%)</td>
</tr>
<tr>
<td>No</td>
<td>19 (60%)</td>
</tr>
<tr>
<td>Unspecified/unclear</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Suicide method:</td>
<td></td>
</tr>
<tr>
<td>Hanging</td>
<td>31 (97%)</td>
</tr>
<tr>
<td>Obstruction of airway/suffocation</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Victim type</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Family member</td>
<td>8 (25%)</td>
</tr>
<tr>
<td>Intimate partner</td>
<td>24 (75%)</td>
</tr>
</tbody>
</table>

1 – Three of the reports did not report the age of the man

**Step 1: Familiarisation with the data**

Initially all reports selected for data analysis were read thoroughly and notes were made about each one, including possible relevant areas of interest. A reflexive diary including analytical notes was kept throughout the main period of coding to record reflections, decisions about coding or sample inclusion/exclusion, ongoing questions and significant thoughts about the data.

**Steps 2 & 3: Initial coding and organisation**

As the study aims to explore vulnerabilities or factors leading to suicide, paragraphs within each report that related only to events and circumstances that occurred after the death were not coded in detail; this included comments about the emergency response or the practicalities of contacting family members. All sections of the report were reviewed for coding except for recommendations and action plans. While template analysis often involves *a priori* codes, which are pre-determined from research or theory, within this study codes were generated using an inductive approach. This refers to the process of generating codes and themes from the data itself. This method of coding was chosen due to the exploratory nature of the research, and the absence of a single or specific theory regarding the research topic.

**Steps 4 & 5: Developing and testing the initial template**
Four reports were coded individually to develop the initial template. All codes for these reports were collated and organised into similar clusters of codes, which were used to develop the first coding template of overarching themes and sub-themes. The template was applied to two further reports and reviewed to ensure that it captured key elements of the data being coded. This involved collating and reading extracts of the data linked to each individual theme.

Step 6: Finalising and applying the template

After the sixth report was coded the template was reviewed and amended slightly to reflect a changing understanding of the data. This process involved adding nuance to the themes and further layers of coding. While the most substantial changes to the template took place through the coding of the initial six reports, the template was refined and developed throughout the coding process as it was applied to subsequent reports. After all reports had been coded using the template, the codes were reviewed in relation to the original data which prompted some further reorganisation. A total of four iterations of the template were developed. Most data contained within the relevant sections of the reports could be coded within the template. See Appendix A for an overview of template development.

4.2.4 Reflexivity and rigour

As outlined in Chapter 3, it is vital to consider how my experiences and role as researcher influence this study and the analysis. As I was not engaging directly with participants in this study, my role as researcher and practitioner and my personal experience did not influence the data collection. However, the PPO is independent to the Ministry of Justice and associated departments, and as such may be highly critical within reports. It was
important to recognise how my employment with HMPPS could impact on my perception of the content of the FIRs, either a reaction to criticisms, a recognition of failings within the service or an uncertainty regarding how to bring my own evaluation and analysis to light within my role. I wrote frequent reflexive notes throughout analysis of the data (see Appendix F for examples) as well as engaging in both formal supervision and informal debriefing with colleagues and peers. These systems allowed me to record any issues and their potential impact on analysis, to engage with the process of ‘bracketing’ (Tufford & Newman, 2012) and reduce any negative impact of my own perceptions and experiences.

In terms of the principles of quality in qualitative research (Yardley, 2000), sensitivity to context, commitment and rigour, transparency and coherence were considered within the present study. The context of the reports has been outlined clearly within this chapter. The question of participant sensitivity is somewhat challenging given the secondary sources; participants could be the investigators contributing to the FIRs, the Ombudsman who wrote the FIR or the men who died by suicide. While the data were publicly available reports, sensitivity was maintained by ensuring anonymity within analysis and the presentation of extracts, and outlining the social and practical context of the data sources (see section 4.2.2). Thorough and appropriate methods were used to analyse the data as outlined in the previous sections. This and the reflexivity issues considered above provide evidence of commitment, rigour and transparency. Coherence will be demonstrated in the following section on the findings of the study, where extracts have been used to illustrate the findings.
4.3 Findings and analysis

4.3.1 Introduction

This section outlines the main themes obtained from thematic analysis of the 32 FIRs that involved a prisoner with an index offence of domestic violence. The content of the reports was organised into nine themes describing common issues, points and concerns raised by investigators. Four of the themes related to situational and management factors around the environment and the man’s management in custody; The Prison Environment, Communication, Healthcare and Risk Assessment. Given the focus of the study on exploring information that may be relevant to the more individual or psychological factors behind the suicide of domestically violent men, the remaining five themes are the focus of discussion and exploration as these relate to the individual factors identified through analysis. However, a summary of the additional themes linked to situational factors is provided in Appendix B. Table 5 illustrates how the findings of the five main themes related to individual factors are organised into main and sub-themes.

The detailed description and analysis of the themes presented in this section includes extracts from the reports to illustrate the themes and sub-themes. These extracts have been copied verbatim from the reports, although where extracts have been shortened, the notation [...] has been used.

The extracts are identified by their allocated report number. The decedents in each FIR were referred to as ‘the man’ therefore this terminology, rather than referring to them as prisoners, offenders or decedents, has been used throughout this section for consistency with the extracts.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub themes</th>
</tr>
</thead>
</table>
| 1: Background and history | Criminal history  
|                  | Current offending  
|                  | Mental health history  
|                  | Violence history  
|                  | Other factors |
| 2: Custodial wellbeing concerns | Current mental health  
|                  | Physical wellbeing  
|                  | Ability to cope  
|                  | Problems and concerns |
| 3: Relationships with others | Personal relationships  
|                  | Professional relationships  
|                  | Isolation |
| 4: Outward presentation and perceptions | Emotional state  
|                  | Perceptions of the man  
|                  | Behavioural problems |
| 5. Suicide risk and behaviour | Circumstances of death  
|                  | Suicidal statements of intent  
|                  | Triggers and known risk factors  
|                  | Self-harm behaviour  
|                  | Suicide notes |
4.3.2 Theme 1: Background and history

This theme outlines the available information within FIRs about the man’s history and experiences before entering custody. The reports provided little information about criminal history, although they usually noted previous periods in custody. Some reports did provide more information about the nature of previous offending. There was sometimes more information related to recalls from a community licence or order, or where there was a history of committing similar offences to the current charge or conviction, for example “On 2 November 2012, the man was sentenced to 15 months in prison […] On 19 February 2013, the man left prison on conditional licence. His licence period would end on 21 April 2014. One of the conditions was that he was not to communicate with his ex-partner or his children, unless approved by [place name] Children’s Services” (114).

Five of the men had been recalled to custody; prison guidelines and the Prison and Probation Ombudsman have highlighted that prisoners recalled to custody are at higher risk of self-inflicted death (Prison and Probation Ombudsman, 2014a) based on their analysis of prisoners between 2007 and 2013 who died by suicide. Recall status has not been included as a variable within analysis of significant risk factors for prisoner suicides (Fazel et al., 2008) so it is difficult to quantify how relevant this may be. Fewer of those included in the present study had been recalled when compared with those with other types of offences who died by suicide during the same period (16% vs 22%). This suggests that recall to custody may not be a significant indicator of increased risk of suicide for domestic violence perpetrators.
Approximately one third of the reports identified specific incidents of previous violence. Information about past violence came from previous convictions, behaviour on previous custodial sentences or from other sources of information “He said that he had previously been in prison in [European country] for fighting” (24). A history of violence is a well-established predictor of future violence (Monahan et al., 2001) so this may be expected with a sample of domestically violent prisoners. However, few of the reports specified the full nature of previous convictions, so this does not necessarily reflect actual violence history. In addition this likely under-represents use of violence which may not have been reported or resulted in formal convictions, as this is a particular problem with domestic violence (Klein, 2009; Office for National Statistics, 2015).

Each report outlined the current charge or conviction and provided information about the length of sentence and sometimes anticipated release dates. Often the description of the index charge or conviction was limited to the name of the offence or charge and the relationship to the victim “He was sentenced to 12 weeks in custody for breaching a restraining order and was also charged with an offence of burglary” (22). Some reports provided more detail about the nature of the incident “the man went to a pub with his mother and father. He drank several pints of cider and became aggressive when told he could not have another drink. When the family returned home, he seriously assaulted his mother and father” (36). Even when some further information was clearly available to investigators, this was not always reported in detail within the FIR; “A nurse carried out a “detailed high-risk assessment” with the man on 9 July. He noted further information about the factors that had led to the charges against him and his subsequent attempt on his life” (33). The lack of detail may be due to the scope and context of the reports, which are
more focused on the circumstances that led up to the death in custody rather than offending behaviour.

There was limited information about general life history or experiences. Largely, references to past problems were related to previous alcohol or drug misuse, as this was often recorded in initial health screenings “He told doctors who reviewed him that he was an alcoholic and used recreational drugs” (114); substance use problems were noted in 17 cases. Addiction problems have consistently been linked with risk of suicide, particularly when co-morbid with other mental health issues (Cavanagh, Carson, Sharpe, & Lawrie, 2003). This seems to have been the case for many of the sample as there was substantial overlap between these issues; of the 17 with substance misuse issues, 13 also had reported mental health problems. Other background information was sparse and even when available the detail was not included in the report “She told the investigator that at their meetings he spoke about his family, about his schooling and about how his life had been in general” (90). The two reports that did provide more general comments about upbringing or background were both about young people (under the age of 21) “The young person found school difficult and when he was 12 he received a statement of special educational needs because of dyslexia and ADHD. He apparently displayed challenging behaviour in mainstream school and spent 12 months at a special unit. After this he attended college, spending time on literacy and numeracy as well as other skills. This appears to have made a real difference to him and his literacy and numeracy improved, as did his behaviour” (73). It was unclear why some reports had more background detail than others, although it may have been down to the particularly concerning nature of a young person’s death in custody that further attention was paid to their histories.
Every report referred in some way to mental health history although again the amount of information included was variable. Much of the information from mental health history came primarily from self-report during health or mental health assessments in prison, although some were obtained through clinical and medical records. There were instances where information about mental health history was inconsistent and full records were not obtained “The nurse who carried out his initial health screen did not have full access to his medical records and was unaware that he had recently harmed himself” (18). A relatively small number of men were noted not to have had any known mental health problems prior to coming to prison “He told him that he had no history of mental health problems and had never been prescribed medication for his mental health” (116). However, consistent with research that mental disorder is one of the most strongly associated risk factors for suicide (Cavanagh et al., 2003; Fazel et al., 2008; Frühwald et al., 2004), most of the sample were reported to have some mental health problems in their history. There was also frequent reference to previous history of self-harm and/or suicide attempts within the reports, which has also been consistently highlighted as a risk factor for suicide (Fazel et al., 2008) “During his reception health screen, the man told the nurse that he had previously attempted to harm himself many years before, but had never done so in prison” (80). Reports were not always clear, but some of the sample were recorded to have engaged in suicidal behaviour in custody previously while for others this had only taken place in the community before.

In terms of the types of mental health problems experienced in the past, several were reported to have experienced previous depression, although it was not always clear whether this was a clinical diagnosis of depression or self-reported symptoms of feeling depressed. Research findings indicate that as well as a diagnosed affective disorder,
specific symptoms of depression such as depressed mood and hopelessness are good predictors of suicidal behaviour (Hall, Platt, & Hall, 1999). However, others have noted that more serious symptoms indicated by requiring hospitalisation have the highest risk (Bostwick & Pankratz, 2000). Some also had histories of more complex mental health problems from psychotic illnesses to personality disorder “He suffered from a complex and longstanding difficult to treat combination of emotionally unstable and anti-social personality disorder” (44). These findings are consistent with prior research indicating that domestically violent men have elevated levels of the psychiatric problems that are linked to suicide risk (Ehrensaft, Cohen, & Johnson, 2006; Nock & Kessler, 2006; Shorey, Febres, Brasfield, & Stuart, 2012).

Overall it was notable that there was very limited information about personal background and history within the reports that may have provided useful evidence to understand why the men in the sample died by suicide. The reports were inconsistent in the detail given, including their individual offending and violence histories. This may be reflective of the focus of the PPO investigation, which appeared to be on what had happened and whether the prison could have prevented the death, rather than understanding in depth personal factors that may have contributed to suicide risk.

4.3.3 Theme 2: Custodial Wellbeing Concerns

While Background Factors covers historical information prior to the current period in custody; this theme outlines wellbeing during custody. This includes mental health during this period as well as physical health, coping and the experience of problems.

Mental health in custody
As may be expected given historical mental health problems and mental disorders, current mental health was an important consideration reflected within the reports and more detail was provided here than when outlining the histories. Some of those in the sample did not report any current mental health problems or did not present with any while in custody. However, consistent with Theme 1, in most cases there were reports of current mental health issues. In a few cases these were unclear or unspecified and there was no specific diagnosis “The man made references to “them” listening to him. He agreed that he would speak to someone about this” (10). This meant that the impact on current wellbeing was not clearly determined. There were numerous references to depression or low mood, although this would not always have met the criteria for a formal diagnosis “His low mood was regarded as a reaction to his charge of attempted murder, rather than clinical depression” (31). Prison staff are guided however to make referrals to the mental health teams in custody if they have any concerns regarding risk of self-harm or suicide (Ministry of Justice, 2011) rather than only where a diagnosis is known, suggesting that any level of mental health concern is of note in a custodial setting.

The FIRs within this study indicated that those in the sample experienced a range of mental health problems or disorders in custody of differing severity including anxiety, drug induced psychosis, schizophrenia and ADHD (Attention deficit hyperactivity disorder) “He was having auditory and visual hallucinations and was suffering panic attacks because of his anxiety about his court case” (42). This is consistent with the research into risk factors for suicide in prisoners, which has highlighted depression specifically (Rivlin et al., 2013) or a current psychiatric diagnosis or identified mental health problem (Fazel et al., 2008; Humber et al., 2013) as increasing risk. The link between mental health and suicide is in some ways unclear, as a large number of people experience mental health problems and
never attempt suicide, however those with mental health issues are at greatly increased risk of suicide (Kapur, 2009). In prisons the prevalence of psychiatric issues can be difficult to identify; the proportion of prisoners with known contact with psychiatric services can be much lower than current mental distress when measured formally (HM Inspectorate of Prisons, 2007). For most, poor mental health seemed likely to have contributed in some way, and in some cases there appeared to be a more direct link between mental health symptoms and suicide attempts “[The psychiatrist] diagnosed him with bi-polar affective disorder and hypomania [...] He said he had hanged himself from the cell light and acted out for the officer how he had done this [...] He said he had not put his clothes on and told him that he needed to be naked to get into heaven” (26).

Physical health

Throughout the reports there was reference to the experience of physical health problems. In some cases, this linked to the physical symptoms of alcohol or drug withdrawal “The nurse noted tremors but otherwise considered that he looked well. He asked whether he drank alcohol and, if so, how much. The man told him he drank half bottle or more of whisky each day [...] The nurse referred him to a prison doctor because of his alcohol use and heart problems” (78). This experience is common with suicide in prisoners more widely, where withdrawal from substances has been linked to motivation for suicide (Rivlin et al., 2013) and been noted as an antecedent for self-inflicted deaths in custody (Prison and Probation Ombudsman, 2014a). Several of the men were noted to experience other short-term health issues while in custody such as vomiting or infections as well as more chronic health problems, some of which had been present for many years “The man told her about his accident and brain injury and she referred him to the doctor to have his
prescriptions for painkillers confirmed (18)”. Most reviews of the healthcare needs of prisoners focus on mental health or substance abuse, however other health needs including those for specific populations (such as older prisoners) have also been identified (Watson, Stimpson, & Hostick, 2004).

FIRs also included several references to poor sleep “He was sleeping for four hours a night, but eating well” (24). For some, this appeared to be related to other health issues “in addition to a diagnosed condition of ME, he suffered from irritable bowel syndrome (IBS) [...] an entry in his records referred to lack of sleep and rest having an adverse impact on his health” (90). Recent research suggests that insomnia is an independent risk factor for suicide (Carli et al., 2011; Woznica, Carney, Kuo, & Moss, 2015), however insomnia has also been noted as a warning sign of suicidal thoughts or behaviour (World Health Organisation, 2007). The interaction between health problems, poor sleep and suicide risk in the present sample is unclear. Overall the findings indicate that there are a range of physical health needs that may require attention in relation to suicide risk other than the narrower focus on issues such as detoxification and substance misuse found more commonly in the literature.

Problems and concerns

A theme throughout the reports was the identification of problems, concerns or worries in custody and how they were dealt with. In most cases there was at least one issue or problem of concern and for some they experienced multiple issues. This is consistent with research into male prisoners who have attempted suicide, who reported a wide range of issues linked to their reasons for attempting suicide including adverse life-events, criminal justice/prison issues, and psychiatric problems (Rivlin et al., 2011).
The problems experienced encompassed many different issues including worries about the prison environment, health problems or being able to obtain goods such as tobacco. Several FIRs noted concerns about victimisation or bullying; in some cases, the men considered themselves to be vulnerable but there was no clear information that they were directly victimised “The man said that he had served a prison sentence for a sexual offence in 2007 and he was worried that there were prisoners who knew about that. He asked to be classed as a vulnerable prisoner and kept separate from the general population” (31). For others, the offence they were in custody for caused them some concern. A few reports indicated that they were trying to cope with their offence “He said that he was having difficulty coming to terms with what he had done” (33). Interestingly this was only reported to be the case for a handful of those in the sample, most of the reported concerns about their offending were linked to worries or uncertainty about sentencing and conviction “A prisoner who was a friend of the man, said that he had told him that he was very worried and troubled about his potential sentence” (86). It has previously been suggested that guilt may play a role within any motivation for suicide or self-injury (Snow, 2002), however this is not directly indicated by the present analysis, at least not for guilt regarding a domestic violence offence.

Many concerns or problems were about relationships. While there was less specific mention about concerns regarding the use of violence within relationships, in many cases they expressed worries about the impact of offending on their continuing intimate relationships “Shortly before he died, he told another prisoner that he was having problems in his current relationship” (86), or were preoccupied with the breakdown of relationships “[He] said that he was still struggling to come to terms with his marriage break up” (91). These problems are perhaps to be expected in a sample of men who have been arrested or
convicted for relationship violence. This is also consistent with the literature on suicide, as relationship difficulties or interpersonal conflict have been cited as precipitating factors for suicide in the general population (Williams, 2014) and in prisoners (Snow, 2002).

The reports highlighted that in many of the cases action was taken to deal with problems and concerns “As there was no separate vulnerable prisoner unit at [the prison], it was agreed that he would be unlocked on his own for his own protection till a suitable place could be found” (31); “The nurse said that he had spent some time reassuring the man and telling him what prison life was like” (10). However, many FIRs noted that the men had difficulties dealing with problems, such as failing to take responsibility or being reluctant to talk about problems “He did not want to talk about his problems and he looked ill at ease” (42). A concern shared by many of the investigations was that there were missed opportunities to provide adequate support “Unfortunately, staff at [prison] did not pick up on the man’s accumulating distress” (78); “There is nothing to show that he was given any other support or that other staff on the wing were made aware that he had received distressing news” (18). In a few cases the reports specifically identified that the support offered by the ACCT process was not utilised “They failed to open suicide and self-harm monitoring, leaving the man without the support he needed (107)”. Poor levels of problem solving ability and a passive approach to dealing with problems have been found in those attempting suicide (Pollock & Williams, 2004), therefore it may be that this group have a particular reluctance to actively approach staff or others in order to deal with problems. Compounded by problems with the processes designed to offer support to those in prison, this may have had a significant impact on the ability to manage difficulties in prison.
Ability to cope

While the FIRs noted many clear difficulties with physical and psychological wellbeing, the reports also commented on how well those in the sample were coping in prison. Several men told staff directly that they were struggling to cope “The man told him that he was ‘not good at the moment’ and had thoughts of doing things to himself, as he could no longer cope with the stress” (114) although in other cases suggestions of poor coping came from the investigators “Almost everyone we spoke to about the man described him as quiet, shy and withdrawn. This is a common presentation of someone who is not coping with prison” (10) suggesting that staff were not always aware of coping deficits. The reports highlighted that issues with coping were often related to the circumstances of being in prison “He said that he did not want to be amongst people and needed some time on his own to deal with his recall” (48). There has been suggestion that the psychological impact of prison may put strain on an individual’s coping skills, even more so for very vulnerable individuals (World Health Organisation, 2007). However, the FIRs do not provide clarity about whether it was due to a struggle to put coping strategies into practice within the prison environment, or whether there were general deficits in effective coping abilities. Previous research has suggested a link between maladaptive or poor coping skills and suicide risk among UK prisoners (Gooding et al., 2015; Mckeown, Clarbour, Heron, & Thomson, 2017), suggesting it could be the latter.

There was little mention in most reports of efforts to improve coping skills or abilities, with some exceptions “The counsellor told the investigator that she spoke to the man about coping strategies, such as developing his relationship with his young nephew and maintaining contact with his wife. She told him to write out his problems on separate
pieces of paper and work out a plan for working through them. She also advised him to eat properly and told him that staff would bring food to him if he did not feel able to go to the servery” (90). It is unclear from the reports whether this related to lack of access to psychological or practical coping support, or that such support when provided was not recorded. Only in a very few cases was there mention that any counselling or psychological support was offered or taken up.

While some men did find it difficult to cope in prison, the reports also identified that for some no coping problems were identified. In a few cases the man stated when questioned that he could cope “He said that he had no problems, had settled in well and could cope with his present circumstances” (22) although in most cases it was the judgement of staff or the investigators that he ‘appeared’ or ‘seemed’ to cope well. Given that everyone in the sample died by suicide, this indicates that there may either have been barriers to expressing feelings and concerns to staff, or that staff had not picked up on the signs of vulnerability. A further explanation may be that the suicide was not related to poor coping for some; it could be that for some in this sample their suicide had other motivations such as instrumental gain or the effects of detoxification (Rivlin et al., 2013).

4.3.4 Theme 3: Relationships

This theme outlines the nature and quality of the man’s relationships with others; those in his personal life outside of prison, other prisoners he encountered, and professional relationships. FIRs often commented on the men’s contact with others both in and out of prison, however they were limited in providing accounts of the quality of these
relationships. A particular issue noted within the FIRs was a lack of active engagement with others.

**Personal relationships**

Family relationships were clearly important, acting as a source of support “*He had visits from and telephone conversations with family members and friends and family wrote to him, so he had their support*” (80) and in some cases, were viewed as a protective factor against risk of suicide “*The man said that his daughters and grandchildren were reasons for him to live because they relied on him*” (91). Research indicates that positive family support or the perception of having positive social support may mitigate suicide risk in some populations (Christensen, Batterham, Mackinnon, Donker, & Soubelet, 2014; McLean, Maxwell, Platt, Harris, & Jepson, 2008; Slade, 2011) although the evidence is mixed and this did not ultimately protect these individuals.

While family and intimate relationships for all of those in the sample had been interrupted due to arrest or conviction, for some this was more extensive “*The same day, his mother was granted a two year restraining order against him to protect her from ‘further conduct which amounts to harassment or will cause fear of violence’. The order prevented him from having any contact with his mother or visiting her home*” (26). Given the nature of offending within this sample it is perhaps not surprising that they experienced problems within their intimate relationships. Even when the relationships continued there were some logistical considerations to maintaining contact “*In the afternoon, the young person asked an SO if he could telephone his girlfriend. As she was the victim of his offence the SO*”

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1 Senior Officer, an experienced officer who manages Prison Officers and other support grades and may be responsible for running areas of a prison
contacted the girlfriend first to obtain her consent. She was happy for him to phone and, as she was over 18, the SO allowed the call” (73). However most recorded information about intimate relationships indicated that the relationships had broken down, contact was not permitted or that they were experiencing complex problems “There were some letters in the man’s cell from his wife questioning the future of their relationship and what they would do when he was released from prison” (10). Relationship breakdown including divorce or separation has been widely linked to increased risk of suicide in the general population (Evans, Scourfield, & Moore, 2016). It has also been identified that while marriage is associated with lower risk of suicide in the general population, this is not the case in prisoners which may relate to losing a significant source of personal support increasing vulnerability (Fazel et al., 2008). This could be particularly problematic for domestically violent men who arguably have been responsible for this loss.

