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A qualitative exploration of the views of people with lived experience of suicide within the criminal justice system

Acknowledgements

The authors would like to thank all the participants who participated in the research. This paper contains transcripts of interviews conducted during the research and contains language that may offend some readers.

Competing interests

The authors declare that they have no competing interests.

Background

Suicide behavior is a major public health problem (Hernandez Anton., Dominguez Alvarez, Rybak Koite et al., 2021). In the United Kingdom (UK), data from the Office for National Statistics (ONS) details that there were 6,507 recorded deaths by suicide in 2021 (ONS, 2022). For England and Wales only, the most recent ONS (2020) figures indicate that there were 5,224 deaths by suicide. For those under the care of mental health services, there were 1,601 deaths by suicide recorded in the UK in 2018 (The National Confidential Inquiry into Suicide and Safety in Mental Health, 2021).

Prison suicide rates are higher than in general populations (Fazel, Ramesh & Hawton, 2017). In prisons in England and Wales, deaths by suicide are the leading cause of preventable death with male prisoners and they are 3.7 times more likely to die by suicide than the general population while the ratio in female prisoners is 9 times higher than in the general population (Fazel, Ramesh & Hawton, 2017).Research predominantly focuses on individuals who die in prison custody, however in recent years attention has been given to identifying risk factors for suicide and self-harm throughout the criminal justice pathway (i.e., from arrest/detention, to sentencing in court, to incarceration, to release on parole; King et al., 2015; Favril et al., 2020).

The period immediately after release from prison, which is a point of transition, carries increased mortality risk, including increased risk of suicide (Binswanger, Stern, Deyo et al., 2012). A report by INQUEST that investigated the number of people dying during post-release supervision in the UK, found almost 1,400 deaths between 2010/11 and 2016/17 (Phillips & Roberts, 2019). Of the 1,378 deaths, 554 were from natural causes, 401 were deaths by suicide and 229 were awaiting classification. Further, Phillips, Padfield and Gelsthorpe (2018) illustrated that the suicide death rate amongst people on probation was almost nine times higher than amongst the general population. This rate ratio is even higher

for women on probation, who are 30 times more likely to take their own life than women in the general population.

Suicide behavior is often presented on a continuum according to severity: from suicidal ideation, communication of suicidal ideation and intent, to planning suicide, and suicide attempts with varying degrees of lethality (Maris, Berman & Silverman, 2000). There are a range of psychological theories to try to explain the individual transitions from suicidal ideation to suicide behavior (O'Connor & Nock, 2014). However, despite continued efforts, the field of suicide prevention remains challenging and identifying those at risk provides results that are only slightly better than chance (Franklin et al., 2017). One important way in which the field can be extended is by including those intimately affected by suicide – i.e., individuals with "lived experience" (Maple et al., 2013). Conducting qualitative research with individuals who have made near-lethal suicide attempts will enhance knowledge of what is likely to be effective in preventing suicidal behavior in prisons (Marzano et al., 2016; Walker & Towl, 2016). Interviewing those who have engaged in near-lethal suicide attempts can therefore serve a dual purpose. It provides insights into the suicidal process in a way that is not achievable from analyses of official records or interviews with staff alone. It allows for a richer understanding of the ways in which contributory and protective factors interact (Smith, 2013; 2014; Marzano et al., 2016; Walker et al., 2020).

In the UK there has been a slow movement of academic work to explore and understand how individuals who come into contact with the criminal justice system (CJS), and the families/carers of those these people, manage to tell of their experience of suicidal ideation and behaviors. The limited work that has been undertaken has found that several factors, including prison-related difficulties, past trauma, mental health issues, and relationship problems all contributed to the near-lethal act (Suto & Arnaut, 2010; Rivlin et

al., 2011). The importance of talking to someone – and being listened to – was also a major theme among imprisoned women prisoners (Borrill et al., 2005; Walker et al., 2020).

This study aimed to expand further the qualitative work in this area and to understand the views of those with lived experience of prison and self-harm/suicide within the CJS. As well as this, this study aimed to capture the perspectives of family members of those who had this experience, to explore what the CJS could do to help and improve services for people who are suicidal within this system.

Method

This qualitative work with men, women, and family members/carers was nested in a larger study (XXXX) that used a mixed methods approach, over three work packages, to explore and improve the identification, management and prevention strategies for suicide and self-harm throughout the CJS.

This part of the study used focus groups and was grounded in a realist epistemological framework in which participant responses were assumed to represent reality: realism recognises that there is a real world independent of our experience whilst acknowledging that we are suspended in webs of meaning that we ourselves put forward and that therefore there can be many layers to our reality (Moses & Knutsen, 2007).

Patient and Public Involvement

Patient and public involvement (PPI) was embedded throughout the wider study with input from experts by experience throughout the design, conduct and reporting of the study with service users attending regular steering committee meetings. For the focus group work specifically, we worked with XXXX, a charity that actively recruits, trains, and supports individuals who are in repeat contact with the CJS and a researcher with lived experience of

the CJS led on facilitating the discussions. This ensured PPI was at the forefront of the work, with service user input integral to planning the discussions (i.e., advising on the need for separate male and female groups) and inputting into the distress protocol to safeguard participants in the study.

Participants

A purposive sample (Mays & Pope, 1995) was selected; this is a form of nonprobability sampling undertaken when strict levels of statistical reliability and validity are not required because of the exploratory nature of the research (Kidder, 1981). XXX employed their established networks of experts by experience and service user forums to recruit participants. Participants were recruited from forums in Birmingham, Liverpool, and London. The criteria to invite participants to take part were that they had recent, previous lived experience of the CJS and self-harm and/or suicide or were a family member or carer of someone who had this experience. An XXX researcher made the initial approach to potential participants, using pre-prepared invitation letters and the study information sheet. There were several opportunities to discuss the study with the research team before volunteering to take part.

Twenty-four people expressed interest in taking part, but some were unable to attend the planned dates or changed their mind. In all, 21 participants took part in five focus group discussions, three groups with male ex-prisoners (each with four participants), one group with female ex-prisoners (six participants) and one group of their significant others (e.g., family and friends; three participants, all female). All participants were over 18. No further demographic information was collected from participants to protect their anonymity.

Procedure

The focus groups took place between March and July 2018, in a private meeting room either at the XXX offices in London or a room at a community location in