Across all types of personal relationships, contact with the outside world was noted within the reports. This reflected contact with family, friends and partners through letters, telephone conversations and visits. There were some who experienced very little contact with personal support networks outside of prison “The investigator has established that during his current sentence the man received only one visit while at [the first prison] and no visits at [his current prison]. From his arrival into custody on 28 January until his death [on 2nd August], he made no phone calls whatsoever so had very little outside contact” (14). It was unclear whether this was a choice not to establish contact, perhaps due to conflict or relationship breakdown, or due to not having any personal support. Others were clearly distressed by their inability to make contact “Prison records show that the man had attempted to telephone his mother on 37 occasions since his arrival on 17 April up till the time of his death [in May], but had been unable to get through” (22). Several of the
reports utilised telephone recordings and transcripts to identify what the man had spoken to others about; this included the court cases, personal thoughts and feelings and to ask for help “The man told his mother that he had not seen a doctor since the last time they had spoken. He believed it was because doctors did not go to the vulnerable prisoners’ wings. He asked his mother to contact the prison to arrange this and she advised him to tell his solicitor, who was due to visit him on Friday” (114). Despite the attention paid to contact in prison, research has failed to conclude a positive effect of family relationships on wellbeing, and there is limited research into whether family visits reduce self-harm or suicide (De Claire & Dixon, 2017). However, in previous research 22% of prisoners attempting suicide reported missing family to be an important reason for their actions (Rivlin et al., 2011), indicating that this may be relevant to understanding their suicide risk.

The nature of relationships and interactions with other prisoners were also noted within the reports. Investigators usually spoke to prisoners who may have known the man during the investigation or obtained comments from staff about his relationships with others while in custody. Such relationships varied, with some appearing to have positive interactions and receiving good support from others residing in the prison “He said he had met the man as part of the induction process on 19 November and quickly realised that he spoke very little English and struggled to understand what was being said to him. He arranged for him to take part in the English language skills class, a course run every day for foreign national prisoners” (24). For others, their relationships with prisoners were limited “Despite staff attempts to encourage him to engage he did not mix with other prisoners and spent most of his time locked in his cell” (31) and in several cases the men experienced conflict with other prisoners “By early December, the man’s behaviour was reported to be causing bad feeling amongst the other prisoners on C wing. They complained about the
smell from his cell and that he was constantly asking for tobacco and taking it from their cells” (36). This suggests that problems within relationships are not limited to those established outside custody and are also present in relationships formed with other men in prison.

Professional relationships

As may be expected, there were a high number of references to the interactions those in the sample had with members of staff while in prison. Interactions were noted to occur with prison officers for a variety of purposes such as during the reception and induction processes “After the initial health assessment, an officer saw the man. The officer’s duties were to interview newly received prisoners and complete the remainder of the CSRA, as well as induction paperwork” (55). Other interactions with officers included for disciplinary action, through personal officer\(^2\) interactions and when ACCT monitoring checks were being carried out. The men also spoke to a variety of other staff members in custody such as substance misuse workers, chaplains and offender supervisors “The same day, his offender supervisor interviewed him again to complete a public protection notification because of the restraining order against him” (26).

While many of the recorded interactions were brief in nature, there were also descriptions of supportive relationships with staff who tried to encourage, engage and advise. This was noted to relate to general support “Overall, staff at [prison] made considerable attempts to engage with the man, manage his anxieties and assist his progression through his sentence” (110) as well as more specific guidance “During his time in prison, the man

\(^2\) Many prisons run a Personal Officer scheme whereby prisoners are allocated an appointed officer to help build effective relationships, act as a contact point and address any problems or concerns.
discussed his religious needs with the Roman Catholic chaplain. At the man’s request, the chaplain arranged for a spiritualist minister to come to the prison to speak to him” (86).

Staff attempts to provide support were not always successful. At times, the men were distant from staff “She said she tried to engage the man in conversation but said he always gave very short replies like “fine” and “okay”” (10) or deliberately uncommunicative “He then refused to communicate with any medical or prison staff. He would not attend an ACCT review on 19 September, as a protest about not receiving the medication” (42). In rare cases, the men were hostile towards staff “She said that the man then became abusive and said that she should know his medical history and that he had a gastrointestinal bleed. The man did not attend triage clinic the next day” (107). Even when there were no specific conflicts with staff, the reports noted some problems with the level of support or interactions offered. For some, they appeared to fall under the radar of staff and investigators found that staff sometimes had trouble recalling the man “A Senior Officer (SO) was managing the prison’s reception, and the records show that she saw the man when he first arrived at the prison, but she said she could not specifically recall him” (37).

This may be reflective of the high number of prisoners seen in some prison locations, for example busy reception areas. Even over a number of days however there was little interaction between staff and some of the men, which was heavily criticised by investigators “it is unacceptable that there is no evidenced interaction between him and prison officers on the wing” (89). Supportive staff-prisoner relationships have been suggested to be critical to developing a positive, therapeutic regime (Bennett & Shuker, 2010) and can have a positive local impact on reducing suicide rates (Slade & Forrester, 2015), therefore inconsistencies in the level and nature of support offered may have a clear negative impact on suicidal behaviour and risk.
Isolation

Isolation and a lack of engagement with others was reported in several cases. At times men were in a cell on their own either at their request or through circumstances “On 6 June, the man’s cellmate was moved, leaving him on his own in the cell” (18). Being in a single cell is a known risk factor for suicide in prisoners (Fazel et al., 2008). This may be due to the characteristics of men who reside in single cells, such as being deemed as a risk to themselves or others and having previous mental health contact, being exacerbated by the isolated environment (Humber et al., 2013). At times, reluctance to form relationships with others was seen in a neutral way “They described him as someone who kept himself to himself” (55) rather than as a problem, potentially indicating staff’s lack of awareness of the risks that isolation may pose to a vulnerable prisoner. Isolation was also noted in other ways such as deliberately withdrawing from the prison regime or available social networks “He appears to have spent much of his final weeks in bed in his cell, paying little attention to personal hygiene, no longer associating with other prisoners and not attending religious services as he had done previously” (78). It is unclear why isolation may have been a particular problem; while there is limited evidence of expressing guilt or shame outwardly, it may be that feelings about offending led to withdrawal from others. Social isolation is also a symptom of depression (“Clinical Depression”, 2016) which could explain the tendency for some men to deliberately withdraw. Whether circumstantial or self-imposed, isolation is likely to have impacted on feelings of being connected to others, which has been identified as protective against suicide in a range of populations outside prison (McLean et al., 2008) and a key part of overcoming suicidality in prisoners (Reading & Bowen, 2014).
### 4.3.5 Theme 4: Outward presentation and perceptions

A central theme identified within the FIRs was how the man presented to others during his time in custody. This included observed behaviour, emotional state and how staff perceived the man. Given the circumstances, the investigators were reliant on information that staff had recorded and perceptions from those they spoke to as part of the investigations. This may have limited the issues identified due to poor recording, poor recall or limitations to staff disclosure of problems within the investigation process.

#### Behavioural problems

Several of those in the sample were reported to have had difficulties managing their behaviour in custody. This ranged from problems complying with prison rules “*In July, the man was asked to move cells but refused to do so and was charged with an offence under Prison Rules of refusing to comply with a lawful order (14)*” to failures to participate in risk reduction work “*He had become increasingly reluctant to engage with any offence related work. This caused problems in progressing through his sentence and moving towards release*” (75) and aggressive or violent behaviour “*On 5 April, the young man was warned for being abusive and threatening to a teacher during his education induction*” (26). Such behavioural problems were not reported for most cases however, although it is not clear whether all instances of impulsive, rule-breaking or aggressive behaviour in custody would have been reported either at the time, or by the PPO investigators. Research has established an association between aggression, impulsivity and suicide risk (Keilp et al., 2006) which may be reflected in the behavioural problems for some of the men, but do not appear to be significant for the majority. Findings have also suggested that domestically violent men may be more impulsive than their generally violent counterparts, although this
may be mediated by other clinical factors (Cohen et al., 2003). The present study does not provide substantial support for high levels of aggression and impulsivity in domestic violence perpetrators within custody, however the relationship between custodial behaviour and continued aggression or violence in the community is somewhat limited (Mooney & Daffern, 2013, 2015). Similarly, it may be that aggression or impulsivity associated with domestic violence may not translate to aggression and impulsivity within a prison environment.

**Emotional state**

Almost every report commented on emotional state; only two reports did not mention mood at all when discussing the man’s presentation or statements to staff. There were many more references to negative emotions or feelings throughout the reports than to positive or stable mood, which is consistent with research into indicators of suicide attempts. A working group aiming to gain consensus about warning signs for suicide highlighted a number of emotions as indicators including hopelessness, rage/anger, anxiety and dramatic changes in mood (Rudd et al., 2006). This was reflected within the reports which identified men experiencing all the above emotions. Interestingly although hopelessness in particular has been extensively researched as a risk factor for suicide (Brown, Beck, Steer, & Grisham, 2000) a relatively small number of reports identified commented on the experience of hopelessness “He stated a clear intention to kill himself many times and often spoke of feelings of hopelessness and worthlessness” (110). Particularly as many of the men were managed under the ACCT process and hopelessness is identified within the guidance for this process (Ministry of Justice, 2013) it is somewhat surprising that this was not commonly identified. It may be that hopelessness was not a
driving feature towards suicidality for this group, however it may be a result of staff not recording the information or it not being included in the FIR rather than hopelessness not being experienced. This highlights some of the limitations to understanding the experience of suicidal prisoners.

As may be expected there were a number of cases in which the man reported feeling depressed or low in mood “At the assessment, the man said that he felt very highly depressed” (50). However, there were also reports of feeling anxious “Throughout June, the man reported feeling low, anxious and having difficulty sleeping” (90), stressed “He said that he was feeling stressed about his pending court appearance” (22) and angry “She said that he told her that he had been angry about some family issues” (114). Consistent with the previously identified warning signs for suicide, some of the reports also described a changeable emotional state “The day after he arrived, the man’s behaviour and mood fluctuated considerably” (121). Domestically violent men have been found to have lower levels of emotional intelligence (recognition, regulation and expression of emotion) than men in the general population (Winters, Clift, & Dutton, 2004). Therefore, it is not surprising that those in this sample were noted to have difficulties with their emotions.

While negative mood states were prominent, the reports also outlined perceptions of more positive or stable emotions. At times, this reflected what the man was saying to others during his time in custody “The nurse next saw the man on 27 August and noted: ‘He seems much happier now that he has transferred to C wing, he spoke about how much happier he is in his own company’” (33). On other occasions, the comments described an overall impression or perception “The nurse considered that he seemed to be in a stable mood” (18) rather than reflecting specific evidence of positive emotions. This again
highlights the difficulty in relying on others’ perspectives of psychological or emotional functioning.

**Perception of the individual**

The reports outlined how staff and other prisoners perceived each man during his time in custody. Some did not stand out to staff during their time in custody “*The nurse was unable to recall him, but said that as he had not recorded anything significant he could only assume that he had been ‘quite ordinary’*” (55) or did not present in a way that caused concern to staff “*The SO told the investigator that the man interacted well with staff, complied with the regime and staff were not concerned about his welfare*” (14). There were some cases where staff clearly had concerns and took appropriate action to raise this “*Later in July, his probation officer passed on her concerns to the prison about his state of mind*” (48).

Interestingly, there were also some cases where there were differing perceptions regarding state of mind “*The counsellor and Officer A appeared to have different understandings about the level of concern about the man on 24 July and how he presented. The officer thought that he was much the same person he had been since he had known him. The counsellor said he seemed different and very anxious*” (90). This could reflect different contact that staff had, or varying levels of understanding about how someone who is distressed or anxious may present. This could also reflect a more deliberate attempt on the part of the man to hide how he was truly feeling. One case (117) illustrates this clearly. No concerns were raised on entering custody “*The officer told the investigator that the man seemed cheerful, self-assured, boisterous and cheeky. He was chatty and outgoing and answered all of the questions properly*”. However later that same day the
man “told the Listener⁴ that he had felt like hanging himself when he first arrived in reception”. He again asked to see a Listener again and staff perceived “that he appeared fine at the time” however the Listener commented “the man looked vacant, said that he felt very down and was withdrawn. He mentioned hanging himself again. He felt that he did not deserve to be back in prison.” This illustrates that some of the men could be experiencing what has been termed masked or covert depression, where individuals may repress or avoid feelings of loss, guilt or depression and not display these outwardly (Cochran & Rabinowitz, 2000). This finding may also indicate barriers to expressing inner feelings to staff and professionals, even when men are able to express these feelings to peers.

While it was generally noted how difficult it can be to predict suicidal behaviour, at times the investigators highlighted that “A common factor in these interactions is that the person interacting with the man gave greater weight to his presentation and what he told them than to several risk factors which are known to increase the risk of suicide or self-harm” (107). This was a comment made across several reports, and indicates problems with effective assessment of risk. There are challenges in assessing risk effectively, with limited evidence about the efficacy of different methods of suicide risk assessment (Logan, 2013). Logan suggests that the current best evidenced tools to assist with suicide risk assessment are the Beck Hopelessness Scale (BHS) and the Beck Scale for Suicide Ideation (BSS), although proposes that a structured professional judgement tool may be more effective.

Screening tools have been criticised in terms of their clinical utility (Fochtmann & Jacobs, 2015), and the large number of different guidelines for assessing suicide risk may be a

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³ Listeners are prisoners trained by the Samaritans to offer confidential support to other prisoners who want to talk about their problems.
limitation rather than an advantage (Bernert, Hom, & Roberts, 2014). Therefore, it is perhaps not surprising that some staff, particularly those who may not be highly trained in the principles and guidelines of suicide risk assessment, may place more weight on what they see in front of them rather than more objective ways of measuring risk.

4.3.6 Theme 5: Suicide risk and behaviour

The final theme related to individual factors is concerned with the man’s suicide and the issues, known risk factors and potential triggers that may have been relevant. In terms of the circumstances of the death, the FIRs clearly outlined in each case how the man died, how and when his death was discovered and actions taken by staff. While much of the information presented within the reports concerns processes and procedures, the reported circumstances can offer some clues as to motivations or intentions. Most men were found by staff either at a routine morning, evening or nightly routine check:

“An officer was asked to perform the day staff roll check [...] She looked through the observation panel once, closed it, then reopened it and realised that he had hanged himself” (120).

“He was found hanged in his cell during a roll check at 8.25pm” (10)

“Just before 6.00am the next morning, the man was found unresponsive in his cell” (36)

This suggests that many of the men killed themselves when they would be alone and undisturbed in their cells and did not attract attention to their attempt, which may indicate an intention to die. This has also been linked to the risk associated with being in a single cell, although not all of the men were, as this can provide the opportunity and privacy to engage in suicidal behaviour (Humber et al., 2013). This intention to die was also supported by the method chosen by all but one; ligatures have a high risk of death and are
associated with higher intent to die (Horesh et al., 2012). The only man not to die by hanging was on constant watch, and obstructed his airway with food leading to suffocation. However, this choice of method may be due to the more limited means available in prisons. In the community, while the most common method is hanging, suffocation or strangulation (John, 2017) this accounts for a far smaller proportion of deaths (58.7% in 2016) with other common methods including poisoning, drowning, falls and other methods. The lack of access to these methods may in a sense ‘force’ prisoners to use higher lethality ways of attempting suicide, irrespective of their ultimate intention.

Suicidal statements of intent

The men within this sample, as is common in all prisons, were asked about any suicidal thoughts, history or plans on reception, often by both prison officers and healthcare staff and their responses were routinely recorded. In a number of cases, the man consistently reported no current suicidal thoughts and no intentions to harm himself “The man said he had no thoughts of suicide or self-harm” (80). However, it was difficult to judge based purely on this whether there was a risk of suicide. Some cases plainly identified that while the man denied any suicidal thoughts to staff this did not necessarily mean that he was not experiencing them “In telephone conversations with his mother, the man had threatened to kill or harm himself […] When staff discussed this with him, the man said that he had been angry at the time and had no current thoughts of self-harm” (114). In other cases, suicidal thoughts fluctuated over time in custody and it seemed that the man himself may have been conflicted “He said that he was still struggling to come to terms with his marriage break up and if he could press a button to end his life he would. However, he also said that he would not end his own life because he did not “have the bottle” to do so” (91).
The literature is clear that not everyone who experiences suicidal ideation will go on to die by suicide (Larney et al., 2012) although it is generally accepted that for an individual to die by suicide they must have thought about it at some point. Some studies have identified that increasingly serious suicide ideation increases the likelihood of future suicide attempts (Roy et al., 2014). There were some men within the sample who expressed clear and consistent suicidal thoughts and plans to staff “He often spoke of his intention to kill himself once the arrangements for the custody of his children had been settled” (110). Despite knowledge of current suicidal ideation in these cases, unfortunately, as one report points out “Ultimately it is very difficult to prevent someone who makes a reasoned decision to kill himself from carrying out that plan, without making living conditions so restrictive as to be inhumane” (50). This is consistent with the suicide literature which acknowledges the difficulties in predicting suicide risk in individuals (Goldney, 2012).

**Triggers and known risk factors**

Few of the investigators commented on what they thought had specifically triggered the suicide. Without clear information, the PPO may have considered this to be speculation not appropriate for an official report. Some of the reports identified that suicide notes had been found which provided further information about motivations or triggers, although these were not often reported in detail. Potential triggers were also identified from previous self-harm behaviour and statements about future suicide risk. The potential reasons for suicide identified from these sources largely involved interpersonal problems with family “The police found a letter in the man’s cell, written to his mother and ex-partner in which he said he found it difficult not being able to see his children and that ‘... it is time for me to go all I do is mess things up, you will all be better off without me’” (22) and
intimate partners “He said that his wife had left him in January 2012 and since then, he had had suicidal thoughts” (33) and for issues around being in prison and sentencing “mum if you are reading this I not alive cos I can not cope in prison people giving me shit evan (sic) staff” (73). However, nearly half of the reports did not identify or report specific triggers for suicide or self-harm. This is likely related to the fact that suicide and self-harm monitoring procedures were opened on only half of men at any point during their time in custody, and there was active ACCT monitoring in only eight of the cases at the time of their death. Therefore, risk of suicide had not been identified in half of the sample, limiting the opportunities to identify triggers or motivations to considering suicide. Previous research into those attempting suicide indicated that only a third of prisoners told someone about their wish to die (Rivlin et al., 2011) and the findings of this study indicate that even less may do so who complete suicide. This highlights the importance of recognising and exploring risk of suicide in prisoners rather than relying on their willingness or ability to seek help.

In relation to this, most of the reports summarised the known risk factors that were present; these were risk factors identified in prison policy for staff to consider when making assessments of a person’s risk of harm to themselves. The majority of these identified that the fact the man was in custody for an offence against someone close to him was a risk factor that should have been recognised by prison staff, although at times it was not “There is no record that his static risk factors were taken into account, which included the circumstances of his offence” (86). The most common of the other factors associated with increased risk of suicide were previous self-harm or suicide, mental health issues and alcohol or drug misuse. While most of the sample had four or more identified risk factors, there were some with few or no other risk factors that prison staff are guided
to consider “Other than his earlier self-harm, which was some years previously, and the circumstances of his offence, which was seven months earlier, there were no obvious known risk factors which would have led anyone to consider that he was at risk of suicide” (14). This has implications for suicide risk assessment and management in custody; it cannot be assumed that those who will go on to complete suicide will have several obvious risk factors. However, the presence of an offence or charge against a family member or partner may be a critical factor that should be easily discernible to prison staff upon the man’s entry to custody.

**Previous suicidal behaviours in custody**

The FIRs also outlined previous self-harm and suicide attempts prior to the final completed suicide. Behaviour during self-harm prior to death appeared to be different in some ways to the final suicide attempt. Despite almost all the men dying by hanging, their self-harm behaviour prior to this included a variety of other methods such as cutting “On 11 July blood stains were noticed on his shirt sleeves and he admitted to having cut his arms” (48) and self-poisoning “He told her he had taken two toilet disinfectant tablets the previous evening and had been sick” (22). While none of the reports indicated that attention was drawn to the suicide attempt that ultimately led to the death, some had informed staff of previous self-harm or suicide attempts “At 6.55pm on 4 May, the man pressed his cell bell and showed the officer who responded, a cut on his forearm. The officer called the duty healthcare officer and the mental health team. The man said that he had cut his wife’s name into his arm, but was otherwise reluctant to discuss what had happened” (123). In previous research, around a third of prisoners who have made a suicide attempt reported that they made specific precautions against discovery, while another third told someone of
their intentions (Rivlin et al., 2011). This supports findings that there are different motivations and intentions within suicide attempters (Rivlin et al., 2013).

4.4 Summary and conclusions

This chapter has explored what is known about domestically violent prisoners who die by suicide from the perspective of information gathered by the Prison and Probation Ombudsman in the process of their investigation. The study provides evidence of a relationship between domestic violence perpetration and suicide risk, as there were a disproportionate number of prisoners with an index charge or conviction of domestic violence who completed suicide during the period represented.

The aim of this study was to explore current knowledge and factors that may explain why domestically violent men have increased risk of suicide as well as to identify any gaps in understanding. Thematic analysis of the FIRs found two main strands of factors relevant to this population, individual and situational factors; given the aims of this thesis the individual factors were focused on within the presentation and discussion of findings in this chapter. The findings were that individual factors relevant to the men included their background and history, their wellbeing in custody, their relationships with others, how they presented to and were perceived by those caring for them in custody, and the nature of their suicidal behaviour. Further discussion of these themes and the key findings will be outlined in Chapter 6 along with the findings of the second study.

In terms of identifying any gaps in knowledge, while relevant factors were identified through the thematic analysis this study revealed the limited nature of FIRs in helping to understand the background, history and decision-making process of individuals who die by
suicide. The FIRs were variable in terms of length and detail and it was not always apparent that this was due to the availability of information. For example, an FIR on a man who had been in custody for many years on an indeterminate sentence was 28 pages long, whereas an FIR on a young person who was in custody for approximately two months was 80 pages long. It appeared up to the discretion of the investigators and PPO what level of detail to report in terms of personal and offending background. In some cases, the man’s age or index offence was not reported. However, it is important to note that the purpose of the FIR is to understand what happened and provide advice to the organisations involved, rather than to fully explain why the suicide happened. This was evident in the focus on processes, procedures and outlining timelines of what happened.

Despite the limited information available, the study provides some insight into the psychological or personal factors that would benefit from further exploration in order to better understand the relationship between domestic violence perpetration and suicide. Much of the research into prisoners dying by suicide has focused on characteristics or environmental factors such as diagnoses, conviction history or location in custody. The findings of this study indicate that to advance the understanding of the relationship between domestic violence and suicide in prisoners, a number of areas require further exploration. This includes how these individuals experience relationship problems in the community and custody, the contribution of physical and mental health problems and ability to cope with stressors and problems, how emotions are experienced and dealt with, and what barriers to seeking help and support may be present. These findings will be used to help shape the second study within this thesis which aims to further develop the understanding of the relationship between domestic violence perpetration and suicide risk by interviewing prisoners who have engaged in near-lethal suicide attempts.
Chapter 5: The experiences of domestically violent men who have attempted suicide in custody

5.1 Introduction

Chapter 4 outlined the findings of the first study within this thesis, which investigated self-inflicted deaths in prison by those charged or convicted with domestic violence by analysing Prison and Probation Ombudsman (PPO) Fatal Incident Reports (FIRs). The findings indicated two overarching aspects; individual factors and situational factors. Individual factors identified issues in relationships, custodial wellbeing, and the way those in the sample presented to others during their time in custody. However, there were clear limitations in the depth of the data and information provided about the personal backgrounds and histories of the sample as well as the triggers and motivations to their suicides. While many of the findings supported the factors identified as relevant generally in prisoner suicides, they indicated that there are further avenues that require exploration in terms of understanding the relationship between domestic violence perpetration and suicide. This included understanding more about how relationships are experienced, coping and problem solving, and the impact of mental and physical health problems.

This chapter presents the second study within this thesis, building on the findings presented and explored in Chapter 4. The first study explored some of the known information about this group by analysing FIRs prepared after suicides in custody. The present study was designed to build on the findings of this study and explore some of the gaps in knowledge identified from this and the wider literature. A significant issue with FIRs was the focus on processes and procedures that were in place within the prison and
the lack of attention paid to the histories and experiences of the men who died by suicide. This is somewhat mirrored in the available research which tends to focus on environmental factors, findings from brief self-report questionnaires or brief descriptions of diagnoses. While these factors are important to know, they do not capture the psychological processes, factors or experiences from the perspective of those at risk that may underpin why prisoners with domestic violence offences are at increased risk of suicide.

5.1.1 Aims of the study

The aims of the present study were:

- To gain an account of the experiences of domestically violent prisoners who have attempted suicide in prison to understand their background and histories.
- To investigate further the factors that may underpin why and how domestic violence perpetration is related to suicide risk in prisoners attempting suicide.

This was achieved through undertaking qualitative interviews with domestically violent prisoners who have attempted suicide while in custody. The nature of their domestically violent and suicidal behaviour was explored as well as the areas identified as gaps in knowledge within prisoners from the first study.

5.1.2 Overview of the chapter

This chapter will begin by outlining the methods, sampling and data analysis used alongside consideration of participant recruitment challenges. This chapter will then present the findings of the thematic analysis of participant interviews, with a focus on learning more about what psychological or personal factors may make domestically violent
individuals at increased risk of suicide. The findings will be discussed and explored in the context of the wider literature on suicide and domestic violence perpetration.

5.2 Methodology

5.2.1 Ethical and safeguarding considerations

This study was approved by the Cardiff Metropolitan University ethics board, and further permission was given by the National Offender Management Service (NOMS⁴) National Research Committee. The processes of obtaining approval to conduct this study involved careful consideration of the ethical implications of interviewing men in custody who had attempted suicide. The main ethical issues that required deliberation were obtaining informed consent, maintaining confidentiality and anonymity of participants and the safeguarding of both the participants and the researcher from harm.

Informed consent was gained by providing a clear information sheet to each participant prior to them deciding whether they wished to participate (see Appendix C). If they indicated that they wanted to contribute to the study, the information sheet was further discussed with them at the interview appointment, and they were offered the opportunity to ask questions or have more time to think about it. Participants were then asked to sign a consent form which outlined each aspect of their participation in the study, and the processes and opportunities for withdrawing consent were discussed.

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⁴ NOMS were the governing body of the prison and probation services in England and Wales at the time of data collection, now Her Majesty’s Prison and Probation Service (HMPPS).
Part of the consent process involved explaining anonymity and confidentiality. As a dual researcher and employee of HMPPS it was important to be clear that the interviews were part of external research and explain how confidentiality would be maintained. It was important that as part of this, I would not be involved with their cases as a practitioner or employee of HMPPS. This in part dictated the locations that participants were drawn from, as my main workplaces were excluded. Participants were informed that, with one exception discussed later, any information disclosed during the interviews would not be used for any other purpose than the research and would not be discussed with other staff. All interviews were recorded onto a Dictaphone and then transcribed verbatim. The process of transcription also involved an element of the anonymising process, as identifying information was removed or altered during the transcription process; for example, substituting initials for people and places. Each participant was initially allocated a number which was used to identify the interview recording and transcript. The participant names were held only on the consent forms, which were kept securely and separately from other participant data, and on the participant database held on a personal but secure system. After transcription, participants were allocated a pseudonym for the reporting of the findings. Pseudonyms were chosen by averaging the participants ages and using a standard list of popular boy’s names from that year of birth.

The exception to confidentiality was linked to safeguarding issues. Participants were informed that if there was information that they were at risk of harming themselves, that this would be passed on to staff and relevant procedures followed. As the participants had all seriously harmed themselves previously and some were still on active monitoring via an ACCT, risk of self-harm or suicide was clearly present and usually known to staff. Therefore, to maintain confidentiality as much as possible it was important to only pass on
information from the research interview that was unlikely to be known to staff, if there was an *imminent* risk and was specifically relevant to keeping the participant safe in custody. This happened on one occasion within the research interviews where a participant informed me that he had a serious and increasing intent to kill himself, and that he did not think that staff knew this. I discussed with the participant that I would need to let staff know what he had said specifically about his intent to die by suicide so that he was aware that this would happen, and he had no objections.

Further mechanisms were put in place to monitor wellbeing and identify safety issues. This included taking a SUD (subjective units of distress) rating before and after the interview. Attention was paid to the emotional wellbeing of the participants during the interviews and it was important to show empathy and acknowledge their experiences. Most of the participants reported that their SUD remained the same or reduced after the interview. Two participants indicated an increased SUD rating, although one commented that he had not taken his usual prescribed medication that morning and that this had probably impacted on his wellbeing. This is consistent with previous research that found limited negative impact on prisoners who were involved in research interviews about suicide (Rivlin, Marzano, Hawton, & Fazel, 2012). After the interviews, participants were provided with a debrief sheet with information about the avenues of support available both in custody and the community (Appendix D). At this stage, informal discussion was held with the participant about how they were feeling and what they might do for the rest of the day to maintain their wellbeing. This allowed further opportunity to identify any issues that may need to be raised with staff, as well as to allow the participants time to reflect on the research interview.
In relation to researcher safety issues, the participant selection procedures involved identifying any risk of harm to others and advice was taken from staff about this. It was also important to be mindful of the impact of the interview processes on myself as the researcher and interviewer. Supervision, reflection and debriefing was sought from University supervisors, fellow students and colleagues to talk through any difficulties with the interviews and the personal impact. This is something that I am used to doing as a practitioner, and I have access to a number of sources of support in this role.

5.2.2 Method

The interviewing of individuals who have made suicide attempts has been a common approach to understanding the psychological characteristics of those who may want to take their own lives (Rivlin et al., 2011). Given the sensitive nature of this issue, a semi-structured interview format was used, which allows for exploration of the participants’ understanding and personal experiences (Braun & Clarke, 2013). Semi-structured interviewing is well established in qualitative research, and involves a relatively small number of open ended questions (Willig, 2013). Willig (2013) also outlines guidance on effective semi-structured interviewing, such as using a well-constructed interview agenda, being aware of social and linguistic differences between the interviewer and interviewee, and carefully considering how to develop rapport.

Several prisons in Wales and the South West were initially identified for inclusion in the study. This was partly for practical geographical reasons due to my location in South Wales, but also to provide a range of different types and locations of prison. Six prisons were approached and initially agreed to support data collection. These included three Category B prisons in Wales, one Category B prison in England and one Category C prison in England.
One Category D prison was initially approached however self-inflicted deaths in such prisons are extremely rare; only one case is recorded on the PPO website which covers custodial deaths since 2004. Given this, it was unlikely that men in such prisons would have recent experiences of serious attempted suicide. Two prisons in Wales were excluded to minimise any conflict of interest, as they were my primary workplaces. While all the prison Governors supported the research, it proved challenging to access the data required to identify potential participants at some sites. Access to the data involved being given specific permission for two prison databases in each site, and processes for this varied among prisons. Data collection also relied on staff being available to provide both electronic and at times practical support. Pressures on staff time and changes in roles during data collection affected some prisons ability to provide this support. Therefore, the data included in this study is drawn from three sites; two Category B prisons in Wales and one Category C prison in England.

5.2.3 Sampling and recruitment

As with the first study, a purposeful sampling approach was used, as the research questions pertain to the experiences of a specific homogenous group (Patton, 2015); domestically violent men in custody who had made a near-lethal suicide attempt. An important consideration was ensuring that the participants’ experiences were as close to those who died by suicide as possible. Given the relatively small numbers of men in prison who may meet the study criteria, and the previous prison studies completed, the definition of near-lethal suicide as described by Rivlin et al (2012) was used for this study (see Table 6). Primarily, prison records on self-harm acts were utilised to identify potential participants. Any self-harm is recorded on the Prison National Offender Management
Information System (PNOMIS) for inclusion in national reporting. These records include the name and identifying information of the individual and a summary of the self-harm behaviour from staff. Generally, this included the type of self-harm and usually referred to whether the injury was deemed to be ‘superficial’, and whether medical treatment was required. Some reports did not clearly identify the individual involved therefore these incidents could not be included.

Table 6
Criteria for the identification of near-lethal suicide attempts (adapted from Rivlin, Fazel, Marzano & Hawton, 2012).

<table>
<thead>
<tr>
<th>Method</th>
<th>Inclusion criteria</th>
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</thead>
<tbody>
<tr>
<td>Hanging</td>
<td>Unconscious after attempting to hang or use a ligature</td>
</tr>
<tr>
<td>Self-strangulation</td>
<td>Witnessed using a ligature and physical evidence of asphyxiation</td>
</tr>
<tr>
<td></td>
<td>Physical evidence of suspension or using a ligature</td>
</tr>
<tr>
<td>Self-asphyxiation</td>
<td>Witness self-asphyxiation or any other physical evidence of self-asphyxiation</td>
</tr>
<tr>
<td>Suffocation</td>
<td></td>
</tr>
<tr>
<td>Cutting</td>
<td>Sustained a puncture wound penetrating a body cavity or major organ</td>
</tr>
<tr>
<td>Stabbing</td>
<td>Lacerations that damage or severed tendons, arteries or large veins or came very close to doing so</td>
</tr>
<tr>
<td>Self-poisoning</td>
<td>Objective evidence of an altered level of consciousness, or unconsciousness</td>
</tr>
<tr>
<td></td>
<td>Transferred or admitted to a medical facility including prison healthcare unit or outside hospital</td>
</tr>
</tbody>
</table>
Jumping | Witnessed jumping from a considerable height or any physical evidence of having jumped
Other | Determined on a case by case basis

All recorded self-harm incidents at the included prisons from 1st January 2016 to 31st March 2017 were reviewed for evidence of fitting the criteria of ‘near lethality’. Although most information was collected through the electronic data, to aid recruitment, Safer Custody Teams at each site, who have responsibility for the implementation and development of safer custody policy (Ministry of Justice, 2013) were informed about the research. They were provided with the criteria used and were asked to refer any individuals that they felt may meet the criteria. This did not result in any further participants being identified. While gathering this information, it was noted that many individuals had several incidents of self-harm, and some had multiple incidents of near-lethal self-harm including using different methods. In the following procedures for identifying those with offences of domestic violence, each individual was only counted once irrespective of the number of incidents. In addition, the most severe/potentially lethal incident of attempted suicide was identified for those with multiple attempts.

Any individuals who met these criteria were reviewed for evidence of domestic violence. As with the previous study, the cross-government definition of domestic violence was used; ‘any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality’ (Home Office, 2016). The literature is unclear on whether the time between a domestic violence incident and a suicide attempt
is relevant to increased risk. However, an index offence (current charge or conviction) of domestic violence has been identified as a risk factor or vulnerability for suicide (Prison and Probation Ombudsman, 2014a) and was the criteria for the first study. Two sources were used to identify those with an index offence of domestic violence; PNOMIS, and the Offender Assessment System (OASys). PNOMIS can provide flags that identify key issues for those in custody, including whether they are a domestic violence perpetrator and specifies the charges or convictions. OASys reports provide a summary and assessment of key criminogenic issues, and can include detail of offending and who the victim was.

There were several difficulties in obtaining accurate information about domestic violence perpetrators. There is no one offence of ‘domestic violence’ and convictions against a partner or family member cover a range of offences. Additionally, PNOMIS does not record who the victim is, therefore it was not always possible to identify whether the victim was a partner or family member even if there was indication of domestic violence. Discrepancies were found between information held on PNOMIS and OASys about domestic violence, and at times there was very limited information. OASys reports can vary across individuals from some having a single basic custody screening assessment to others having multiple full assessments. For those with a very recent conviction or charge, or who had not yet been convicted, there was less likely to be a comprehensive assessment and history. The basic screening assessments generally included very little information and were based on self-reported information from the men themselves. Both sources were used to try and increase the accuracy of participant identification. However, it is possible that a lack of information meant that some suitable participants were not screened in to the study.
As recruitment progressed, the small numbers of participants identified as suitable and who subsequently agreed to participate in the study meant that the criteria around domestic violence were widened to include those where there was evidence of a history of such offences. This was considered suitable as the available research into domestic violence perpetration and suicide does not specify a time period over which risk may increase. Therefore, individuals who were not currently in custody for domestic violence, but who had previously been so, were included. The same methods of identifying suitable participants was used as PNOMIS flags issues for both previous and current offences, and OASys assessments are usually available for all previous convictions. However, the same difficulties as noted above applied. To keep the participant pool as homogenous as possible, only those where there was clear evidence of a prior domestic violence charge or conviction were included, and attention was paid to how recent the charge was. Further to this, additional records were utilised from PNOMIS which identified those flagged as at risk of suicide or as domestically violent, and these were cross referenced with OASys to identify individuals with a recent serious suicide attempt in custody. Again, information available through this method could be limited and was dependent on the detail included by report writers.

Exclusion criteria were identified at the start of the study, and to maintain as wide a participant pool as possible were kept limited. Participants were excluded if they were released or transferred to a prison establishment outside of the approved sites, had active symptoms of mental illness that would impact on consent and ability to be interviewed, or if staff deemed them to pose too high a risk to themselves or myself as the researcher to be interviewed. Potential participants were reviewed using their prison records for any evidence of learning disability, poor reading comprehension or language barriers, and
steps were in place to use adapted information sheets or translation services if needed. None of the participants screened required these specific adaptations, although as there can be limited information on literacy and learning difficulties, the information provided was kept as simple to understand as possible. Time was also spent at the start of the interviews gauging participant understanding and providing additional explanation if required. One potential participant was excluded due to my previous involvement in his case as an employee of HMPPS, which could also have required future involvement and led to a conflict between this and my role as researcher. Figure 2 outlines the criteria and selection processes for recruitment.

The researcher provided potential participants the information sheet, a covering letter and a sheet to indicate whether they were interested or not. They were provided with an envelope addressed either to myself as the researcher or a specific individual as a contact point in the prison. Where possible, the information was provided to the potential participant in person by a staff member, usually a member of the Safer Custody team or their Offender Supervisor. In some cases, the information was sent via internal mail. While it had been my intention to meet with as many potential participants as possible in person, practical difficulties prevented this from happening. This included the distance to travel to establishments and difficulties in finding available staff to escort me around the establishments. If a potential participant indicated that he wanted to contribute, he was sent a further letter outlining the time and location of the interview.
Figure 2: Study two participant selection processes

Of those who did not agree to participate in the research after being invited, 13 of these did not respond to the invitation, 13 declined verbally and 3 initially agreed to participate in the research but declined after being invited to interview. One agreed to the interview but when talking through consent, denied receiving any arrests, charges or convictions for domestic violence despite his files saying otherwise. The numbers of men screened out or excluded from the research was relatively high (approximately 50%). In similar research, for example Rivlin et al (2011), potential participants were screened out for similar reasons. The researchers reported that of 102 referrals, 42 were excluded, however this
number included those who declined to participate. In the present study only around 20% of those approached to participate agreed.

While recruiting participants, it was noted that while a relatively small number were specifically excluded for risk concerns, many appeared to have behavioural issues and were currently, or had recently been in Care and Separation Units (units designed to house prisoners who require segregation for punishment, safety or support reasons). Some had received behavioural warnings or been adjudicated for breaking prison rules including fighting, threats to staff and substance misuse. Therefore, the general instability of this group may have affected motivation or ability to engage in research interviews. In addition, the challenges of accessing potential participants due to prison pressures may have had an impact on recruitment. It may have been that in previous studies where participants were selected based on referrals, those making the referrals may have prioritised those who they felt would agree to participate.

In total, eight men agreed to participate in the study. Characteristics of the men who consented are presented in Table 7, alongside the characteristics of those who declined and those who were screened out.

Table 7
Participant characteristics – suicide attempters in prison

<table>
<thead>
<tr>
<th></th>
<th>Consented N=8</th>
<th>Declined N=31</th>
<th>Screened out N=40</th>
<th>All N=79</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>29.1</td>
<td>28.7</td>
<td>29.5</td>
<td>29.2</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>6 (75%)</td>
<td>28 (90%)</td>
<td>28 (70%)</td>
<td>62 (78%)</td>
</tr>
<tr>
<td>Victim type</td>
<td>White Other</td>
<td>Black British</td>
<td>Mixed</td>
<td>Other</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
<td>---------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Partner</td>
<td>1 (3%)</td>
<td>2 (5%)</td>
<td>2 (7%)</td>
<td>2 (25%)</td>
</tr>
<tr>
<td>Family member</td>
<td>1 (2%)</td>
<td>1 (3%)</td>
<td>3 (10%)</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>Both</td>
<td>2 (25%)</td>
<td>2 (5%)</td>
<td>2 (5%)</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Not specified</td>
<td>10 (32%)</td>
<td>2 (7%)</td>
<td>2 (7%)</td>
<td>3 (12%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suicide attempt method</th>
<th>White Other</th>
<th>Black British</th>
<th>Mixed</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ligature</td>
<td>6 (75%)</td>
<td>21 (68%)</td>
<td>27 (68%)</td>
<td>54 (69%)</td>
<td>54 (69%)</td>
</tr>
<tr>
<td>Cutting</td>
<td>-</td>
<td>3 (10%)</td>
<td>6 (15%)</td>
<td>9 (11%)</td>
<td>9 (11%)</td>
</tr>
<tr>
<td>Overdose</td>
<td>2 (25%)</td>
<td>4 (13%)</td>
<td>5 (12%)</td>
<td>11 (14%)</td>
<td>11 (14%)</td>
</tr>
<tr>
<td>Suffocation/strangulation</td>
<td>-</td>
<td>2 (6%)</td>
<td>2 (5%)</td>
<td>4 (5%)</td>
<td>4 (5%)</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>1 (3%)</td>
<td>-</td>
<td>1 (1%)</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sentencing</th>
<th>White Other</th>
<th>Black British</th>
<th>Mixed</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determinate sentence</td>
<td>4 (50%)</td>
<td>21 (68%)</td>
<td>21 (53%)</td>
<td>46 (58%)</td>
<td>46 (58%)</td>
</tr>
<tr>
<td>Indeterminate sentence</td>
<td>-</td>
<td>1 (3%)</td>
<td>1 (2%)</td>
<td>2 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Remand</td>
<td>1 (13%)</td>
<td>2 (6%)</td>
<td>8 (20%)</td>
<td>11 (14%)</td>
<td>11 (14%)</td>
</tr>
<tr>
<td>Recall</td>
<td>3 (37%)</td>
<td>7 (23%)</td>
<td>10 (25%)</td>
<td>20 (25%)</td>
<td>20 (25%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domestic violence</th>
<th>White Other</th>
<th>Black British</th>
<th>Mixed</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>5 (63%)</td>
<td>6 (19%)</td>
<td>12 (30%)</td>
<td>23 (29%)</td>
<td>23 (29%)</td>
</tr>
<tr>
<td>Past</td>
<td>3 (37%)</td>
<td>25 (81%)</td>
<td>23 (58%)</td>
<td>51 (65%)</td>
<td>51 (65%)</td>
</tr>
<tr>
<td>Unclear</td>
<td>-</td>
<td>-</td>
<td>5 (12%)</td>
<td>5 (6%)</td>
<td>5 (6%)</td>
</tr>
</tbody>
</table>
5.2.4 Interviews

Interviews were conducted face to face with the participants in a private environment. This was usually a quiet room in the visits area of the prison, or in a private office. The interviews lasted between 50 and 120 minutes. A semi structured interview schedule was followed, which was developed from reviewing the literature and the findings of the first study. In particular, the first study identified gaps in knowledge about domestically violent prisoners who die by suicide, such as the nature of relationship difficulties, coping deficits, and their physical and mental health problems. In addition, it was important to capture information about their histories of domestic violence and suicide, in order to investigate whether there was any information to suggest a temporal relationship between the two. From this, four key areas were identified for exploration within the interviews (see Appendix E for a full interview schedule with prompts):

Current experience in prison: Participants were asked about their mental and physical health, any problems they have faced and how they coped with them, and relationships with people in prison.

Personal history: This area covered different aspects of the participants lives including prior experiences of suicidal or self-harming behaviour, their past physical or mental health problems, and their experience of close relationships.

The suicide attempt: Participants were asked to describe the circumstances of the most recent suicide attempt, including triggers, thoughts and feelings. They were also asked whether they sought support or informed anyone of their intent prior to the attempt and any barriers to doing so were explored.
**Offending:** Participants were asked about the circumstances of the domestic violence offence they were charged or convicted of, and the impact of this on themselves and others. They were also asked about previous offending, both related to domestic violence and other types of offending.

It was decided when developing the interview schedule not to specifically ask the participants whether they thought there was a link between their domestic violence and suicide attempt, to avoid leading them. Instead, the interview guide included prompts to carefully explore the participants’ experiences of domestic violence perpetration and the circumstances around their suicide attempt or attempts. The interviews primarily used open questions and allowed the participants to give detailed responses about their experiences.

Given the specific nature of the topics being asked about and the small numbers involved, it was not possible to pilot the interview schedule. However, the interview schedule was reviewed regularly to check whether it was eliciting information relevant to the research question. As expected with semi-structured interviews, the question guide was not rigidly adhered to as participants tended to respond to the initial questions around their current experience in very different ways. At times, the initial gathering of demographic information prompted further explanation and discussion with the participants. Participants were given the time and opportunity to talk about experiences and issues that were important to them, and the interview guide was used at various points within interviews to ensure that all topics had been covered, albeit generally in a variety of orders.
5.2.5 Data analysis procedures

Thematic analysis was used to analyse the data collected within interviews. The specific method and processes suggested by Braun and Clarke (2006; 2013) as described in Chapter 3 were followed.

Phase 1: Data familiarisation

All interviews were conducted and transcribed by the researcher, which allowed for full engagement and familiarisation with the data. As each interview was transcribed, initial thoughts and ideas about coding were noted down. After transcription, each interview was read again fully and additional notes were made about potential themes to review and follow up within full coding. Transcription involved a full and verbatim account of the participants’ verbal, and at times non-verbal, utterances (Braun & Clarke, 2006).

Phase 2: Generating initial codes

After familiarisation and general thoughts, each interview was worked through systematically and coded. This was done manually through Microsoft Word, and involved phrases, sentences or paragraphs from the interviews being assigned a specific code. This was done using a complete, data driven, inductive approach rather than applying any preset codes to the data. Data derived codes are those which provide a “succinct summary of the explicit content of the data... based in the semantic meaning in the data” (Braun & Clarke, 2013, p207). Some data was given a single code, whilst other chunks of data attracted multiple codes. Codes were frequently reviewed to ensure that they captured the core meaning of the data, and re-coded if necessary. Extracts that were given the same or similar codes were then collated together, and an initial list of codes generated.

Phase 3: Searching for themes
Once all interviews had been fully coded and the codes collated, these were then sorted into potential themes. The initial phase of this used the codes separated from the data extracts; the codes were printed out and physically organised and re-organised into possible themes. However, once a provisional set of overarching themes had been identified, all the relevant coded data extracts were collated together and reviewed. This ensured that as themes were developed and the data analysed, from an early stage the link to the actual data was considered. Codes that could not be initially assigned to a specific theme were collated together for later review as the analysis proceeded.

**Phase 4: Reviewing themes**

This phase involved the refinement and reviewing of themes identified in phase 3. Potential themes were considered in relation to how representative of the data they were, whether they were similar or substantially different from other themes, and whether they form a coherent pattern when the relevant extracts are read. A small number of codes and themes were discarded from the full analysis as they were not representative of the data and others were subsumed into other themes. At this point an initial thematic map was developed to consider how the themes worked together to represent the overall meaning of the data. Again, the coded extracts were reviewed against the themes and sub-themes and additional refinements made as necessary.

**Phase 5: Defining and naming themes**

This process involved further reviewing the themes and analysing the relevant data, by providing clear definitions for each theme. This process again involved some changes to the thematic map as the analysis was refined. Extracts were then chosen to illustrate each
theme and sub-theme. Themes were presented and discussed in supervision to test the coherence and relevance of the thematic structure.

5.2.6 Reflexivity and rigour

In contrast with the first study, within this second piece of research I engaged directly with participants through qualitative interviews. Therefore, reflexivity in terms of how I influenced and impacted on the methods chosen and data collection as well as analysis (Finlay, 2003) was important. In my professional role, I regularly interview those in prison for a range of purposes such as risk assessment and formulation, and usually utilise a semi-structured approach which allows a balance of obtaining information as well as allowing interviewees space to have their say. While my familiarity with this method may have influenced my research methodology, semi-structured interviewing is a well-established and helpful technique for qualitative interviewing (Willig, 2013). However, it was important to acknowledge that research interviewing can be different from clinical interviewing (Rain, Lawley & Harwood, 2015). As a practitioner my purpose is often related to therapeutic change or assessment (e.g. of risk, treatment needs or progress) and in a forensic context this can involve challenging or reframing an account. However, in the research interviews for the present study, the aim was to gain the participants’ own accounts and explore their experiences rather than develop their understanding. For example, some participants made victim blaming statements when talking about their domestic violence. In clinical practice I would likely have challenged these statements and encouraged personal responsibility taking. However, within the research interviews, my focus was on understanding more about the participants’ perspectives and how they experienced and made sense of domestic violence. Therefore, I did not engage in a process of challenge or reframing with them to try and change their attitudes or beliefs.
My work often brings me to engage with men in prison who have made a serious suicide attempt, and with the processes and procedures that are designed to safeguard them. Throughout my working life I am mindful that as a white, professional, heterosexual woman I am often less marginalised and more privileged than many of the individuals that I work with. I generally do not have direct shared personal experienced with these individuals, but must aim to understand their experiences and perspectives by careful listening, reflection and checking. This was done throughout the qualitative interviews to check the meaning behind the participants responses and clarify my understanding. It was also particularly important to demonstrate non-judgemental listening and empathy given the sensitive topics being discussed, and I was mindful of the need to encourage open and honest conversation within the interviews. One of the issues that I was conscious of when interviewing was how the participants would talk about their offending behaviour; I wondered whether they would talk about domestic violence openly, but it was important not to assume that I knew what their experiences or understanding was prior to engaging in the interviews. Therefore, I made a conscious decision not to challenge or query the participants’ accounts of their domestic violence.

Within this study it was also important to note that my role as a researcher, gathering information and experiences but not actively engaging with them, was different to my practitioner role. This conflict was important to be aware of in terms of the ethical issues inherent in interviewing those at risk of suicide; as a practitioner I would be tempted to offer solutions or advice regarding the participants’ experiences, which was not appropriate as a researcher. For example, one participant was actively seeking to challenge one of his convictions and was clearly at a loss as to how to proceed with this, however it was important for me to listen to his concerns and experiences, but not provide advice on
what he should do next. As noted, the use of a reflexive diary, which covered both reflections on the interview process and analytical notes, and supervision enabled me to maintain focus on the role of the researcher; Appendix F provides extracts from the reflexive diaries.

Sensitivity to the participants’ experience was of key importance, including the environment and context they were in. The prison environment is known to put strain on individuals (Leban, Cardwell, Copes, & Brezina, 2016), and it has been suggested that prisoners may put on a ‘front’ in order to cope with this environment (de Viggiani, 2006). The ability to be sensitive to this within interviews was important, but has also been considered within the analysis of findings. The position of researcher as well as my professional role creates a level of power imbalance and hierarchy between myself and the participant. This was evident within some of the interviews, where although I made my role as a researcher clear some participants referred to me as ‘Miss’; "it’s not miss unfortunately no I’m a naughty boy miss" (James), highlighting that they viewed me in a professional role. Karnieli-Miller, Strier and Pessach (2009) offer suggestions for considering power relations in qualitative research to maintain professional ethics and respect for participants. These suggestions include presenting the study and aims openly, being clear about my role, using language tailored to the participants experiences, representing the participants voice within the analysis and presentation of results and protecting anonymity. Clarity of the research aims and process within this study was provided through a clear information sheet and consent form, as well as taking time to talk through the study in more detail before the interview. I am used to tailoring my language to the needs of individuals within my role as a Forensic Psychologist, I therefore drew on
these skills within interviews, which also helped in creating rapport and exploring participants responses beyond the surface level. Ensuring that the participants voice was heard while protecting anonymity is demonstrated in this study through using participants pseudonyms to give direct quotes and extracts.

The information presented within this section on the recruitment, interview methods and analytical approach provides evidence of commitment, rigour and transparency within this study, for example the use of analytic guidelines and developing an appropriate interview schedule. As with the first study, coherence will be demonstrated through the presentation of the findings and the use of extracts to illustrate the themes.

5.3 Findings and Analysis

5.3.1. Introduction

To place the findings in context, Box 1 presents a summary of each of the participants in terms of their demographics and some of their key experiences.
**Box 1: Study two participant summaries**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michael</td>
<td>Michael is a 22-year-old male, serving a sentence for Assault by beating against his sister; he has a history of family violence but not IPV. He attempted suicide by hanging, and has a history of self-harm and suicide attempts including cutting and overdoses. Michael reported significant mental health problems including paranoid schizophrenia, and that he had been diagnosed with the condition ADHD. Michael was in a relationship and had a young child.</td>
</tr>
<tr>
<td>Chris</td>
<td>Chris is a 23-year-old male recalled to custody for allegations of domestic abuse and accommodation problems. He has previous other convictions largely acquisitive in nature. He attempted suicide by hanging, which he had also done on one previous sentence, however Chris had never self-harmed or attempted suicide in the community. He experienced low mood and post-traumatic stress symptoms, for which he had never received treatment. He was not in a relationship and did not have any children.</td>
</tr>
<tr>
<td>Joshua</td>
<td>Joshua is a 32-year-old male recalled to custody for allegations of contacting his ex-partner. His original conviction was for domestic violence against his partner and her mother. Joshua attempted suicide by hanging and taking an overdose, and he had previously attempted suicide in custody by hanging. He did not report a self-harm or suicide history in the community, but said that he experienced difficulties with depression and anxiety. He was not in a current relationship and said that he had two children with his previous partner.</td>
</tr>
<tr>
<td>David</td>
<td>David is a 38-year-old male, serving a sentence for Rape and Common Assault, both against his partner. He has an extensive offending history including serious violence, although no previous domestic violence convictions. He attempted suicide by ligature and overdose while on the present sentence, and self-harmed by cutting. David said he had not self-harmed previously, but that he had attempted suicide by jumping off a bridge in the community. He was not in a current relationship, and had three children with his previous partner.</td>
</tr>
<tr>
<td>Andrew</td>
<td>Andrew is a 23-year-old male, who at the time of interview was convicted but not sentenced for domestic coercion and controlling behaviour against his partner. This was his first conviction and time in prison. Andrew reported one previous suicide attempt by overdose while in the community, and attempted suicide by suffocation and hanging while in custody. He described extensive mental health difficulties including bipolar disorder. Andrew was not currently in a relationship although said he hoped to reconcile with his partner on release. He has one child.</td>
</tr>
</tbody>
</table>
Thomas is a 21-year-old male, serving a sentence for various offences including common assault against his then partner. He described a history of previous prison sentences for domestic violence and other offences. Thomas stated that he had taken three previous overdoses, one of these in custody, and most recently had attempted to hang himself in custody as well as threatening suicide. Thomas had recently ended his relationship and said that he has one child.

James is a 27-year-old male, who was serving a sentence for Section 20 Grievous Bodily Harm against a male acquaintance. He had a history of being arrested or convicted for both general violence and domestic violence and had been in prison before. James stated that he had attempted suicide in prison by cutting and had overdosed prior to custody. He was in a relationship, and has one child with his partner.

Robert is a 41-year-old male, serving a sentence for Actual Bodily Harm and threats to kill his partner and her father. He stated that this is his third time in prison, and he had previous convictions for robbery and malicious wounding. He reported a history of self-harm through cutting outside prison, a suicide attempt in prison by overdosing and that he had self-harmed by banging his head against walls. Robert said that he had a diagnosis of paranoid schizophrenia and had previously been sectioned under the mental health act due to this. Robert was in a relationship, and said that he had an adult child from a previous relationship but they had limited contact.

Five overarching themes were developed from the data that tell the ‘story’ of the participants from their life experiences to their most recent suicide attempt in custody; these are presented in a visual format in Figure 3, which also highlights some of the key links between themes and sub themes. The themes identified were:

1. Trauma, victimisation and life struggles
2. Relationship ideals versus relationship reality
3. Explaining domestic violence
4. The impact of prison
5. Suicide as a coping strategy
Figure 3: Thematic map for domestically violent prisoners attempting suicide
The thematic map demonstrates how the themes describe a sequence of events and experiences in the lives of the participants. While the themes and sub-themes have links across each other and describe to an extent standalone experiences, there is a clear sense of early experiences influencing behaviour within relationships, leading to custodial experiences for the men and ultimately to their suicide attempt in custody. This emphasises the combination of different factors relevant to suicide risk for the participants and the possibility of a pathway to suicidal behaviour in prison. While the map views the suicide attempt in custody as the ‘end point’ in this pathway, there is a potential link between this experience as a traumatic event and the reinforcement of previous traumatic experiences. Therefore, this could also be seen as a cycle of behaviour.

The initial two themes build on the gaps in knowledge identified from first study, where little was known about the histories of the participants. Participants’ interpersonal relationships were a key focus, and the second theme reveals how the participants viewed and experienced their close relationships. The third theme considers the participants’ explanations, perceptions and attitudes towards their allegations or convictions for domestic violence; this is something that has not been considered in previous studies looking at the relationship between domestic violence perpetration and suicide. The custodial context that the participants were in is considered in the fourth theme, and finally, how the suicide attempt itself was viewed and explained by the participants in relation to their emotional and coping experience. The findings are integrated with discussion of the wider literature.

The following sections in this chapter explore the themes as outlined above. Illustrative quotes are presented throughout the findings and associated discussion; extracts have
been taken verbatim from the transcribed interviews. Where extracts have been shortened or words replaced to provide clarity brackets [...] have been used.

5.3.2 Theme 1: Trauma, victimisation and life struggles

A prominent theme was how the participants described their life experiences; they provided a range of information about their backgrounds and histories which was missing from the available data in the first study. The participants talked about experiencing victimisation, abuse and trauma, usually starting in early life, which left them feeling that life was generally a struggle that they had to cope with. Participants described poor mental health and prior self-harm or suicide attempts, however as well as being victimised themselves, participants identified histories of criminality and violence perpetration. Despite the challenges that they faced, participants could identify ways that they had tried to build a pro-social lifestyle, change their behaviour, or manage their difficulties. However, participants struggled to take responsibility for their behaviour and changing it and identified finding this process problematic.

Traumatic life experiences

Participants generally described living chaotic and unsettled lifestyles prior to custody, often linked to substance misuse “I was homeless I was vulnerable, I was causing trouble I was drinking alcohol I was taking loads of drugs” (James). More significantly, participants’ accounts of their personal histories included a variety of traumatic and adverse life experiences across their lives. These ranged from childhood experiences of sexual or physical abuse and being in the care system, to brain injury and adult victimisation.
[My mother] would lock me in my bedroom and keep me in there for weeks on end (James)

There’s a lot going on but um, it might be that I’m traumatised from my childhood as well (Michael)

When I was young a guy took me in the woods and made me touch him and things like that (Joshua)

I lost another one of my friends as well in a car crash [...] and then another one of my friends passed away a couple of months ago (Chris)

Although most of these events happened in childhood or the community, the participants also noted victimisation experiences within prison “I’ve got somebody who abused me on here [...] sexually [...] it’s been happening over the past few weeks” (Robert). For many there were a series of negative life events illustrated by Thomas “from where I’ve been homeless like I’ve been jumped in my sleep I’ve been whacked round the head with metal grinders in socks, I’ve been beaten up in groups all things like that like people have pulled blades on me”. Participants early experiences appeared to leave them vulnerable to victimisation in some ways, however they also linked early adverse experiences to their own problematic behaviour. For example, Joshua talked about his experience of brain injury after a car crash leading to impulsive and aggressive behaviour ‘my mother said I’ve never been the same since so... whether it’s from back then...’ Some of the participants recognised that their own attitudes or decision making affected their lives, suggesting a tension between their behaviour being a product of negative early experiences but also within their control;

“I was living that world with no boundaries [...] and no-one could tell me what to do” (Thomas)

“I’ve had a shit life I’m not looking for sympathy it’s been self-inflicted most of it” (David)
Participants did not tend to directly blame their past for their current situation, however research has indicated that adverse childhood experiences predict suicide attempts and/or violence (Christoffersen, Soothill, & Francis, 2007; Dudeck et al., 2016). One possible reason for the significance of past experiences is the impact on participants’ ability to form secure attachments. The experiences they talked about suggested a history of separation from their primary caregivers whether due to neglect, abuse or their parents’ struggling to manage their behaviour “I was in care due to my mum ended up post-natal depression and bipolar [...] I didn't realise why I was being disowned like so I've obviously kept running away saying that I wanted my mum” (James). These experiences are likely to have impacted on the participants’ ability to form secure attachments both in childhood and as they grew older. Insecure attachment styles have been linked to perpetration of intimate partner violence (Park, 2016), and also to increased risk of suicide (Grunebaum et al., 2010; Li et al., 2017) including in male prisoners (Mckeown et al., 2017). This seems to be a key problem for the participants, and may relate to their propensity to harm both others and themselves.

One type of victimisation that many of the participants talked about was as victims of domestic violence, which seemed to have a significant effect on them. Chris identified the impact of having a violent partner, and of her allegations that he was also domestically violent “she just kept hitting me in the face and all [...] I can deal with it like you know um but it can be quite impacting as well I suppose [...] because of my record as well if there was no witnesses I think they would have believed her”. Thomas linked his issues in relationships directly with his experience of domestic violence “she used to beat me up all the time [...] I wouldn't lay a finger back on her yeah, but me doing that and not hurting her back or nothing... basically give me all these problems”. The finding that many participants
are both victims and perpetrators of domestic violence is broadly similar to research that indicates that domestic violence is often bidirectional (Renner & Whitney, 2012) and experiencing or witnessing violence as a child has been identified as a risk factor for both domestic violence perpetration and victimisation (Riggs & Caulfield, 2000). While most of the research into the effect of experiencing domestic violence has focused on female victims, male victims experience high levels of psychological distress and depression, and view their experiences as traumatic (Hines & Douglas, 2009). These findings suggest that the combination of poor attachment and experiences of violence within relationships contributed to participants’ vulnerability to suicide.

**Violence and criminality**

Most of the participants had been in custody before, and they spoke about a range of violent and non-violent behaviours, including convicted offences. Some of the participants had long histories of criminal behaviour, although they often did not see this as serious “petty things it was breaking into things just obviously trying to fund the amphetamine it was [...] anything and everything like I wasn’t staying they’d lock me in a room cos I’d keep doing a runner I’d be out the window” (Joshua). They were regularly frank in their descriptions of their own aggressive behaviour, such as Thomas “so obviously me being me intoxicated I pulled out a blade on him and told him I’m going to cut his face and then he went to pull a blade on me”. Participants described their violence as serving several functions, from self-protection and protection of image or reputation to problem solving and revenge:

> If then I’m irritated provoked or poked then I’ll attack (James)
All it really took was someone to do the wrong thing or like rip me off or something and that was it, I was in a fight cos the way I see it I don't let no-one walk over me innit (Thomas)

They tried to check me and all and tried to steal my wallet and we ended up fighting then (Chris)

There was a clear link between drugs, alcohol and criminality for the participants. For some like David, this was about dealing drugs to fund his lifestyle “We moved to another house then I started growing weed then in my loft so money, I was still selling lots of drugs and making lots of money”. For others, they were under the influence of substances when committing aggressive or violent acts “that’s cos I was drunk and dr-drink and drugs […] I was drinking the day the crime happened the assault happened” (Robert). The finding that participants were involved in varying criminal and violent offences in the past indicate that most may fit the typology of the general or antisocial domestic violence perpetrator (Holtzworth-Munroe & Stuart, 1994; Johnson et al., 2006). Andrew was the only exception to this, as he had no previous arrests or convictions, and had been charged with domestically coercive behaviour. This could indicate that it is not just one ‘type’ of domestically violent offender who is also at risk of suicide.

Poor mental health

All the participants described problems and concerns about their mental health that covered a wide range of issues, from anxiety and depression to post traumatic stress disorder. For some this related to long histories of diagnosed mental illness, such as for Robert “I’ve got schizophrenia uh traumatism trauma sorry, and uh... I what’s that one behaviour disorder thing... oh something behaviour disorder... I can’t remember what it’s called some behaviour disorder...”. Robert was not the only participant who had difficulty identifying and describing their mental health diagnoses. James similarly found it hard to
remember diagnoses he had been given “I’ve got anxiety disorder split personality disorder and I’ve got a paranoid paranoid... what is it, some paranoia disorder paranoia schizophrenia disorder somewhere along those lines but not schizophrenia” and David described concerns about underlying mental health problems that he did not understand fully “I’m not a doctor I’m no psychiatrist I can’t diagnose myself with anything but […] the things I think and the things I say to myself I don’t think it’s right”. This suggests that participants may not have been fully engaged or supported to understand their mental health difficulties or what a diagnosis may have meant for them. It is unclear what impact this may have had on participants, however overcoming stigma and the need to connect with patients with mental health difficulties have been established as important in mental health care (Shattell, McAllister, Hogan, & Thomas, 2006).

Despite the lack of clarity at times, participants could articulate their experiences and perception of mental health difficulties. Andrew talked about a history of bipolar disorder that affected his life in the community “I just lost all sort of normal ability to function so um I wasn’t socialising I was isolating myself I was you know not doing any work I was just unable to concentrate”. Some participants also linked their mental health to their offending behaviour, such as Michael “with my mental health I’m unpredictable they think and um they don’t know what could happen cos someone could say something bad to me in front and I will freak out without even knowing”. Participants described contact with mental health services in the community, suggesting that they sought help and support for these issues. Prisoners tend to have high levels of mental health needs, and prison itself can exacerbate mental health problems (HM Inspectorate of Prisons, 2007) as highlighted by Robert “I was locked in that cell all the time and I said I’m going to smash my head against the wall if you don’t... get me out that cell”. The extent of the participants mental
health difficulties is consistent with the literature that describes a high prevalence of such problems in domestic violence perpetrators specifically as well as prisoners more generally (Shorey et al., 2012).

Another aspect of poor mental health for the participants was self-harm and suicide. Self-harm and suicide attempt histories covered a wide range of behaviours from cutting to use of ligatures, overdoses and jumping from heights and occurred both in the community and on previous prison sentences:

- I done all this not in prison but in mental health homes all these scars all here all here and all here [showing] and here... (Robert)
- I have self I have overdosed before but... it wasn't in prison it wasn't in prison it was outside (James)
- Um the first time in custody when I was like 15 I tried to do the same thing then as well (Chris)

As may be expected given that a history of attempted suicide is a risk factor for suicide in prisoners (Fazel et al., 2008) all the participants had previously engaged in some form of self-harm or suicidal behaviour. This occurred often multiple times, suggesting that for most this was something that they had struggled with in a variety of contexts, which is further explored in Theme 5.

In terms of managing their mental health problems, many were prescribed medication specifically for mental health issues. Most found this helpful and that they could gain stability through medication “No I have been on medication for a few years like different ones, but now they've got me on a steady dose” (Joshua). While medical intervention was common, there was little talk about any psychological or psychiatric interventions to help participants understand or manage their mental health symptoms. Given the limited
contact and support participants identified from mental health teams in custody, this is perhaps not surprising.

**Limited personal responsibility for change**

As may be expected given the extent of the participants’ reports of adverse life experiences, participants found that trying to live a positive, pro-social life was a struggle. Michael described how his ability to care for himself had been negatively affected by his time in the care system and custody “I find it hard in the community because I’ve always had someone to tell me what to do, and then... when I’ve got no one to tell me what to do my head’s everywhere”. His experiences appeared to have left him lacking in self-efficacy with limited ability to take responsibility for himself. Participants’ reflected that even when they were trying hard, their limited life experience and previous time in custody impacted on their ability to form a pro-social lifestyle in the community “I find it hard getting jobs because... you might be qualified but you haven't got experience” (Joshua).

While the participants mostly had histories characterised by offending, instability and adverse life experiences, many of them spoke about attempts to change their behaviour and desist from crime. Some said that they had been trying to make changes before coming into prison “I had a lot going for me out there really like um, so... starting to get somewhere where I hadn't been for a long time” (Chris). Other participants were taking steps towards change on their current sentence. This included asking for help, such as Joshua “I've asked to see the counsellor I have, I've never been one like I am now speaking I've never really been one to talk, so I thought that obviously after this now perhaps I need to start talking to get somewhere”. Some saw the future in positive terms “no... I'm not gonna do no more crime now [...] I'm not gonna do any drugs I'm not gonna drink alcohol I
am quite positive about my future” (Robert). However, the participants had few realistic plans about how they would achieve positive change. It is likely that participants own experiences growing up gave them limited opportunities to learn appropriate skills to lead a pro-social life.

Despite some attempts to change, this process was not an easy task for many of the participants, and there was a sense of feeling stuck in a cycle of behaviour, illustrated by Thomas “because when like the way the system is yeah once you’re stuck in the system it’s hard work getting out of the system”. The main barrier to successful change seemed to be a lack of self-efficacy or personal responsibility, and the tendency to focus on external factors as agents of change. For Michael, this was his family “yeah yeah and like they’re the only people who can keep me on the straight and narrow... cos, I got... I got to have someone to look after to keep me on a straight track”. Similarly, when talking about their criminal, aggressive or violent behaviour, participants tended to describe themselves as not in control or losing control:

I haven’t got very good um... dunno what the word is I’m looking for, I can’t seem to contain myself properly you know (Chris)

I’ve never been in control I told you before I’ve never been in control of what I do what I say... (David)

With my mental health and with like I get angry real quick and heated, they don’t really know how to control me (James)

When I cut that guys throat in 2007 I didn’t mean to do that I didn’t want to do that I just lost control and I just flipped (Robert)

While these comments could reflect general impulsive or reactive tendencies, the way the participants describe their behaviour suggests that they do not believe that their behaviour is within their power to control or change. This is further supported by participants’ tendencies to focus on other people making them respond in a certain way when
describing violence, such as Joshua “obviously it was her mother I don’t think it would have happened if her mother hadn’t come to the house” and Michael “you’re approaching me now antagonising me and with my mental health you know my reactions what they will be.” An external locus of control (Azjen, 2002) could explain why despite their stated efforts participants have continued with patterns of violence, aggression and criminality, and potentially acted as a barrier to seeking help and support from professionals or their friends and family. Domestically violent offenders have previously been found to have an external locus of control and believe that their lives are controlled by random events or other people (Bowen & Gilchrist, 2004). High levels of external locus of control have also been found in individuals engaging in a range of aggressive or socially maladaptive behaviour including sexual offences (Fisher, Beech, & Browne, 1998), suggesting this is not an issue specific to the participants due to their domestically violent behaviour. Given the role of hopelessness in suicide, it may be expected that an external locus of control is also characteristic of those who have attempted suicide, although the literature is mixed; some studies on young people have indicated that external locus of control is linked to increased risk of suicide (Beautrais, Joyce, & Mulder, 1999; Evans, Marsh, & Owens, 2005), however others have not found this association when controlling for depression (Lester, 1999).

5.3.3 Theme 2: Relationship ideals vs relationship reality

This theme outlines the participants’ accounts of personal relationships across their lives, both with family and intimate partners. Exploring the participants’ experiences of their relationships was important given the lack of information about this in the first study, and they described a range of contrasting relationship experiences, perceptions and attitudes.
Many did have positive experiences to draw from including from family, partners and fatherhood. However, positive accounts were less common and conflict, instability and tensions more often characterised their relationship experiences. Despite this, and participants’ views of relationships as problematic, they continued to strive towards an idealised version of relationships and family life.

**Relationships can be ‘alright’**

Participants could identify several good experiences in their relationships with family, friends and partners. Some spoke about supportive relationships that they had with family members such as Joshua who had developed a good relationship with his brother “So like he said I don’t mind if you got anything any issues or want to talk to me or anything when we get out, he said ring and speak to me whatever”. Many of the participants mentioned positive relationships with their mothers; “I only ever speak to my mum I find it easier to speak to ladies” (Chris), “my mum that’s all that’s keeping me [going]” (David), [I have contact with] my mother that’s it” (Thomas), although actual contact could be limited.

In terms of intimate relationships, some participants said that they had positive intimate relationships:

- **We both understand each other and we both support each other through everything uh I’ve known her all my life anyways since we was kids** (Michael)
- **I was very very close with my fiancée we were sort of inseparable** (Andrew)

However, most described their relationships in more lacklustre terms as “alright” (Chris, Thomas, Robert), “fine” (Joshua) or “seemed to be OK” (David). This contrasts with what participants said that they wanted to be like in their relationships such as “loved up” (Chris) or “a happy little family” (Thomas). Overall, few of the participants seemed particularly
satisfied with their intimate relationships, which has been linked to increased risk of relationship violence (Stith, Green, Smith, & Ward, 2008) and with suicide in prisoners (Topp, 1979).

Many of the participants were parents and were involved in child-rearing. Having children may have increased the investment participants had in their relationships (Henning & Connor-Smith, 2011) and fatherhood was generally seen as a positive and important aspect of their lives. For some such as David, fatherhood was linked with the motivation and intention to make changes “subconsciously I wanted children I knew that it would straighten me out you know something I wanted” although the reality of his situation did not match his desired outcome. This contradicts prior research that has suggested that men in prison may detach from or abandon their roles as fathers (Dyer, 2005). Fatherhood may contribute to domestically violent men’s ability or motivation to change (Fox, Sayers & Bruce, 2001), however this may represent an idealised and ultimately unrealistic representation of fathering (Harne, 2011). This was certainly the case for the participants who were fathers, as they had all continued to offend after becoming parents.

Tensions, problems and conflict

As can be expected given their circumstances, participants spoke about a range of problems they had in relationships with family and partners. Many of the participants had somewhat tense and uncertain relationships with family members. Some of these tensions stemmed from abusive or neglectful home environments, such as for James “as I got older like I've sort of... despised her a little bit from what she's done [...] I still doesn't forget and I'm still a little bit on the verge of... like forgiving like but I will forgive you due to you're my mum and I know it would hurt you if I disowned you”. Others acknowledged that it was
their disruptive or offending behaviour that caused problems within the family home “I was just putting holes in the walls and obviously my dad's had enough he's thinking fucking hell I'm paying for all this and he's just smashing up everything I got” (Michael).

Participants also described a range of difficulties they had in intimate relationships, which often involved high levels of conflict:

*Little arguments would turn into massive ones and all um over silly things [...] just done each other's heads in really* (Chris)

*She used to kick me out quite regularly as well we’d have arguments and she’d kick me out* (David)

*Up and down it wasn't very good at all, it was alright it was alright but it was up and down* (Robert)

*I’ve had rocky ones I’ve had mild ones I’ve had ones that's not worked one's that's gone completely pear shaped* (James)

While conflict mostly stemmed from the participants’ own behaviour or lifestyle many described that their partners also lived chaotic lifestyles; “she was a proper weedhead as well so smoking weed with her and all that it all just went bam and plus the first ever girlfriend used to cheat on me every day non-stop” (Thomas). This may indicate that participants viewed their partners as having similar difficulties to them, which likely contributed to their instability and attachment problems. Even for those in more stable relationships, they experienced worries and concerns. Michael, despite describing his relationship in mostly positive terms, frequently worried that his relationship would end “when I’ve got a visit coming up I get anxious about it or I get like um worried um, that I’m doing to have a ‘Dear John’ visit”. This supports the suggestion from their childhood experiences that participants may have developed insecure attachment styles. Relationship problems are one type of stressor that this group is highly likely to experience, and such stressors have been linked to increased suicide risk (Jollant et al., 2007).
They don’t understand me

A specific difficulty that many of the participants’ identified in their relationships with others was the sense that they were not understood, that people did not ‘get’ them. This was mostly spoken about in relation to personal but also professional and staff relationships. For some it was a feeling that they had always struggled with, for example Andrew who felt that his mental health difficulties were not understood by his family “I’ve not been the most close to them because when I was going through a period of mental illness and everything I don’t think they fully understood you know how best to support me and it did drive a bit of a wedge between us”. David struggled with his personal identity and mental health which seemed to reflect a conflict between an external image as a violent drug dealer, and internal low self-esteem “I’m not good enough […] it’s just hard to get your head round none of my friends understand none of my family understand…” Low self-esteem, which is an established characteristic among men convicted of violence (Broady, Gray & Gaffney, 2014) was alluded to by a number of the participants; “like when… I haven’t got work your esteem goes down don’t it you feel worthless” (Joshua), “insecurity I think it was and due to the lack of confidence in myself” (James), “It’s just bad I’m just messed up in the head like” (Michael). Low self-esteem has also been linked to increased risk of suicide in adults and specifically prisoners (Gooding et al., 2015), suggesting that this may be a common feature in those at risk of harming both themselves and others.

There was also the sense that prison staff did not take the time to fully understand the problems that the participants were facing “they’re saying well stick with them then you’ll be alright [...] but you’re not asking you’re not really understanding the whole picture [...]”
you don’t actually understand what’s gone on through my life d’you know what I mean if you actually sat down like…” (James). This reflected the sense that staff could depersonalise men in prison and not view them as individuals “he don’t know me from Tom Dick and Harry he just knows me from a prison number” (Michael). Staff-prisoner relationships have been identified as important in increasing prisoners’ quality of life (Blagden, Winder, & Hames, 2016; Molleman & Van Ginneken, 2015), however the impact of positive relationships on suicidal behaviour specifically is unclear. Overall these findings suggest that being understood by others is an important part of care, as has been found in mental health settings (Shattell et al., 2006), and may be particularly relevant to managing suicide risk in custody.

Conflicting descriptions of relationships

When speaking about their experiences, participants outlined a range of often contradictory thoughts about and perceptions of relationships. For example, Michael talked about being protective towards his family “but my twin sister got beat up in a nightclub obviously... you've got to look after your family [...] obviously I can't see any of my family hurt I think well I gotta do something about that”. However, he had been convicted of violence towards his sister, and spoke about violence against his father although he did not acknowledge this contradiction within the interview. Similarly, Andrew saw his relationship in extremely positive terms, and saw himself as his partner’s protector “she’d had quite an abusive upbringing and she’d been kidnapped as a teenager and she’d really really been through a lot of stuff and that made me very protective of her as well because she’s a very vulnerable person”. Given that he was arrested for kidnapping and emotional abuse of his fiancée, his behaviour appeared to contradict his views about being protective
towards his partner. Joshua saw relationships as protective for him in terms of leading a pro-social life away from substance misuse “when I'm in a relationship I'm in a relationship I don't do none of that”, but did not seem to consider that his domestic violence is also anti-social and criminal behaviour. Participants seemed to be able to separate their domestic violence perpetration and see it as independent from other beliefs and aspects of their relationships. Domestic violence perpetrators frequently use justifications, rationalisations and minimise their behaviour (Henning & Holdford, 2006), which may explain some of these contradictions.

There was a sense for many of the participants that they saw relationships as challenging and difficult. Thomas identified problems with trust that stemmed from his family members’ experiences but impacted on his own relationships “I've sort of picked that up as well not to trust people and people I have trusted have stabbed me in the back so, I just keep myself to myself”. For Chris, who had witnessed extensive domestic violence as a child, he saw relationships as hard work when they involved any disagreement or conflict “I don’t like the hard work side of it where it gets all like tense all... dunno it starts making me feel ill”. Given the participants difficulties dealing with problems and emotions (see Theme 5: Suicide as a coping strategy), it is perhaps not surprising that managing the complexities of relationships was not easy for them. In David’s case, he had now given up on having a relationship in the future due to what he perceived as the way he had been treated by his ex-partner, and his concerns about disclosing a sexual conviction “you really think I'm gonna get out get with another woman and live in the same house as her after what they've just done to me [...] I will never ever get into a deep relationship with a girl again after what I've been through”. However, this is another example of an external locus of control, attributing blame for his present circumstances to others.
Despite the perceptions of relationships as difficult, low satisfaction and the negative experiences many of the participants had, there was also a strong sense that they were striving for a ‘perfect’ vision of family life. Having a partner and children seemed to be something the participants were almost desperate to achieve; “tryin'a... get myself a perfect life and get myself a decent relationship decent family, decent house have everything else I know it's difficult but that's what most other people normal people have got like” (James). Joshua also reflected on his need for a relationship “when there's nothing there that's when I go off the rails then cos I didn't have [a relationship] I think growing up, that's why when I'm in a relationship I'm in it”. His comments indicate where striving for positive relationships may have come from; many of the participants had difficult childhoods characterised by neglect, abuse or separation from caregivers. While participants seem to have poor relationship skills to help them develop secure intimate relationships, it is nevertheless clear that this is an important goal for them. For some like David, this goal seemed to keep them within unsuitable relationships; when asked why he remained in a relationship with a partner he described as violent, chaotic and unfaithful he replied “I didn't want to lose what I had because it was the best thing I'd ever had in life”. Participants seemed highly invested in their relationships, even if they were difficult or unsatisfying, which may have increased their willingness to continue in the relationship (Henning & Connor-Smith, 2011). Striving for intimate relationships whether suitable or not, is characteristic of preoccupied or fearful attachment styles (Bartholomew & Horowitz, 1991) and also points towards insecure attachment styles among the participants.
5.3.4 Theme 3: Explaining domestic violence

This theme captures how participants described and explained their domestic violence perpetration in the context of their general attitudes to violence. Participants tended to see violence as acceptable, minimise their responsibility and personal control, and blame victims for ‘triggering’ their behaviour. In contrast to their descriptions of general violence, participants saw domestic violence as unacceptable and not characteristic of them. They tended to use minimising language when describing their domestic violence behaviour, portray the partner as the problem, and were keen to place their behaviour in an explainable context.

Attitudes to violence

When speaking about general violence, participants appeared to accept violence and aggression in various contexts. There was a sense that violence was a suitable response to another person doing something that the participants thought was unacceptable. For example, Chris described his violence as a response to a general ‘attitude’ from another person “Oh just the usual attitude type like the ones whose looking for trouble like”. This linked with participants general externalisations of responsibility. Even serious violence was viewed by some participants as a valid way to deal with problems “the hammer attack thing that was just impulsive that was just gang retaliation it was planned it was premeditated like the judge said and he was bang on the nail with it y’know what I mean” (David). This was not only in their lives outside prison, but to deal with problems in custody as well “What happens behind doors stays behind doors innit just that’s how it’s always been like um. Or in the shower [...] You try not to do everything on camera pretty much” (Michael). Attitudes that violence has a positive outcome are established as important in
generally violent behaviour (Bowes & McMurran, 2013), however the relevance of these more general attitudes to domestic violence perpetration is unclear.

When talking about domestic violence specifically, participants’ descriptions were somewhat different. Many of the participants reported explicit attitudes that domestic violence was unacceptable, and something to be rectified:

*You don’t hit a woman full stop anyway* (Michael)

*It’s completely abhorrent to do something like that* (Andrew)

*I’ve got a lot of making up to do I’ve gotta say sorry* (Robert)

While participants mostly accepted that general violence was a part of their lives, they saw domestic violence as something that was not characteristic of them. Chris had talked about witnessing his mum being the victim of domestic violence, and found the prospect of being seen as someone who would engage in such behaviour very difficult “I’d be labelled as like someone who hits women and all and has no respect for ladies like [...] disgusting I think”. David had similar concerns linked to sexual violence and how this was perceived “Well I mean when I, when you ask me why I’m here and you say rape it’s you automatically think you jump out of bushes at people, it just wasn’t like that”. While domestically violent men are understood to minimise, justify and neutralise their behaviour (Bullock & Condry, 2013; Henning & Holdford, 2006), this separation from the identity of a domestic violence offence has not been well explored in the literature. Only one of the participants explicitly identified shame as an issue for them “I was feeling totally ashamed that someone you know of impeccable character as me had somehow ended up in a prison” (Andrew). However, underlying feelings of shame may explain the tendency for participants to distance themselves from their behaviour. Shame in domestic violence offenders has mostly been considered as a trigger or precursor to anger and aggression
(Wallace & Nosko, 2003), however in other offender groups, minimisations and lower responsibility taking have been postulated as a way to lower distress and difficult emotions associated with the acceptance of offending (Xuereb, Ireland, & Davies, 2009). It has more limited evidence as a predictor or risk factor for suicide, and may only serve a mediating role (Arditte, Morabito, Shaw, & Timpano, 2016; Wiklander et al., 2012).

Domestic violence as an understandable response

While descriptions of general aggression and violence were seemingly frank, participants’ openness to discussing their domestic violence was more varied. Two participants said that they had not used any acts of physical violence; one acknowledged controlling behaviour and the other aggressive behaviour around, but not directed at, his partner. Neither had been convicted of violent acts however. The remaining participants all described violent behaviour towards partners and/or family members although some maintained their innocence of certain offences. This was a significant struggle for David, who accepted that he had been violent to his partner but denied that he had raped her, for which he had received his longest sentence and seemed to contribute to an overall sense of innocence “the main problem? Being innocent... it’s the hardest thing I struggle with”. This was also the case for other participants, who recounted times that their partners or others had alleged violence to the police that they did not admit to. Consistent with literature around domestic violence perpetrators, there was also evidence of more general minimising; of consequences, seriousness or impact “ok I’ve had a couple of domestics where I’ve been arguing and I’ve pushed them or I’ve started shouting and they’ve got a bit scared and they’ve rung police but apart from that I’m not I don’t I’m not a threat d’you know what I mean” (James). Interestingly, quite a few of the participants described avoiding
responsibility for their offending behaviour by evading arrest. For some this was due to the perception that they had not done anything wrong “I went on the run for 24 days cos at the end of the day I hadn’t done nothing wrong so in my head, cos I was released without my medication as well so in my head I haven’t done nothing wrong so why should I hand myself in” (Joshua). For others, it seemed that they did not want to face the consequences of their actions “I never answer police bail I always just run away [...] if you go and answer to police you’re going in that custody cell and I can’t be assed with that I’d rather run away” (Thomas). This may reflect tendencies towards impulsivity and poor decision making that are common in suicide attempters (Bender, Gordon, Bresin, & Joiner, 2011; Jollant et al., 2007) and those with a domestic violence history (Cohen et al., 2003; Tweed & Dutton, 1998). This behaviour is also consistent with the avoidant approach to problem solving outlined in Theme 5.

The participants’ accounts of domestic violence could generally best be described as Situational Couple Violence (Johnson, 2006), with the participants being both on the receiving and perpetrating end of violence or aggression, and describing little overtly controlling behaviour. Although acknowledging the reality of this type of domestic violence is important, participants’ descriptions of their behaviour often used words or phrases that seemed to minimise the seriousness of their part or focus on the victim’s behaviour:

- *I just grabbed the knife and just put it in* (Michael)
- *It wasn’t really an assault I didn’t punch her in the face or nothing* (David)
- *I’d end up probably being a bit violent back* (James)
- *I just grabbed her hair and kneed her* (Thomas)
These minimisations and neutralisations are consistent with research into the implicit theories that domestic violence perpetrators hold, such as ‘nature of harm’ ‘violence is out of control’ and ‘women are dangerous (and at fault)’ (Gilchrist, 2009). Participants wanted to provide explanations for their behaviour, and for people to understand why they acted in the way that they did. This was particularly important to Joshua, who struggled with being seen as ‘domestically violent’ by others in prison “but at the same time there’s... an explanation behind it as well, whereas some people then like they just shut off don’t they you’re in for that so they don’t want to know so... you’re explaining then”. For Thomas, it was important that his behaviour occurred in the context of being victimised himself “the way I seen it yeah if I didn’t do something she would have killed me innit”. It is unclear if these minimisations have any direct implications for suicide risk; it may be that they are a mechanism for the participants to internally cope with their own behaviour.

Participants interpretations of the circumstances around their domestic violence included a high level of victim blaming, which is a common form of denial and minimisation in domestic abusers (Levesque, Velicer, Castle, & Greene, 2008). Given that many of the participants described being victims of domestic violence themselves, it is important to acknowledge the part that being victimised themselves may have played. However, some participants tended to focus on their victim’s behaviour in the lead up to the offences they were talking about. At times this was a more general perception of their partner’s negative behaviour. David for example tended to blame his partner for many aspects of life, including having children together “straight away she got pregnant I mean she didn’t care that we weren’t using protection or anything like that”. At other times, this was linked directly to offending; Thomas saw his partner as deliberately provoking him, implying that she wanted him to become angry and aggressive “my ex decided to kick off at me when I
was a bit tipsy and obviously she knows how to trigger my buttons she knows how to make me get really angry”.

While wanting in some senses to distance themselves from their domestically violent behaviour, the participants could identify triggers which largely revolved around heightened emotion and arguments or conflict with the victim.

I just lost it... my mrs was getting drunk every day then I had seven different witnesses that said she'd been giving people blow jobs (Robert)

I've heard her say [to him] I just want to talk to you all the time I just want to be with you, now... I went mad (David)

She come out abusive bring she brung up dead relatives innit like that’s one thing I don’t allow yeah, she told me to go and jump off a car park like my best mate's dad did yeah I flipped that was it (Thomas)

These types of attributions for violence are common in perpetrator endorsements of the triggers to violence (Neal & Edwards, 2017), and suggest that the participants’ violence was an emotional response to a problematic situation rather than an attempt to deliberately control or manipulate. The exception was Andrew, who was arrested for domestic coercion. However, he also described his abusive behaviour as being in the context of being abused himself by his partner’s parents and wanting to ‘do the right thing’ “her mother and stepfather are not nice people they were abusive to her and abusive to me and I was trying to take her away from that situation [...] I thought I was doing the right thing of course I just ended up hurting her because she wasn't ready to leave”. Given the participants tendencies to minimise their behaviour both overtly and within their language used, it is difficult to be certain about their motivations for domestic violence incidents. However, while perpetrators minimising their behaviour concerns practitioners, this does
not necessarily lead to further negative behaviour in the real world (Bullock & Condry, 2013).

5.3.5 Theme 4: The impact of prison

This theme describes how the participants experienced prison, and the varying impact it had on them. Some saw prison in a neutral way, or even as a positive experience. Most had been in prison before and the routine was familiar to them, although they could reflect on how different this could be when first coming into custody. Some found their current prison sentence particularly difficult to accept, and they experienced a range of problems leading up to their suicide attempt. While participants could form relationships in prison to some extent, being in custody impacted negatively on their relationships with children, family and partners. This contributed to a sense that being in prison was a significant influence in the participants’ suicide attempts. The relationship between the prison environment and suicide risk is explored further in Theme 5: Suicide as a coping strategy.

The prison experience

For all but one of the participants, the sentence on which they made their most recent suicide attempt was not their first time in custody. While being in prison for the first time has been highlighted as an issue in previous reviews of prison suicides, this has decreased more recently (Prison and Probation Ombudsman, 2015) and has not been identified as a risk factor for increased suicide risk (Fazel et al., 2008). Some participants were used to the prison routine and in some senses, they could take it in their stride “it’s basically just like being on the road, there’s not really a difference apart from you just got bang up that’s it” (Thomas). Prison was still a negative experience for most of the participants. For
Andrew, the only participant who had not been to prison before, the environment was a particularly difficult one “it was completely overwhelming it was everything I’d imagined a prison to be [...] it was a really hostile environment”. Some of the other participants reflected on their early experiences of prison and that they had a similar reaction. This seemed to be about adjusting to the prison environment and a process of ‘learning the ropes’, as suggested by Thomas “my first ever sentence, sort of struggled cos I didn't know what I was doing”.

Even with previous experience of being in custody, prison could be difficult. Most participants identified that their current sentence was particularly challenging compared to previous experiences. This was for several reasons; some participants viewed their current sentence as an injustice or unfair. Michael linked his current sentence to a sense of loss and changing perceptions of where he wanted to be “any other time I've got nothing to lose but this time I've lost everything I've lost my job I've lost my flat, obviously I've lost, I've lost my family really and I've just lost everything”. It was unclear what influence the current sentence specifically had on their most recent suicide attempt, as all participants had previously engaged in self-harming or suicidal behaviour in custody, whether on a previous sentence or earlier on their present one. However, as well as issues related to their current sentence, the more negative perception of their current sentence may also be linked to issues of boredom, lack of activity and overcrowding. Although most worked or took part in some activity there was a sense that the prison routine was minimal, and left participants feeling bored and with a lot of time on their hands. This suggests that some of the possible protections against suicide risk such as purposeful activity (Leese, Thomas, & Snow, 2006) were not present for participants. Joshua noted the lack of educational or vocational work to do “normally I do courses and things whilst I'm in here,
**but there's nothing running here**” and Chris reflected on the impact that boredom and a lack of things to do could have “it's too much thinking time in here really like there's not enough things to do”. Issues such as overcrowding, larger population size and high turnover have been linked to increased suicide risk in prisoners, and it has been postulated that this means that prisoners become more anonymous and less supported by staff (Dye, 2010; van Ginneken, Sutherland, & Molleman, 2017). Given the current pressures on prisons it is likely that this is the case for the participants of the present study.

**Problems in custody**

The participants described a range of different issues that they faced, although had differing perceptions of problems in prison versus the community. For Chris, prison exacerbated his difficulties “I only really have bad issues and problems in here and then I find it hard to deal with them in here” while for Thomas, “I'd have said prison's nothing innit cos it isn't it's like Disneyland.” This may have reflected how difficult participants felt their lives outside prison were; for some with more chaotic lives, the structure and support of prison may have offered some stability. However, most participants experienced problems on their sentence such as having health and pain problems “[I] developed a problem with my back I've got a bulging disc in my back they've taken they took my meds away from me in here” (David), issues with money “I was putting tobacco before my phone credit you see because I was earning enough to either get one or the other, and I couldn’t get both” (James) and conflict with other prisoners “I've gone up there and said look where's my canteen [...] I've got a tin of tuna and I've put it in my sock and I've walked back up [...] he said well I haven't got it so I hit him with it and then I went under his bed and it was all there” (Michael). Psychosocial stressors have been identified as potential
contributors to suicide risk in prisoners (Daniel & Fleming, 2006), and it is clear that most participants experienced several of these.

Most participants also described aggression and conflict with staff or other prisoners “just silly things innit nickings for like being abusive to staff telling them to fuck off and things like that” (Joshua). New Psychoactive Substances (NPS) were a significant issue ‘spice yeah I lost my head I was meant to have hit my like hit one guy and then hit [...] one of the members of staff but I don't remember doing it I didn't even know it happened (James).

Several participants acknowledged getting into trouble in prison and receiving punishments, although few identified violent incidents. Recent attention has been paid to violence within prison and the links to self-harm, indicating that there is a ‘dual harm’ risk in prison where prisoners are likely to harm both themselves and others (Slade, 2016).

While this is not specific to domestic violence or suicide attempts, participants in the present study did appear to have issues with their behaviour and aggression within custody.

Participants reported current issues with their mental health in custody, which is not surprising given the high levels of mental health problems in prisons (HM Inspectorate of Prisons, 2007), and their accounts of prior mental health difficulties in the community. Some participants felt that their mental health difficulties were worse in prison

“I've had anxiety and that before but I’d never noticed it as much as I notice it now” (Joshua)

“They told me [my pain] is to do with stress levels and depression I said well I got that in fucking abundance cos of you lot, you've took the meds away from me I get stressed, I'm depressed cos of what's going on anyway” (David)

Participants also found it difficult to access suitable mental health care in custody. Some, such as Robert who had complex and long-standing mental health problems did report
feeling supported in relation to their mental health. However, many had issues related to lengthy periods of time waiting to be seen or referred for appropriate assessment. Even when they were seen, ongoing support could often prove difficult to access; “I was trying to engage with mental health and they like cos they cos I had a good couple of weeks [...] the day after that they closed my case” (James). The pressures on mental health teams in prison who can fall short of providing equivalent care to that received in the community (Forrester et al., 2013) were obvious when speaking to participants about their mental health care.

The effect of prison on relationships

Despite the limitations of building relationships in prison (“you're pushed together you are” - Joshua; “you do meet some honest people in jail... it’s hard to believe I know that” - Michael), participants nevertheless indicated that both staff and other prisoners could provide support and help. Andrew noted that there were other men in prison that were similar to him, which offered a source of comfort “a couple of the other prisoners in here who are [...] a bit more sort of a bit older and a bit more mature than a lot of the people in here you know I've found a bit of solace in talking to them one of them is a father like me [...] he's a first time in prison as well and we've got quite a bit in common”. Prisoners making near-lethal suicide attempts have been found to have lower levels of perceived social support both inside and outside prison (Rivlin et al., 2013), so it is perhaps surprising that the participants generally reported positive relationships with other prisoners. Some did note conflicts with others and it may be that the relationships that did exist were superficial and therefore did not contribute to increased wellbeing or reduced risk of suicide.
Despite some support coming from within prison, a clear negative impact that prison had on many of the participants was the limited contact they could have with family members while in custody. This was often either due to distance, lack of funds to maintain telephone or in-person contact, or due to their previous family difficulties. This was a significant issue for participants for whom family were a source of support:

*My family live about 150 miles away so I’d suddenly been cut off with no support [...] so I sort of had no line to support then my usual sources of support my family and friends I couldn’t talk to any of them* (Andrew)

*I just wasn’t getting no contact from my family at all no-one was writing to me or I couldn’t get their numbers* (Chris)

*I didn’t have enough I had like 40p I didn’t have enough credit to really finish off the conversation that and you gotta wait a week before you can even chat to your family* (James)

While most of the research into the impact of prison visits and social support has focused on recidivism (De Claire & Dixon, 2017) this has also been given consideration in relation to their risk of suicide. Being married is associated with lower risk in the general population, but not necessarily in prisoners, which may be linked to the loss of social support increasing vulnerability (Fazel et al., 2008). Receiving visits while in prison is also associated with lower risk of suicide (Frühwald et al., 2004). The issue of contact with families and partners for domestically violent men in custody is particularly complex; there may be risk and victimisation issues in some cases, and even with the wider support networks participants described many complicated relationship dynamics. For a group with potentially high levels of attachment anxiety and insecurity, the limited contact with family and partners may be particularly difficult.

As noted in Theme 2, many of the participants were also fathers, and both the struggles of parenting in the community and current separation from their children were a challenge
for them. Some of the participants such as Joshua had been primary caregivers for their children prior to custody “I had the first hour with him I give him his first feed so I think I had more of a bond with him [...] she wanted to go back to work cos she was working as a carer, I was looking after him then so I miss him more”. Coming into custody was not only difficult for those who already had positive bonds and caregiving responsibilities for their children, but for other participants meant that their chance to develop relationships was limited “I ain't got a bond with my child or nothing and now with all this I'm not going to have a bond with my child” (Thomas). The effect of separation from children for fathers in prison is unclear although separation from children after divorce has been linked to psychological impairment and increased suicide risk (Bartlett, 2004), and some studies have found higher numbers of suicide attempts in male prisoners with children (Encrenaz et al., 2014). Even for those with a continuing role in their children’s lives, the participants were effectively in a period of enforced separation from what they saw as a positive factor, and as such may have impacted on their mental health and suicide risk. The participants experiences’ appear to fit with the idea that separation from their children is a burden, rather than the idea that men may abandon their identities as fathers while in custody (Dyer, 2005) and presumably be less affected by the separation.

5.3.6 Theme 5: Suicidality as a coping strategy

Within the context of their difficult life histories, relationships and prison experiences, suicide and self-harming behaviour was described as a coping strategy. Participants outlined a range of overwhelming, difficult emotions that they linked to their suicidality. While they sought support on occasions, and did receive a level of support, this process was hindered by a number of barriers and difficulties and participants tended towards
avoidant and maladaptive coping styles. Self-harm and suicide was part of this, and participants expressed both types of behaviour as being linked to coping with overwhelming emotions. While the emotional experience was common, participants described a range of triggers to their suicidality; from interpersonal conflict, to mental health difficulties and dealing with their current situation.

**Emotions as triggers**

The experience of different emotions was often problematic and overwhelming for the participants, and reflected a range of feelings. This was not specific to being in prison, but reflected a general pattern of experiencing difficult emotions such as stress, anxiety, depression and anger ‘I’m getting angry all the time irritated I get upset I get confused I get anxious I get paranoid’ (James). This is consistent with previous research indicating that those engaging in self-harm or at risk of suicide may experience a wide range of emotions (Power, Beaudette, & Usher, 2012; Rudd et al., 2006). Emotions seemed to be something that built up over time for the participants, until they were at a point where they were difficult to cope with as Joshua described ‘With me [anxiety] builds up and then all of a sudden [...] I either explode or I sleep’. Some of the participants found these feelings more difficult due to their current circumstances, and others felt a sense of being alone in prison; ‘um it feels like I’ve just been left in the corner to rot really to tell you the truth and... everyone’s against me’ (Michael). Problems with the experience of anger (Birkley & Eckhardt, 2015) and depression (Dutton & Karakanta, 2013) have also been identified among domestically violent men, although other emotional problems have been given little attention in the literature.
The participants linked their suicidality to coping with emotions and overwhelming feelings, often triggered by facing difficult situations. There were numerous descriptions of negative emotions occurring in the lead up to the serious self-harm, including stress and feeling low/depressed. The thought of having to cope with their current thoughts and feelings appeared to be too much, and even when they were unsure if their intention was to die, they seemed to be looking for a way out of their current situation “it all just got to a stage then where it felt like the world was on my shoulders and I just couldn’t move forward and I was just stuck” (Chris). Many of them, such as Joshua, described that there was a build-up that they struggled to manage “when I first come in for the offences I’m in for now I took an overdose down [prison] as well but that was just a build-up of everything it just got too much it did”. Even for Robert, who experienced significant psychiatric problems, his description indicated a struggle to cope with his illness and circumstances rather than his intention to harm himself being directly influenced by psychotic symptoms “I didn’t feel safe in my cell I didn’t want to go in there I didn’t have a job”. Suicide as an escape route out of feeling trapped has been well explored through suicide literature, for example the Cry of Pain model (Williams, 2014) which has been supported as a model for self-harm and suicide in prisoners (Slade & Edelman, 2014; Slade, Edelmann, Worrall, & Bray, 2014). The present findings offer some support for this in terms of the participants experiencing intense emotions that they struggled to find a way out of while in custody.

**Poor coping skills**

Participants had clearly faced significant difficulties across their lives, and a key issue for them appeared to be the lack of sustained, appropriate coping strategies. Some of the participants identified ways that they tried to cope, which could be effective for periods of
time. Andrew noted that he used to write to deal with feelings “I used to do a lot of writing; I used to write a letter every day [...] it was a way of getting my feelings out”. However, he also recognised that he experienced barriers to effective coping “that was the thing before I didn’t want to cope I didn’t want to settle down into prison life”. Most of the participants identified that they had felt like they could not or did not know how to, cope. David found the prospect of a long prison sentence extremely difficult “I just can’t cope with this I can’t be in prison for this long for something I haven’t done I’m going to miss all my kids growing up”. The idea of keeping feelings bottled up and not expressing them was repeated across participants, and particularly in relationships participants took an avoidant approach:

Go out for a walk and all come back and hope for the best, you know (Chris)
Walk off go about my business go and walk for about half hour maybe just [...] take myself away from it all... (James)
I would just I’d want to go for a walk that’s my way of dealing with it is I’d rather go for a walk come back and the dust has settled innit (Joshua)

This suggested a lack of active strategies to deal with problems, arguments or emotions. Participants seemed to feel that walking away was the best option for them, and while this may have been an attempt to avoid conflict or violence ultimately it did not. They lacked the skills to deal with the underlying problems in their relationships; as explored within previous themes, the lack of positive attachments and role models for many of the participants may have played a part.

David’s description of his relationship gave some clues about why participants attempted to avoid conflict rather than deal with it “I didn’t want to lose what I had because it was the best thing I’d ever had in life”; dealing with a problematic relationship may have raised issues or difficulties that the participants did not want to face, which is consistent with their general approach of bottling up their feelings. This sense of avoidance coping is
similar to that found in previous studies of prisoners and psychiatric patients who have attempted suicide (Mckeown et al., 2017; Sunnvist, Träskman-bendz, & Westrin, 2013). Similar issues have been identified for domestic violence perpetrators; there have been suggestions of verbal skills deficits in dealing with problems (Johnson, 2010), and that those who are violent under the influence of alcohol have coping styles characterised by avoidance coping strategies (Schumacher, Homish, Leonard, Quigley, & Kearns-Bodkin, 2008). Mckeown et al. (2017) also highlighted the contribution of insecure attachment to coping styles, finding that higher levels of attachment anxiety were associated with emotional coping, and attachment avoidance connected with avoidant coping. Thus, the participants insecure attachments may have contributed to both relationship conflict/violence and suicide attempts through the mechanism of avoidant or emotional coping.

**Seeking support**

There were a range of barriers to the participants seeking or receiving help from others. Participants generally found it difficult to talk about their problems to anyone, whether that was staff, family or other prisoners. This was for various reasons, from perceptions that they had to deal with their own problems, to giving up due to the time taken to access support “I've just sacked off them cos obviously I've tried getting support out of them every time I go to see em, it will be either once a month or once every like three weeks six weeks eight weeks ten weeks now that's no good miss if you you're struggling and you need an appointment” (James). While the Listeners were mentioned by a few of the participants as a positive avenue of support, participants’ experienced difficulties with this scheme “the problem with that I've found is they got so many different ones once you talk to somebody
you want to speak to that person again cos they already know [...] it's hard enough talking so once you've spoken to somebody you want to keep going to that person don't you” (Joshua). Connected to the finding that the participants tended towards avoidant coping strategies, they showed low levels of rational, active coping. Active coping, including asking for help, has been identified as protective against suicide risk and disengagement including ‘giving up’ linked to increased suicidal ideation (Horwitz, Czyz, Berona, & King, 2017). Participants in this study linked not being able to talk to people about their difficulties to their suicidality; they appeared to experience a build-up of negative emotions and problems but were unable to either resolve these themselves or to effectively gain support to help them.

An avenue of support for the participants in custody when they were struggling with suicidal feelings was being on an ACCT; as may be expected all the participants had been on an ACCT during their sentence. Some identified benefits to this process, such as David who noted the additional offers of help “well they try you go on the ACCT reviews and they say what can we do to help you how can we make your life easier”. A common thread to the participants’ perceptions of ACCT was that it was invasive due to the frequent checks made on their welfare “I don't like it miss no cos they're always constantly watching me within every half hour opening my flap closing my flap [...] it gets annoying miss and like shining torches on you they’re not letting you sleep properly” (James). Another problematic aspect of the ACCT was the limited nature of the support; once the ACCT was closed the support reduced “it was almost as if well we'll close your ACCT down now because you've not said that you're actively suicidal um and we'll ship you off to the other wing and hopefully you'll be alright” (Andrew). This mirrors previous comments about mental health support, where if participants are not displaying active symptoms they receive less support
despite sometimes wanting continued help. Deficiencies in the use and application of the ACCT process have been previously identified (Prison and Probation Ombudsman, 2014b), and participants’ experiences would suggest that one particular issue is the provision of ongoing support for men who may be at risk of suicide generally rather just at times of acute risk.

There were some exceptions to the above issues. While coping skills generally appeared poor, participants did describe attempts to seek help and support from people. Chris recognised that he needed help “I need professional help and someone to speak to and, get to the bottom of my problems” and Robert described being able to talk to staff about his mental health difficulties “I can talk to the staff quite often about my illness they get quite concerned”. Participants received help from a range of staff including healthcare teams, but also commented that they had support from friends and men in prison “my padmate I got now obviously he’s […] just trying to talk to me like to say ‘look everything’s going to be alright you’ll be ok’ […] and he’s just very supportive really” (Michael). However, the barriers to accessing support appeared to outweigh any positive experiences for most of the participants.

Experience of suicidality

Most of the participants had made a serious attempt using a ligature/noose which is consistent with the types of suicide methodology linked with death by suicide (Liotta, Mento, & Settineri, 2015). Two of the participants had used other methods, cutting and overdosing, which had nonetheless led to the need for medical intervention. While all participants had previously engaged in self-harming or suicidal behaviour, for some participants such as Michael this was mostly or exclusively expressed within custody “it’s
mostly in prison. I’ve tried hanging myself in prison I’ve tried overdosing, I’ve tried um cutting”. While research highlights previous suicide attempts (Fazel et al., 2008) or recent self-harm (Hawton et al., 2014) as predictors of suicide in prisoners, either the location is not specified or the recency suggests that the behaviour was also present in custody. For some, self-harm or suicide attempts may be a unique coping response to the stressors and difficulties of custody (Liebling, 1999) as illustrated by Chris who commented that he found it difficult to cope in custody, but when struggling in the community there was “lots more to do innit and more people to speak to”.

Further to the participants’ descriptions of their self-harm and suicidal behaviour, participants spoke about triggers to suicidality and their intentions and thoughts about their behaviour. Despite all the participants having engaged in behaviour that would be considered a near-fatal suicide attempt, some but not all described a clear intention to die:

- I just felt that low I just didn’t want to be around no more I thought it’s better off if I was dead really (Michael)
- When I took that overdose I wanted to die (Robert)
- I was just following a process that I’d developed to end my life really without any emotion involved but it was just I didn’t feel like I had any other option (Andrew)
- I really want to kill myself sometimes and sometimes I do and maybe we all go through that point of like ah we’re useless we don’t wanna be here (James)

However, after the fact participants seemed to feel differently. Andrew specifically said that the suicide attempts were a “mistake”, and Michael viewed his past behaviour as “selfish”. Other participants did not specifically couch their suicide attempts in these terms, but given their accounts of attempts to change and help-seeking described in previous themes, most did not present as currently suicidal. David was a more complicated
case, as his description of self-harming behaviour initially appeared to be as a release of pain and to effect change in the help he was getting from healthcare. However, as his situation progressed, his behaviour became more extreme “I’m getting closer and closer it’s gone from my leg to my wrist I’ve had a noose round my neck several times [...] if I have a noose round my neck I’m jumping and there ain’t gonna be no-one there to stop me”. This seemed to reflect an increasing hopelessness about his circumstances and ability to cope with his conviction which was still present at the time of interview.

While for some there was a general build-up of difficulties, for others there were more specific triggers to their decision to engage in a suicide attempt. This was often linked to difficulties in relationships which have long been established as a contributor to suicide risk (Evans, Scourfield, & Moore, 2014; Till, Tran, & Niederkrotenthaler, 2017). Thomas described how his perception of a difficult relationship with an ex-partner led to suicidal thoughts and actions “the same person got into my head again my ex she made my just feel suicidal down low... she made me not want to bother any more cos like she didn’t understand the amount of stress she was giving me”. This account further reflects tendencies to externalise responsibility; here it was for suicidal behaviour rather than violence or aggression. For Andrew, the prospect of relationship breakdown was the main trigger “my mum told me that my fiancée had sent her a series of messages just which she didn’t really understand and after that really I just sort of fell into a massive kind of pit and it’s then that I made the sort of serious attempt on my life”. This suggests that these participants’ experience of difficult, chaotic relationships and the impact of coming into custody on these was significant to their suicidality.
5.4 Summary and conclusions

This chapter presents the findings of qualitative interviews exploring the backgrounds, relationships and experiences of domestically violent men who have attempted suicide in custody. The aims of this study were to investigate factors that may underpin why and how domestic violence perpetration is related to suicide risk in prisoners attempting suicide, and to gain an account of the experiences of domestically violent prisoners who have attempted suicide in prison. The study allowed more in-depth examination of the backgrounds and histories of domestically violent prisoners, and identified a sequence of experiences leading up to the participants’ suicide attempts in custody. The findings identified the relevance of trauma and adverse life experiences, relationships characterised by insecure attachments, external locus of control when accounting for domestic violence, how prison impacted on various aspects of the participants’ lives, and their use of suicidal behaviour as a coping strategy.

Although there were key differences among the participants in terms of their individual experiences, the findings of a pathway from early experiences to later suicide attempts in prisons were applicable to all the participants. For many of the participants such as James and Michael, their early experiences were of trauma, neglect, abuse or inconsistency in parenting and attachments. Their resulting behaviour involved substance misuse, aggression and criminality, further perpetuating a disconnect from family and society, and impacting on the development of fulfilling intimate relationships. Domestic violence, among other issues, brought these participants into custody where they experienced a range of difficulties, culminating in a serious suicide attempt. Other participants’ experiences were different however followed a similar path. Andrew and Robert for
example experienced more mental health challenges in early life rather than direct victimisation, however also noted difficulties in relationships and attachments to others, and both noted later experiences that they saw as abusive. They likewise were unable to form and maintain appropriate relationships, and experienced similar issues within custody and with suicide as a coping strategy or response. This suggests that while individual motivations and risk factors can vary, the findings offer a coherent explanation for how suicide risk accumulates over time.

While the pathway suggested by these findings focuses on experiences leading up to a suicide attempt, it is important to note the potential impact of such suicide attempts on the participants. Research has indicated that those undertaking multiple suicide attempts differ from those making just one attempt in some respects, such as increased likelihood of Borderline Personality Disorder pathology and impulsivity (Boisseau et al., 2013). However much of the research focuses on trauma and adverse experiences prior to a suicide attempt, and there is limited information about what effects a suicide attempt may have on an individual’s psychological functioning or relationships. It may be that for some, the suicide attempt triggers help seeking behaviour or intervention that subsequently reduces further risk, although long term impact even when interventions are provided is unclear (Inagaki et al., 2015). However, for others it is possible that negative experiences associated with a suicide attempt reinforces earlier trauma. The findings of this study will be discussed further in the next chapter, in the context of the first study and implications for further research and practice.
Chapter 6: Conclusions and implications

6.1 Introduction

The overall objective of this thesis was to fill a gap in the wider literature by exploring the relationship between domestic violence perpetration and suicide in male prisoners. The two studies presented have provided a detailed analysis of suicide in domestically violent prisoners from two perspectives. Chapter 4 outlined findings of an analysis of FIRs written by the Prison and Probation Ombudsman on the self-inflicted deaths of domestically violent prisoners. The findings of this study were that the FIRs reveal little information about the histories and backgrounds of those who die by suicide in custody. This limited the conclusions that could be drawn regarding why domestically violent prisoners may be at increased risk of suicide. However, the findings illustrated a range of other individual factors relevant to this population; their custodial wellbeing, their relationships with others, their outward presentation and perceptions, and the nature of their suicide risk and behaviour.

Chapter 5 presented the second study, which explored the experiences of domestically violent men who have attempted suicide in prison through thematic analysis of participant interviews. The aims of this study were to gain an account of the experiences of domestically violent prisoners who have attempted suicide in custody, and to investigate further the factors that may underpin why and how their domestic violence perpetration is related to suicide risk. This built on the first study and explored some of the issues that were identified to be of interest. The findings of the second study emphasise the complex nature of understanding suicide risk. The thematic map developed from the study (Figure
suggests a framework or pathway for understanding the sequence and accumulation of difficult experiences leading to increased risk for suicide attempts in custody. The findings highlight the relevance of trauma and adverse life experiences, complex relationships, how the participants view their domestic violence, the impact of the prison environment and the nature of suicide as a coping strategy.

The findings of each study have been discussed in their respective chapters in the context of the wider literature on domestic violence, suicide and prisoners. This chapter considers further the findings of the two studies together to explore the factors relevant to the relationship between domestic violence perpetration and suicide. This will focus on a summary of some of the key issues, and how these may help to understand the relationship between domestic violence perpetration and suicide. The strengths and limitations of the studies will be outlined, and finally, implications for practice including suggestions for the identification of those at risk of suicide in prisons and directions for future research.

6.2 The relationship between domestic violence perpetration and suicidal behaviour in male prisoners

6.2.1 Domestic violence as a risk factor for suicide and suicide attempts

The two studies were designed to fulfil an overall objective of exploring the relationship between domestic violence perpetration and suicidal behaviour in male prisoners. The first study indicated that the relationship between domestic violence and suicide risk identified in offenders and other populations is also relevant to prisoners, as a disproportionate amount of those with an index charge or conviction of domestic violence
completed suicide during the period represented within the analysed FIRs; 30% of all self-inflicted deaths by prisoners that had available FIRs during 2012-13 were men who had an index offence of domestic violence, compared to the statistics suggesting a rate of around 11% of recorded crimes (not convictions) involving domestic violence (Office for National Statistics, 2017). This is consistent with other findings on suicides among domestic violence offenders indicating an over-representation (Starr & Fawcett, 2006). The prevalence may even be under-reported as some of the FIRs were unclear about the victim, and prior criminal history was rarely outlined; men with any history of domestic violence may have made up a further increased proportion of FIRs. However, not all deaths during the time period studied were reviewed due to some FIRs not yet being published, so these findings should be taken with caution.

The second study provided a more mixed picture of domestic violence as a risk factor for suicide attempts; only 12% of those identified as making a near-fatal suicide attempt had an index offence of domestic violence. However, a further 27% had a previous domestic violence offence and 3% had reference to domestic violence that was unclear as to what offence it linked to. This indicates that over 40% of prisoners who had made a serious suicide attempt had a history of domestic violence. As with the first study, this may be an under-estimation due to the difficulties in consistently capturing domestic violence histories. It is unclear why prevalence of index offences of domestic violence among attempters was less than half that of suicide completers when comparing the two studies. Those dying by suicide in 2013-14 were found to be significantly less likely to have been charged or convicted with a violent offence towards someone close to them than those dying between 2012-13 (Prison and Probation Ombudsman, 2015) which could indicate a decreasing trend in the relationship between domestic violence and suicide in prisons,
potentially due to the increased awareness of this risk factor increasing management of risk. However, the same review notes an increasing trend for men who died by suicide in prisons to be subject to restraining orders, particularly those serving short sentences. Another relevant issue is that the numbers of suicides in prisons almost doubled between 2012 and 2016 (Ministry of Justice, 2016). It may be that there are other pertinent issues to this rapid increase that dilute the impact of having an offence of domestic violence. Given the recency of this increase there is limited published work on the matter, however it has been suggested that the pervasiveness of mental health needs, new psychoactive substances (NPS), staffing reductions and strains, and poor implementation of suicide and self-harm procedures may be relevant (Prison and Probation Ombudsman, 2016).

Another potential reason for this discrepancy is the different populations studied; suicide completers versus suicide attempters. While those engaged in near-fatal suicide attempts were chosen in the second study to try and be as near to those completing suicide as possible, there may have been some differences. DeJong et al. (2010) found that compared to suicide attempters, suicide completers were older, were less likely to have previously attempted suicide, were more likely to have consumed alcohol or drugs prior to the suicidal act, and were more likely to have struggled with employment and financial problems. Interestingly, no differences were found in interpersonal or partner conflict or marital status. DeJong et al. (2010) studied a psychiatric population however, and it is difficult to relate the findings to the present two studies given the qualitative nature of the information gathered. The finding that suicide completers are less likely to have previous attempts was supported by the present research, as less than half of the men in the first study had been identified to have attempted suicide before, while all of those in the second study had attempted suicide at least once before their most recent attempt.
However, the studies similarly indicate that interpersonal conflict was present in both suicide attempters and completers; it may be that the presence of a range of other problems is important in distinguishing which domestic violence perpetrators may go on to complete suicide. Another potential explanation for the larger proportion of domestic violence perpetrators among those completing suicide in the first study versus attempting suicide in the second could be that domestic violence perpetrators choose more lethal methods. This could include methods that have life-threatening impact and are completed in circumstances that might reduce the likelihood of medical aid being provided (Magaletta, Patry, Wheat, & Bates, 2008). This is particularly worrying as half of those in the first study had not been identified as being at risk of suicide, emphasising the importance of robust risk screening or assessment procedures in custodial settings. It is worth noting however that the methods available to prisoners engaging in suicidal behaviours are more restricted; while restrictions in access to suicide methods have reduced suicides in the community (Barber & Miller, 2014), it may be that suicide by hanging being the most ‘accessible’ method for prisoners leads to deaths due to the lethality of this method over other types of suicide attempt, even in cases where the intention to die is not clear.

6.2.2 Risk factors associated with suicide in prisoners

Both studies identified that domestically violent prisoners share many of the key risk factors that have been identified for suicides in prisoners generally, including significant mental health problems, substance abuse, and histories of self-harm or suicide attempts (Fazel et al., 2008; Humber et al., 2011; Humber et al., 2013). They also experienced a range of interpersonal problems, and had difficulties coping and dealing with problems,
indicating a key role for adverse life events and the ability to cope as previously identified among suicide attempters (Rivlin et al., 2011; Rivlin et al., 2013). While the first study provided limited information about the nature of these problems and backgrounds of the men, the second highlighted increased levels of adverse life events and traumatic experiences, which have been found in those at risk of suicide and making near-lethal suicide attempts (Marzano et al., 2016). The coping and problem-solving deficits that were identified in the first study were also expanded on, identifying a particularly avoidant approach both generally and to issues present in custody. Previous explorations of coping and suicide risk in prisoners have identified emotional and avoidant coping styles to be prevalent (Mckeown et al., 2017; Sunnqvist et al., 2013) both of which appeared problematic within the sample. The role of emotions also appeared to be particularly important, as negative or overwhelming emotions were identified within both studies, and in the second study as important to understanding the both participants domestically violent and suicidal behaviour. The commonalities between domestically violent suicide attempters and suicide completers in prison could indicate that domestically violent men do not differ substantially from other types of prisoner in terms of different risk factors being relevant. Rather, vulnerability to suicide among this group may be explained by an increased likelihood of domestic violence perpetrators experiencing the known problems and factors associated with increased risk of suicide. Given the qualitative nature of the studies contained within this thesis, these findings should be taken with some caution as they cannot offer a controlled analysis of risk factors or comparison to other groups.

One of the findings from the first study was the number of known risk factors identified by the Prison and Probation Ombudsman (PPO); men had between one and seven distinct risk factors that the PPO considered to be associated with increased risk. While most men had
four or more risk factors, a quarter had three or less and for a handful the only known risk factor was their index offence of domestic violence. This has implications for the identification and management of risk in prisoners. Suicide screening tools have to balance sensitivity and specificity of risk, however issues have been found with the predictive validity of the tools (Perry & Johnson, 2010). The fact that only half of those in the first study had been identified as being at risk of suicide adds weight to the current argument that prison screening procedures for suicide risk lack sufficient sensitivity, or may not include the most relevant risk factors (Gould et al., 2017). It is not yet clear whether certain combinations of risk factors in prisoners may predict risk over and above a simple ‘count’ of such factors. The present research suggests that domestic violence perpetration could be particularly helpful when identifying individuals who are likely to have a range of the vulnerabilities and experiences known to increase suicide risk in prisoners when limited other information is known. The findings of the second study also suggest that there may be a sequence or pathway that links the identified risk factors together.

As well as further exploring individual factors and characteristics of the samples, both studies highlighted the relevance of the prison environment, situational or management factors. This provides further support that a combination of the deprivation and importation models of suicide may best explain why domestically violent prisoners are vulnerable to suicide (Dye, 2010); they may ‘import’ more factors associated with risk of suicide than other prisoners, and also experience more difficulties within the prison environment.
6.2.3 Discrepancies between findings

There were some different findings between the two studies which warrant further exploration. In the first study, less than half of the men who had died by suicide were reported to have had behaviour problems in custody linked to impulsivity or aggression. In the second study however, this seemed to be a larger issue. All but one of the participants had reported some conflict or problems with others that linked to impulsive or aggressive behaviour, including the use of substances in prison. While it is difficult to draw parallels, it is of note that recruitment was impacted in the second study by challenges due to the negative behaviour of potential participants. Eight were specifically screened out due to behaviour deeming them a risk to the researcher, and of those who declined, a number were noted to have behavioural concerns. Transfers between prisons often happen due to concerns about behaviour, therefore the high number of potential participants transferred may also point to behavioural issues. This suggests that this group of domestically violent suicide attempters had tendencies towards impulsive and aggressive behaviour. While there is some lack of clarity and coherence in the literature, impulsivity and aggression have been associated with suicide risk across studies of the general population (Gvion & Apte, 2011) and prisoners making near-fatal suicide attempts (Rivlin et al., 2013), although there has been suggestion that particularly when studying less serious suicidal tendencies, the relationship can be explained by depression (Dear, 2000). These issues are also associated with violent recidivism (Craig, Browne, Beech, & Stringer, 2004; Daffern, Ferguson, Ogloff, Thomson, & Howells, 2007) and domestic violence (Ruddle, Pina, & Vasquez, 2017). It may be that the lower levels found within the first study are due to reporting issues rather than impulsivity and aggression not being a concern. Another explanation could be related to age; the mean age of those in the first study was slightly
higher than those in the second (34 vs 29). Higher levels of impulsive-aggressive traits have been found to play a greater role in suicide among younger individuals (McGirr et al., 2008) which could explain this discrepancy, although the mean age difference was not particularly large.

Another finding of the first study was the potential impact of physical health problems among those completing suicide. While the severity of the issues varied considerably, more than half of the men within the first study had reported some physical health issues while in custody compared to only two in the second study. However, these two participants in the second study indicated significant issues with pain, which is associated with increased suicide risk (Calati, Laglaoui Bakhiyi, Artero, Ilgen, & Courtet, 2015; Racine, 2017). It may be that more serious health problems are associated with increased risk, although a relationship between several physical health conditions of differing severities and suicide has been found (Ahmedani et al., 2017). These findings may offer support to the concept of the acquired capability for suicide, a two factor model of lowered fear of death and elevated pain tolerance stemming from painful and provocative events (Van Orden et al., 2010) which forms part of the Interpersonal Theory of Suicide (Joiner, 2005). A scale for measuring such events includes a range of experiences that may be painful including experiences of surgery, accidents, and injuries (Bender et al., 2011) although does not capture ongoing health problems. The acquired capability for suicide has been associated with the experience of violent or painful incidents (Bender et al., 2011; Christensen et al., 2014) and aggressive life experiences (Smith et al., 2016), thus it is challenging to separate the experiences of domestically violent men in order to identify whether their physical health issues contributed to capability to engage in suicidal behaviours over and above their experience of other painful and difficult events.
6.3 Understanding the relationship between domestic violence and suicide

The first study aimed to explore what is known and identify gaps in knowledge regarding why domestically violent prisoners have died by suicide in prisons. The second study aimed to further understand the relationship between domestic violence perpetration and suicidal behaviour by gaining an account of the experiences of domestically violent prisoners making suicide attempts. The findings of these two studies explored a number of factors that may help understand this relationship.

6.3.1 Trauma and adverse life experiences

The first study provided little insight into the backgrounds and histories of the participants, highlighting a gap in understanding the experiences of prisoners who have died by suicide. The second study enabled further exploration of life histories and identified high levels of traumatic, adverse experiences among the participants illustrated in Theme 1: Trauma, victimisation and life struggles. This is consistent with research into adverse childhood experiences (ACEs), which have been associated with a range of negative outcomes including violence perpetration and incarceration (Bellis et al., 2015; Bellis, Lowey, Leckenby, Hughes, & Harrison, 2014). Attention has also recently been paid to the relevance of such experiences to increased risk of suicide (Brodsky & Stanley, 2012; Choi, DiNitto, Marti, & Segal, 2017; Fuller-Thomson, Baird, Dhrodia, & Brennenstuhl, 2016), although not yet in UK samples. In relation to IPV specifically, high rates of witnessing or experiencing physical abuse have been found in men convicted of IPV, particularly those who are ‘generally violent’ perpetrators (Ernst et al., 2009; Fowler, Cantos, & Miller, 2016) and children experiencing neglect are more likely to perpetrate IPV as adults (Widom, Czaja, & Dutton, 2014). Furthermore, Duke, Pettingell, McMorris and Borowsky (2010)
explored outcomes in adolescents with ACEs in a large population based study. The likelihood of dating violence perpetration, as well as other types of violence, in male and female adolescents increased as the number of adverse events increased, as did the risk of self-harm, suicidal ideation and suicide attempts. This indicates that it may be early experiences that create vulnerabilities for both self-directed and other-directed violence.

The participants in the second study indicated their involvement in traumatic or problematic experiences as adults as well as in childhood. Most of the literature has focused on ACEs and/or childhood trauma, and the impact of adult victimisation and trauma appears to have been neglected. Adults with Post Traumatic Stress Disorder have been found to have significantly higher rates of suicidal thoughts and behaviours (Tarrier & Gregg, 2004) however overall this relationship does not appear to be consistent for suicide completers (Krysinska & Lester, 2010). This may be accounted for by methodological limitations in studies investigating PTSD and completed suicide, or it may be that other factors such as the focus on veterans over other populations are more significant. In either case, this finding suggests that the impact of adult trauma and interaction with early experiences may also be important when understanding why domestic violence perpetration and suicide risk are related.

6.3.2 Attachment and borderline personality characteristics

Both studies presented in this thesis highlighted that domestically violent men in prison experience difficulties with interpersonal relationships; while the first study identified a range of these problems in Theme 3: Relationships, the second study developed further the understanding of why these problems may occur in Theme 2: Relationship ideals vs relationship reality. The findings presented within this theme, as well as the participants’
early experiences, are indicative of insecure attachments. Insecure attachment has been suggested to be a mediating factor between early trauma and a range of later problems including anxiety (Wiltgen, Arbona, Frankel, & Frueh, 2015), depression (Fowler, Allen, Oldham, & Frueh, 2013) and psychosis (Pilton et al., 2016). It has also been linked to maladaptive coping in prisoners (Mckeown et al., 2017). High levels of insecure attachments have been found in offenders (Ogilvie, Newman, Todd, & Peck, 2014), domestic violence perpetrators (Dutton, Starzomkis, Saunders, & Bartholomew, 1994; Park, 2016), male prisoners attempting suicide (Mckeown et al., 2017) and linked with suicidal behaviours in psychiatric populations (Stepp et al., 2008). Given these overlapping outcomes of insecure attachments, the findings of the present studies indicate that insecure attachment may also be a mediating factor between early trauma and suicidal behaviour in domestic violence perpetrators.

A further finding related to attachment and relationships however was the tendency for participants in the second study to describe some of their relationships as ‘alright’ or ‘okay’ while acknowledging conflict and difficulties. Attachment literature posits that attachment styles can be categorised as secure or insecure and early relationships with caregivers form blueprints for later attachments (Bowlby, 1988; Mckeown et al., 2017). However, the findings within the second study suggest that attachments may vary across or even within different close relationships and may not fall neatly within categories. Alternatively, there may be a disconnect between individuals’ perceptions of their relationships and how close they are, and more objective measures of attachment and intimacy.

Buck, Leenaars, Emmelkamp and van Marle (2012) further explored attachment and domestic violence and proposed that this relationship can be explained by personality
characteristics. They found that insecurely attached domestic violence perpetrators were more likely to experience separation anxiety, partner distrust and low self-esteem. The combination of insecure attachments and personality difficulties has also been explored in relation to both suicidal and domestically violent behaviour in the context of Borderline Personality Disorder (BPD) or associated sub-clinical borderline traits. BPD has been conceptualised as stemming from problems in attachments which is supported by research associating BPD with insecure attachment styles (Levy, 2005). The diagnostic features of BPD not only include a pattern of unstable relationships, but also recurrent suicidal behaviour, affective instability, chronic feelings of emptiness, impulsivity and inappropriate anger (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Consistent with the features of BPD, as well as the noted interpersonal difficulties the first study found that emotional state and ability to cope were prominent sub-themes, and the second highlighted further the relevance of criminality and violence and suicide as a coping strategy.

BPD has been consistently associated with interpersonal aggression and perpetration of violence, specifically IPV (González, Igoumenou, Kallis, & Coid, 2016; Jackson, Sippel, Mota, Whalen, & Schumacher, 2015; Stepp, Smith, Morse, Hallquist, & Pilkonis, 2012) and with suicide risk (Zeng et al., 2015). While the applicability of such findings to a prison population is unclear given the generally clinical or community populations used, personality disorder prevalence in prison populations is high (Bebbington et al., 2017; Fazel & Danesh, 2002). Despite these connections, only one of the participants in the first study was reported to have a diagnosis of BPD within the fatal incident report, and none in the second study self-reported BPD. Many presented with the associated traits or features, which may indicate an issue with under-diagnosis of BPD as a problem in male prisoners; while several studies have explored the prevalence of personality disorder among
It is unclear whether in normal practice such prisoners would receive a diagnosis. A further possibility is that this group may present with sub-threshold traits or psychopathology that would not attract a diagnosis, but still causes significant problems.

Navigating the relationship between these interconnected problems can be challenging, however given the relationship between insecure attachment and the tendency to both hurt oneself and others, the findings of this thesis indicate that both attachment and personality psychopathology play a significant role in understanding why domestic violence perpetrators are also at risk of harming themselves. Stepp et al. (2008) suggested that while insecure attachment predicts suicidal behaviours, this is mediated by the experience of interpersonal problems. The authors found that relationship aggression specifically did not lead to increased risk of suicide in either anxious or avoidantly attached individuals. This suggests that it is not the aggression within relationships per se, but the insecure attachments present in domestic violence perpetrators and subsequent experience of interpersonal conflict or problems that increases suicide risk. This is an important consideration, as it would indicate that while domestic violence can be considered a risk factor for suicide, the reason for this is not due to behaviour specific to domestic violence. Rather, the findings of this thesis indicate that it is underlying features of trauma, attachment and personality pathology that are important in explaining increased suicide risk in prisoners, and that these features may be more prevalent in domestic violence perpetrators.

6.3.3 Domestic violence typologies

The typology literature has been postulated to be useful in targeting the specific needs of heterogeneous domestic violence offenders (Cavanaugh & Gelles, 2005), suggesting that
understanding whether suicidal domestically violent perpetrators fit with a certain typology could provide useful guidance when assessing suicide risk. However, the findings of the two studies present some questions about the utility and definitions of domestic violence typologies in male prisoners. The findings do not suggest that a single typology of domestic violence perpetrator is obvious, and in fact the characteristics of the participants indicated that they could fit into more than one ‘type’ of perpetrator. In the second study most participants had histories of chaotic lifestyles and violence outside the home, suggesting that they may fit in with the typology of the antisocial or generally violent domestic violence perpetrator (Holtzworth-Munroe & Stuart, 1994; Johnson et al., 2006). This finding could suggest that it is not the specific nature of violence directed towards a partner or family member that increases risk of suicide, as the participants were also engaged in aggressive, violent or impulsive behaviours directed at a range of people. However, given the prevalence of issues such as substance misuse, suicidal ideation, anger and insecure attachment among this group, and within the first study, these characteristics also fit with the borderline subtype as defined by both Johnson et al (2006) and Fowler and Westen (2011). The ‘borderline’ cluster of perpetrators have been identified to have the highest levels of suicidal ideation and suicide attempts (Johnson et al., 2006) which would seem to fit with domestic violence perpetrators who attempt suicide. However, this subtype has also been proposed to be less likely to have extrafamilial violence or other criminal activity, although it is unclear what exactly would constitute borderline-dysphoric perpetrators committing ‘some extrafamilial violence’ versus generally violent perpetrators committing ‘the most extrafamilial violence’ (Holtzworth-Munroe & Stuart, 1994, p482). An overlap in the typologies is also suggested in research investigating personality pathology in domestic violence perpetrators. Gibbons, Collins and Reid (2011) found that
among those with severe borderline personality pathology, there was substantial comorbidity (75%) with elevations on antisocial, aggressive and passive-aggressive personality patterns.

These findings illustrate some of the criticisms that have been levelled at the typology literature. Ali, Dhingra and McGarry (2016) note that the range of different typologies in the literature makes it difficult to understand how they fit together and whether they are measuring the same concepts, and the literature lacks information on the psychological aspects of IPV. When investigating whether perpetrators could be classified into the three main sub-types using MMPI data only 75% could be classified into any of these groups, and only 64% of clinicians placed individuals into the ‘correct’ group as per the empirical data (Langhinrichsen-Rohling, Huss, & Ramsey, 2000). This difficulty with the clinical application of typologies was supported by Capaldi & Kim (2007), who noted the limited research examining the clinical utility of the typology framework or how to make accurate assessments, particularly in custodial populations. The authors also criticised the typologies for failing to consider the characteristics of the partner, which may be important given the prevalence of bidirectional IPV. This suggests that even if the theoretical typologies are accurate, it may be difficult to apply this knowledge in a meaningful way to help identify those domestic violence perpetrators who are at risk of suicide. The findings of the present studies question whether the typologies do in fact distinguish separate types of perpetrator, as there is evidence of overlapping presentations.

6.3.4 A pathway to suicide for domestically violent men

One of the key findings of the second study was how the different factors accumulated over time and formed a sequence of experiences as illustrated by the thematic map (Figure
Thus, early trauma and adverse experiences impacted on attachment, relationships, a tendency towards criminality and maladaptive coping skills. Participants’ had experiences of both domestically violent and other criminal behaviour which they viewed in different ways. Further victimisation experiences were noted throughout, however the participants’ behaviour led to negative prison experiences, and culminated in suicide attempts in custody as a coping strategy. It should be noted that for many, suicidal behaviours linked to poor coping began prior to custody, or at least prior to the most recent prison experience.

Pathways and processes to suicide have been considered for the period of time between initial suicidal thoughts or ideation and a suicide attempt (Millner, Lee, & Nock, 2017; Rivlin et al., 2011), and profiles of suicidal prisoners have suggested different pathways to suicide depending on their circumstances at the time and triggers (Liebling, 1999; Rivlin et al., 2013). These studies have taken a somewhat narrower slant however, and have not sought to describe the pathways towards suicidal behaviour from a more life-encompassing perspective. Some studies have taken this approach through the use of life charts, for example in Australian lesbian and gay populations (Skerrett, Kõlves, & De Leo, 2017), Australian farmers (Kunde, Kõlves, Kelly, Reddy, & De Leo, 2017) and UK adolescents (Fortune, Stewart, Yadav, & Hawton, 2007). The present research suggests that considering the pathways to suicidal behaviour in domestically violent offenders, with a focus on their life experiences, sequences of events and interactions, may provide useful information when considering suicide risk, assessment and prevention.
6.4 Strengths and limitations of the studies

Taken together, the two studies presented in this thesis offer the first exploration of the relationship between domestic violence perpetration and suicide risk in prisoners. This has been investigated from two perspectives; how men completing suicide are understood and perceived by professionals involved in their care, and how men engaging in a near-lethal attempt understand and explain their own behaviour. The two studies captured differing types of suicidal behaviour across a range of prisons. A limitation to the second study was the relatively narrow sampling as participants were drawn from only three prisons within a relatively small geographical area and as such prison specific factors may have influenced the findings. However, these prisons did represent different types and categories of custodial environment, from a local public-sector prison, to a large contracted site and a prison focusing on resettlement issues.

Both studies within this thesis explored suicide and associated behaviours in domestically violent men, and do not offer a comparison to men convicted of other offences. Purposeful sampling in qualitative research offers advantages in terms of obtaining information to answer the research questions, and confers a degree of transferability within the sample studied (Malterud, 2001). While the focus on domestically violent men was deliberate, it is not possible to state whether the individuals represented are substantially different from men convicted of other types of offences who died by suicide during the same period. A further 22 (21%) of the FIRs published for deaths in custody between 2012 and 2013 indicated the man had engaged in a violent offence against someone other than a close family member or partner, and 13 (12%) had engaged in sexual violence. Given that violence against the person generally is also associated with
suicide in prisons (Webb et al., 2012), understanding whether the findings in these studies are unique to domestic violence perpetration, or whether they may also be relevant to other types of violence and suicide risk would be helpful. Another issue of note is the lack of literature exploring domestic violence against family members other than intimate partners; most relates specifically to child to parent abuse or elder abuse, neither of which are relevant to the present study. Eight of the participants in the first study and three of the participants in the second study, representing a significant minority, were involved in violence against a family member as an adult; usually a parent or sibling. While no specific comparisons were made, all the themes were relevant to all participants irrespective of their victim type. However, this type of domestic violence warrants further investigation in the wider literature.

Within the second study, there was some suggestion that the demographics of the participants differed from those who complete suicide. None of the participants were Asian, although only 4-5% of all deaths in custody have been identified to be of Asian ethnicity (Prison and Probation Ombudsman, 2015) compared to approximately 8% of the prison population (Allen & Watson, 2017). In addition, none of the participants were serving a life or indeterminate sentence and only one was on remand or unsentenced. These groups have tended to be over-represented in prison suicides (Fazel et al., 2008; Prison and Probation Ombudsman, 2015) therefore there may be some fundamental differences between participants who took part in this study and those who complete suicide in prison. Table 7 (Chapter 5, p116) outlines that only two indeterminate sentenced prisoners were screened as suitable for the second study. Therefore, it may be that the general prison populations within the prisons from which the participants were drawn had fewer indeterminate sentenced prisoners, or held those with different issues
than those in the population across England and Wales. A further potential explanation may be that domestically violent prisoners on such sentences are more likely to complete suicide than unsuccessfully attempt it, which raises concern for suicide risk management.

Further to this, the difficulties in recruiting participants for the second study is likely to have had an impact, as only those participants who were motivated and stable enough to discuss their experiences were able to be included. Capturing the experiences of those who struggle most with prison life is likely to be important, however is difficult to achieve. In addition, the limitations of qualitative interviewing more widely apply, in terms of the potential for self-reporting bias. This is a problem with any research using self-reported data including surveys or questionnaires (Krumpal, 2013). Such difficulties may be reduced by choosing appropriate methodologies, paying attention to reflexivity and engaging in good practice interviewing technique (Roulston, 2010). Chapters 3, 4 and 5 outline how the principles of good quality qualitative research were followed, aiming to limit or acknowledge potential bias within the researcher and participants.

6.5 Implications for research and practice

The findings of the two studies suggest several areas that require attention in future research. As they represent a qualitative exploration of domestic violence perpetration and suicide risk in prisoners, a clear next step would be to investigate further some of the findings related to the experience of attachment, trauma and coping among domestically violent prisoners at risk of suicide. This may provide further evidence as to the mechanisms through which suicide risk may be present for this population, and whether domestically violent prisoners experience higher levels of these issues than other
prisoners. Such studies could help to control for key variables with this population and tease out how different factors contribute to suicide risk. This may include how physical health problems and pain interact with other painful life events to contribute to capability to engage in suicide, whether avoidant coping over other maladaptive coping styles is particularly prevalent among domestic violence perpetrators, how significant current experiences of interpersonal conflict or problems are, and the role of childhood versus adult trauma.

As noted, further exploration of the pathways to suicide for this population would be helpful, for example testing more thoroughly how early experiences influence the development of later issues. This could include investigating the interaction of known risk factors and identifying which if any may be most critical to understanding suicide risk in already vulnerable populations. In addition, how the participants’ understood and explained their domestic violence could benefit from further exploration. Participants did not make explicit links between their domestically violent behaviours and suicide attempts, therefore more exploration of their attitudes to domestic violence, how they perceived and explained this after the fact, and any impact on suicidal thoughts or behaviours would be beneficial. This is likely to offer scope for the development of more practical suicide risk assessment tools in prisons.

In terms of practical implications, both studies highlight the difficulties in identifying domestic violence perpetrators among those who have died by suicide or those who are at risk of suicide in prison. Given the implications of domestic violence as important to understanding vulnerability to suicide, consideration should be given to ways to improve recording of a domestic violence history. This may aid prison staff in suicide risk screening
as well as future research. The first study also drew attention the limitations of current policies and procedures after a self-inflicted death in terms of understanding why that individual died by suicide. Despite the wealth of information available to the PPO, FIRs are focused primarily on the procedures and processes that were followed, and making recommendations to prevent future deaths. However, given the levels of suicide in prisons it is debatable whether this is having the desired impact. It may be that paying further attention to understanding the complexities of the interactions between individual histories and circumstances and the prison environment can shed light on why such deaths take place and what can be done to intervene. Whether FIRs are the appropriate place to do this is arguable, and considering methods such as psychological autopsy (Hawton et al., 1998) for the prison service to gather further information to learn from such incidents has value. This has previously been suggested as necessary for suicide prevention alongside more administrative mortality reviews such as those completed by the PPO (Daniel, 2006) however to my knowledge this does not take place.

The two studies have highlighted the challenges that are faced when attempting to predict suicide risk in an individual, particularly in a prison setting where prisoners present with many of the factors known to increase risk of suicide. While some suicides cannot be predicted easily, it seems key that staff consider the range of risk factors and the possibility of ‘masked depression’ or similar concepts rather than relying only on a man’s presentation to them in custody. While an index offence of domestic violence has been highlighted as a vulnerability for suicide, the findings presented here indicate that it may be a history of domestic violence rather than just the index offence that is important as this points to a constellation of factors known to increase suicide risk to be present. This has implications for suicide screening processes in prisons which may focus on the index
offence rather than whether there is a history of domestic violence. While the background literature suggests that higher severity violence may be more related to suicidal behaviour, this was not the case for all men involved in the current studies. Therefore, it is important to consider severity of violence in the context of other known risk factors.

There are clearly complex relationships between the individual factors that a man brings into prison, and the environment he finds himself in. This highlights the need for consideration of both issues and more sensitive or nuanced ways of identifying those at risk of suicide in prison, for example moving away from ‘checklists’ of risk factors and considering processes, mechanisms or pathways towards suicide. This has implications for information gathering about those coming into, or returning to custody, and how prison staff may be able to find out whether an individual prisoner may have experiences that fit with a pathway to suicide. Another practical implication of the present research are the findings related to the barriers participants experienced to managing their difficulties. These included a lack of confidence when seeking support, poor problem-solving abilities, an external locus of control and external difficulties such as limited provision of mental health care or ongoing support after acute risk has been managed. This indicates that there are practical steps that may be taken by prisons to manage suicide risk, such as improving after-care once an ACCT has closed, providing problem solving or emotional regulation training, and improving communication with men deemed to be at risk of suicide.

The potential key role of trauma and attachment issues among domestically violent prisoners provides a persuasive argument for the development of trauma informed practices in prisons. Trauma informed practice or care goes beyond providing specific
trauma intervention, and instead focuses on the organisational level in order to help contain, manage and transform the lives of those who have experienced trauma (Bloom & Farragher, 2013). This approach has been suggested for substance misuse, mental health and sex offender treatment services (BC Provincial Mental Health and Substance Use Planning Council, 2013; Levenson, 2014; Shier & Turpin, 2017) which all offer parallels with the population within prisons. Shier and Turpin (2017) offer a conceptual framework that may be of use when considering how to develop trauma informed practice. This involves four key principles of care; safety, choice, collaboration and empowerment. Prisons are already starting to develop similar approaches to the care of prisoners through Enabling Environments approaches, which also have standards such as empowerment, structure, safety and belonging (Royal College of Psychiatrists, 2013). This has tended to be applied to individual units however, rather than as an organisational or systemic approach. While the present research focuses only on domestically violent prisoners, high rates of trauma have been found in prisoners including those serving life sentences (Payne, Watt, Rogers, & McMurrann, 2008), suicidal and non-suicidal inmates (Blaauw et al., 2002) and older adult prisoners (Courtney & Maschi, 2012). This approach could be applied specifically to suicide risk management processes in prison such as ACCT. However, consideration to how trauma informed practice may shape the overall care approach that prisons take is likely to have a positive impact on the assessment and management of suicide risk.
References


Clinical Depression (5th October 2016). Retrieved from https://www.nhs.uk/conditions/clinical-depression/


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Appendix A: Overview of template development for study one

Template v1

Background factors
- Criminal history
- Offending factors
- Mental health history
- Other factors
- Violence history

Communication
- Information and knowledge sharing
- Staff/prisoner communication

Healthcare
- Assessment of health
- Positive involvement
- Problems with healthcare involvement
- Standard of clinical care

Prison factors
- Activities
- Change
- Procedures and processes

Prisoner wellbeing
- Emotional state
- Mental health wellbeing
- Physical wellbeing

Problems and concerns
- Absence of problems or concerns
- Concerns expressed by the prisoner
- Coping with problems
- Staff concerns about prisoner

Relationships
- Contact with the outside world
- Intimate relationship problems
- Staff relationships
- Peer/prisoner relationships

Risk assessment
- Assessment of suicide risk (ACCT)
- Known risk factors
- Problems with risk assessment

Other issues of note
- Circumstances of death
- Criticisms by report writer
- Suicide note
Template v2

Background factors
Criminal history
Current offending
Mental health history
Other factors
Violence history

Communication
Barriers to communication
Communication issues
Failures to obtain information
Positive communication
Referrals

Healthcare
Assessment
Health professional involvement
Problems with care or assessment

Other issues of note
Circumstances of death
Other criticism by report writer
Suicide note

Presentation
Emotional state
Perception of individual
Statements regarding self harm or suicide

Prison environment
Activities
Changes
Isolation
Procedures and processes

Prisoner wellbeing
Coping
Mental health
Physical wellbeing
Self harm behaviour

Problems and concerns
Absence of problems or concerns
Adjustment to prison
Behavioural problems
Concerns expressed by the prisoner
Dealing with problems
Staff concerns

Relationships
Contact with the outside world
Personal relationships
Staff relationships
Interactions with staff
Support from staff

Risk assessment
ACCT process
ACCT reviews and assessments
Issues with ACCT
Use of ACCT to manage risk
Assessment of suicide risk
Known risk factors
Problems with risk assessment
Triggers for self harm or suicide

**Template v3**

**Background factors**
- Criminal history
- Current offending
- Mental health history
- Other factors
- Violence history

**Communication**
- Communication issues
  - Poor record keeping
  - Problems with communication or information sharing
  - Information not actioned
  - Difficulties communicating with the man
- Positive communication
  - Good recording of information
  - Good practice in seeking or sharing information
  - Overcoming barriers

**Referrals**

**Healthcare**
- Assessment
  - Health professional involvement
  - Problems with care or assessment
    - Limited or no involvement
    - Problems with care
    - Problems with assessment
    - Other issues
  - Failures to obtain records

**Other issues of note**
- Circumstances of death
- Suicide note

**Presentation**
- Emotional state
  - Negative emotions
  - Positive, stable or improved mood
- Perception of individual
- Statements regarding self harm or suicide
- Behavioural problems

**Prison environment**
- Activities
- Change and movement
  - Movement within prison
Prison transfers
Court appearances
Isolation
Procedures and processes
Adjustment

Wellbeing
Coping
Poor coping
Positive coping strategies
Mental health
Current mental health issues
No diagnosed or presenting problems
Physical wellbeing
Physical health problems
Good health
Self harm behaviour

Problems and concerns
Absence of problems or concerns
Experience of problems
Dealing with problems
Staff support and actions
Coping with problems

Relationships
Personal relationships
Family
Partners
Contact with the outside world
Relationships with prisoners
Staff relationships
Contact with staff
Positive, supportive relationships
Hostile or difficult relationships
Lack of staff interaction

Risk assessment
ACCT general process
Management of risk
Problems with management of risk
Assessment of suicide risk
Known risk factors
Problems with risk assessment
Triggers for self harm or suicide

Final Template

Individual Factors

1. Background and history
Criminal history
Current offending
Mental health history
Violence history
Other factors

2. Custodial Wellbeing Concerns
   Current Mental health
   - Current mental health issues
   - No diagnosed or presenting problems
   Physical wellbeing
   - Physical health problems
   - Good health
   Ability to cope
   - Poor coping
   - Positive coping strategies
   Problems and concerns
   - Absence of problems or concerns
   - Experience of problems
   - Dealing with problems

3. Relationships with others
   Personal relationships
   - Family
   - Partners
   - Contact with the outside world
   - Relationships with prisoners
   Professional relationships
   - Contact with staff
   - Positive, supportive relationships
   - Hostile or difficult relationships
   - Lack of staff interaction

Isolation

4. Outward Presentation and Perceptions
   Emotional state
   - Negative emotions
   - Positive, stable or improved mood
   Perception of the man
   Behavioural problems

5. Suicide Risk and Behaviour
   Circumstances of death
   Suicide notes
   Self harm behaviour
   Suicidal statements of intent
   Triggers and known risk factors

Situation and management factors

6. Communication
   Communication issues
   - Poor record keeping
   - Problems with communication or information sharing
   - Information not actioned
   - Difficulties communicating with the man
   Positive communication
   - Good record keeping
   - Seeking or sharing information
   - Overcoming barriers
7. Healthcare
   Assessment
   Health professional involvement
   Problems with care or assessment
     Limited or no involvement
     Problems with care
     Problems with assessment
   Other issues
   Failures to obtain records

8. Prison environment
   Activities
   Change and movement
     Movement within prison
     Prison transfers
     Court appearances
   Procedures and processes

9. Risk assessment and management
   Assessment of suicide risk
   Management of suicide risk
   Risk to others
Appendix B: Summary of study one situation and management themes

6. Communication

This theme relates to how well staff communicated with each other and to the man during his time in custody

<table>
<thead>
<tr>
<th>Communication issues: Problems noted or experienced in communicating effectively or recording information about the man; for example between different teams or staff members</th>
<th>Poor record keeping: ‘Although this is recorded in the young person’s medical records, it was not in any other records and does not appear to have been communicated to other staff.’ (73) Problems with communicating or sharing information: ‘We believe that communication between departments should have been better and it is clear that those making decisions about the man’s location were not always in possession of the full facts about his medical or personal issues’ (36) Information not acted on: ‘In addition, his cell sharing risk assessment was not updated, when his perceived needs changed and concerns noted on the form were not discussed.’ (55) Difficulties communicating with the man: ‘Although his English improved while he was at [prison], communication was difficult.’ (24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive communication: Examples of positive communication between staff or with the man</td>
<td>Seeking or sharing information: ‘That afternoon, the SO held a case conference with the man, a nurse, his personal officer, an A wing officer and a wing representative (an A wing prisoner). She said she explained to him again the reasons why he had been moved.’ (36) Overcoming barriers: ‘The offender manager had arranged for a Tamil interpreter to accompany her and this enabled the two probation officers to talk in depth with him.’ (78) Record keeping: ‘The healthcare assistant noted in the man’s medical record that she had passed this information to the SO, who said that he would look into it.’ (91)</td>
</tr>
<tr>
<td>Referrals: Referrals made between or to departments</td>
<td>Appropriate referrals: ‘On 12 November, he asked for a referral to receive help for his problems. He was referred to CARAT service (Counselling, Assessment, Referral, Advice and Throughcare) which provides assessment and services for</td>
</tr>
</tbody>
</table>
prisoners with drug and alcohol problems.’ (86)

Problems with referrals: ‘We are concerned that he asked to see a substance misuse worker but no referral was completed.’ (42)

<table>
<thead>
<tr>
<th>7. Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>This theme outlines contact that the man had with both mental and physical health professionals, and the quality of assessment and care that he received</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health professional involvement: Ongoing involvement that the man had with mental or physical health professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessments:</strong> ‘The man was given a cell in the healthcare inpatient unit, for a period of close monitoring and assessment. He was referred to the prison mental health team and was quickly assessed by the prison psychiatrist and the mental health team leader.’ (53)</td>
</tr>
<tr>
<td><strong>Ongoing case involvement:</strong> ‘She also planned to monitor his mental state in prison and attempt to ascertain any developing psychotic illness.’ (26)</td>
</tr>
<tr>
<td><strong>Decisions not to engage:</strong> ‘He then refused to communicate with any medical or prison staff. He would not attend an ACCT review on 19 September, as a protest about not receiving the medication.’ (44)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problems with care or assessment: Noted concerns and problems in effectively assessing the man’s health or in the care that he received</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Limited or no involvement:</strong> ‘The clinical reviewer notes that disclosure of recent self-harm should have prompted a primary mental health review or a referral to the mental health in-reach team but there is no evidence that this was considered.’ (18)</td>
</tr>
<tr>
<td><strong>Problems with care:</strong> ‘We agree with the clinical reviewer’s concerns about the delivery of mental health services and we are concerned about the failure to seek the man’s community health records.’ (31)</td>
</tr>
<tr>
<td><strong>Problems with assessment:</strong> ‘When he arrived back at [prison], a nurse saw him and decided that a first healthcare reception screen interview was unnecessary as it had not been that long since he was last in custody. (In fact it was four months, and 10 months since he was last in custody.)’ (90)</td>
</tr>
<tr>
<td><strong>Failures to obtain records:</strong> ‘No attempt was made to get his community health records although he said he had been treated in a psychiatric hospital not long before.’ (31)</td>
</tr>
</tbody>
</table>
| **Other issues:** ‘An officer acted as an interpreter for psychiatric appointments, which should have been confidential. There is
no evidence that he consented to the officer’s presence for these sensitive appointments.’ (24)

8. The prison environment

This theme covers any information about the external environment such as what he was involved in and whether he was moved or his environment changed in any way. The policies and procedures the prison followed are also reflected within this theme.

| Activities: Prison activities that the man was offered or engaged in including work, education and hobbies | ‘He said he wanted to be employed as a wing cleaner to keep busy.’ (31) |
| Change: Changes and movements within the physical environment such as between prisons, wings or on court appearances | Movements within prison: ‘On 28 May, the man moved to a double cell on K wing, which he shared with another prisoner [...]On Thursday 6 June, the prisoner moved to another cell, which left the man on his own’ (18) |
| | Prison transfers: ‘The man’s partner wanted to know why he was transferred from [prison A] to [prison B] as this was disruptive for him and would have caused him additional stress.’ (42) |
| | Court appearances: ‘The man attended court on 7 December 2012, 11 February 2013 and 23 April 2013, the day before his death. In addition to his original offence, on 23 April, he was charged with a further violent offence against his partner.’ (24) |
| Procedures and processes: References to the prison specific procedures used in relation to the man’s care | ‘He submitted a formal complaint about his medication on 11 October. The complaints clerk acknowledged his complaint the next day, indicating that a formal response would be sent after it was investigated and then passed the form to the Head of Healthcare.’ (44) |

9. Risk assessment and management

Assessments of the risk the man posed to himself and others and any identified problems with the assessments are reflected within this theme.

<p>| Assessment of suicide risk: Records of the assessment of risk of | Staff assessments of risk: ‘He had a number of risk factors when he arrived at Gloucester which indicated that he was at risk of suicide and self-harm and appropriate steps were taken |</p>
<table>
<thead>
<tr>
<th><strong>Management of risk:</strong> How risk was managed using ACCT or other procedures, including positive examples</th>
<th>to support him.’ (33)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with risk assessment: ‘Too much reliance appears to have been placed on the man’s personal presentation when assessing his risks when he first arrived.’ (86)</td>
<td></td>
</tr>
<tr>
<td>Use of ACCT: ‘Because of his complex needs and risks he was reviewed several times over the next three days using enhanced care management procedures and moved to a cell designed to have limited ligature points (known as a safer cell).’ (26)</td>
<td></td>
</tr>
<tr>
<td>Positive management: ‘His ACCT observations were increased slightly while he adjusted to life back among the general prison population.’ (42)</td>
<td></td>
</tr>
<tr>
<td>Problems with risk management: ‘Healthcare staff were not sufficiently involved in reviews of his progress and the monitoring ended without the mental health team being consulted. I am concerned that not all the issues which had been causing him anxiety had been resolved when his monitoring was ended’ (22)</td>
<td></td>
</tr>
<tr>
<td>‘The man spent the first two nights in custody in a single cell while his cell sharing risk assessment form was completed. An officer interviewed him and determined that he was not a risk to other prisoners and was suitable to share a cell.’ (37)</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C: Study two consent form and information sheet

Participant Information Sheet

Understanding the link between violence in close relationships and suicide

Background

This research project is being done to try and help prison staff understand how to identify and support men who are at risk of making a suicide attempt in prison. One of the things that might increase this risk is if someone has been arrested for being violent towards someone they are close to. I hope to learn more about why this might be the case by interviewing men who have made a serious attempt to hurt themselves in prison, and who have been involved in violence towards someone they are close to. This could be a partner or family member.

The study is being run with Cardiff Metropolitan University, and the results will be written up and submitted for a Forensic Psychology Doctorate.

I would like to invite you to take part in this research study. Before you decide whether you want to be involved, please read all of the information below.

Participation

Why have I been asked to take part? You have received this information as your experiences are important, and will help us understand why some people try to hurt themselves in prison.

What will happen if I agree to take part? If you choose to take part, you will be asked to attend one interview with me. This will take about an hour, and will involve talking about parts of your life history. This could include talking about past and current close relationships you have had, offences you have been charged with and times when you have tried to hurt yourself. The interview will be audio recorded so that it can be written up word for word later on to make sure that I do not miss anything. As soon as the interviews are written up the recordings will be deleted.
What are the benefits of taking part? I cannot promise that the study will help you, but people often find that telling their story can be a positive experience and can help them make sense of difficult times. You may also be able to benefit others by helping us understand better why some people are at risk of harming themselves in prison. This could improve how you and other prisoners are offered help and support in the future.

Are there any risks? The topics of the interview might be difficult to talk about and could bring back negative thoughts or feelings, although I will do everything I can to help you feel safe and comfortable. Most people who talk about these types of situations do not find it distressing and some can even find it helpful. However it is possible that this could be upsetting for you. You can stop the interview at any time, and if you do feel upset you can talk to me, a Listener or another member of staff afterwards.

Do I have to take part? No, it is up to you to decide. Whether you decide to take part or not, your care and treatment in prison will not be affected. If you do decide to take part, you can withdraw consent for your information to be used at any time during the interview, or afterwards before the interview is transcribed. You can also ask to review the information you provided before the interview is transcribed.

Will the information I give be confidential? Yes, I will not use your name in any of the written or published information, so no one will know that it is you. Only I will have access to the information that identifies who you are. Parts of what you have said will be used in the research reports, to highlight important information. However no information that identifies you will be printed. The data will be kept securely in a locked cabinet for 10 years and then destroyed.

If during or after the interview I am worried about the safety of you or another person from what you say I would have to let someone know.

What will happen afterwards? The information you give will be written up as part of a Forensic Psychology Doctorate thesis, which will be submitted to Cardiff Metropolitan University. A report will also be written for the Prison Service to outline the key results. You can request a copy of this report at any time. If you wish to see this report please provide me with your full details so that this can be forwarded on to you.
PARTICIPANT CONSENT FORM

Understanding the link between violence in close relationships and suicide

Participant name:

Name of Researcher: Claire Dewar

Please initial next to each line:

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and am satisfied with the answers given. ___

I understand that my participation is voluntary and that I am free to withdraw before the interview is transcribed, without giving any reason. ___

I agree to take part in the above study. ___

I agree to the interview being audio recorded ___

I agree to the use of anonymised quotes in publications ___

_______________________________________   __________________
Signature of Participant                          Date

_______________________________________   __________________
Name of person taking consent                    Date

______________________________________________
Signature of person taking consent
Appendix D: Study two debrief sheet

Participant Debrief Sheet

Dear Participant,

Thank you very much for taking part in my research. Your experiences are important, and what we have talked about in the interview will help me and others understand more about risk of suicide. This will help us to know who needs support, and what kinds of support they might need.

Many people feel better after talking about difficult experiences. Some people do find it upsetting to talk about their past. If you feel upset, now or at a later point, please be aware of the following support that is available:

In custody:

- The Listener’s Scheme
- The Samaritans
- Personal Officer Scheme
- Prison Chaplain/Imam
- InReach mental health team
- Pact Cymru
- ACCT

Please speak to an Officer on your landing/wing if you are feeling upset and need to access any of the support above. If you have thoughts about hurting yourself, please let someone know.

In the community

- The Samaritans (call 116 123 for free)
- Your GP/doctor
- Your Probation Officer
- Turn2me.org
- SupportLine Telephone Helpline (call 01708 765200)
- CALL (Community Advice and Listening Line) Helpline 0800 132 737 or text 'help' to: 81066
- CALM (Campaign Against Living Miserably)
Appendix E: Study two interview schedule

Exploring the link between domestic violence and suicide

Interview Schedule

Introduction: Check consent and review information sheet. Explain probable length of interview and topics of discussion, explain that research is to help find out why some men who have been violent to someone they are close to go on to attempt or die by suicide. Check in with mood (SUDS rating) and find out if any significant negative events currently happening that might impact.

Demographic information:

First I’d like to ask you a few questions to gather some information about you:

- Age:
- Ethnicity:
- What are you currently charged with or convicted for?
- When did you first come in to custody?
- Have you been sentenced? If so how long for?
- Is this your first time in custody? If not how many previous times have you been in prison?
- What kinds of offences have you previously been charged with or convicted of?

Current experience in prison

1. How have things been for you overall since you came into custody on this sentence?

   - What has your experience of being in custody been like? How does it compare to previous times?
   - How have you occupied your time?
   - How has your mental health been during your time in custody?
   - What about physical health?
   - Have you had any problems or issues? If so, what? Prompt for emotional experience/reaction
   - Have there been any big changes since you came into prison?
   - How have you coped with problems? How do you normally cope?
   - What are your relationships like with other prisoners?
   - How do you get on with prison staff?
   - What kind of support have you received in prison?
   - Have you been on an ACCT? When/how many times? What was your experience of this?
Suicide attempt

2. What happened when you seriously self harmed/attempted suicide most recently?
   - What was going on just before/in lead up to attempt?
   - What is your understanding of why it happened/key factors?
   - Similarities/differences with any previous suicide attempts or self harm?
   - What did you say or tell people about what was going on for you around this time?
   - Did anything get in the way of you seeking or accessing support? What/how?
   - Was there anything that other people could have done to help or support you more around this time?

Personal history

Now I’d like to ask you a bit more about your history and things that have happened in the past

3. Have you ever tried to hurt or kill yourself in the past? What happened?
   - Were you in custody?
   - What was going on in your life at these times?
   - What do you think were the triggers (what do you understand by the word ‘triggers’?)

4. Have you experienced any problems or challenges with your mental or physical health in the past?
   - When did you start having these problems?
   - How have they affected you? Your family/those closest to you?
   - How have they affected your relationships?
   - What support or help have you received?

5. I’d like to know a bit about your relationships – who are you closest to?
   - Tell me about your most important family relationships or friendships –what contact do you have in prison?
   - What were your intimate relationships like?
   - What experiences do you have (as perpetrator or victim) of domestic violence?
   - How has that affected you? Explore any impact on wellbeing, health etc.
   - How do you deal with problems in relationships usually?

6. Are there any other past experiences you have had that are important to you?

Offending

7. What happened that led to you being arrested/charged/convicted this time?
• What were you accused of/charged with/convicted for doing? What happened?
• What was your experience like of being arrested/charged/coming to prison for the incident?
• What impact did the offence/arrest have on you and others?

8. Is there anything that I haven’t asked you about that you think might be important?

Closure: Check mood (SUDS), ask if any concerns or worries about anything we have talked about. Provide with debrief sheet including information on where to seek support. Inform if passing on information on wellbeing to specific staff.
## Appendix F: Reflexive notes - Extracts

### Study One:

<table>
<thead>
<tr>
<th>Date</th>
<th>Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>11&lt;sup&gt;th&lt;/sup&gt; September 2015</td>
<td>Analysing PPO report 18, I noted that the report does not explain the nature of the domestic violence or who the victim was. Given that he had contact with his partner while in custody it is not clear if she was a victim. If so what was the impact of continuing to have contact? Could this be as problematic as not having contact with a partner or loved one if the relationship is conflictual? Of note in the report was a sense that staff communication and support offered was poor when the man was going through a difficult time. However, it’s unclear how much staff knew about his distress or previous self-harm. Is this a failure to ask the right questions or did he deliberately hide his feelings and concerns from staff? It’s frustrating to have unanswered questions about the man who died, the report offers little detail of his life before prison including the nature of his domestic violence, and somewhat vague detail about his life during prison. This is making it somewhat difficult to find information that would help to explain or clarify the relationship between DV and suicide.</td>
</tr>
</tbody>
</table>
| 30<sup>th</sup> October 2015   | Reviewing the coding for the first four reports, and considering the suggestions by Braun & Clarke on questions to ask myself for coding report data.  
- how is the report writer making sense of the information?  
- why might this information be reported in this way?  
- in what way does this information make sense of the suicide?  
- what assumptions do they make?  
- what information is revealed through their account?  
- what information is not revealed? |
It seems clear that the PPO are focused on what facts they can glean from the time in prison and how to explain why the man was able to die by suicide in a custodial environment. Less attention is paid to why the man completed suicide and what motivated him, perhaps the PPO want to stay away from making assumptions about this in the absence of clear information. This will also be important for me in terms of my analysis of the data, and staying true to the data rather than trying to interpret or guess what I think motivations for suicide may have been.

There is detailed information about official records and staff involvement with the case (or lack of staff involvement in some cases). There seems a large gap in terms of background information about the man, although such information must have been available. This may reflect the focus of the reports on the process of the suicide itself rather than the motivations and triggers.

8\textsuperscript{th} December 2015

| Coded PPO report 80 – this report is significantly longer than most of the other reports, which may reflect that it is about the death of a young person. I have conflicting feelings about this, in some ways it is particularly sad that a child has died by suicide while in the care of a prison and must in some sense reflect failings of the organisation. It is also clear from reading the report that the young person had a lot of issues and problems and was clearly presenting a complex picture to staff. I also wonder though, why adults are given less attention, to me it is just as sad and concerning that anyone dies by suicide in prison irrespective of age. In particular there seems to often be far less thought (or at least reporting) about the background and experiences of the adults in the sample. Why do we need to know more detail about a young person than an adult? |

\textbf{Study two:}

8\textsuperscript{th} January 2017

| Conducted interview with ‘Chris’ today. I found it challenging as he was clearly upset and anxious prior to the interview due to a recent bereavement, which he disclosed when I took a SUDS rating. I checked whether he wanted to postpone the interview however he wanted to go ahead; I got the sense that he wanted to talk with someone. This was also reiterated from later in the interview when he said that he prefers speaking to women, and does not express his feelings to male friends or acquaintances in prison. This idea of how and when |
prisoners choose to express themselves may need following up with other interviews. Although he seemed to want to talk, I was conscious about how much to explore issues given how he was feeling, and at times the interview felt somewhat stilted. I made sure that I used empathic reflection and gave him time to answer which did seem to encourage participation as time went on.

Chris denied any violence in his relationships although acknowledged behaviour that could be seen as controlling/aggressive – I’m not sure he saw it this way though. There seemed to be a clear sense that DV was ‘wrong’ but also quite a ‘macho’ attitude to violence generally.

| 30th January 2017 | Conducted interview with ‘Andrew’ today. He was very polite and engaging in the interview, and seemed keen to talk about his experiences, very articulate. I go the sense that how he sees himself and his experiences may be different from how others experience them. He alluded to being accused of malingering previously by a mental health professional, but was convinced of his own serious mental health issues. Although I was somewhat dubious about his account this is something I have come across many times before in my work and I tried to keep in mind that my role isn’t to challenge his perceptions, but to record, understand and interpret them.

Andrew seems somewhat different to some of the other participants I have interviewed – no previous offending history, almost a ‘stereotypical’ presentation of a first time vulnerable prisoner. May need to keep this in mind when completing the analysis in terms of whether he presents as a deviant case or his experiences are still consistent with the overall themes.

| 7th May 2017 | Initial read through and analytical notes related to ‘Michael’. There is a clear sense of him trying to change and trying to cope differently and be there for his family despite his negative experiences in family and intimate relationships. This positive sense conflicts with how he talks about change being external to himself – that his family help him change, that he ‘loses his head’ and can’t control himself. It seems he has insight into some areas of his life and functioning such as how prison is an extension of the care system, but lacks awareness of how his experiences may be affecting his attitudes and behaviour.

There is also a sense that while prison impacts on coping strategies due to the restrictions of being in a custodial environment, the strategies
were not particularly well developed or robust in the first place.

Michael denies some of his DV – may need to think about how I manage aspects of denial and minimisation in analysis. He gave a very different explanation of his offending to that in the official records. My decision not to challenge or question their explanation I still believe helped build rapport and gain an insight into how the participants wanted to articulate their experiences, but may have limited some of the nuances of why they explain their DV in a certain way. However, uncertain at this stage if this is critical to understanding the relationship between DV and suicide risk – it may be an area to follow up in a different context.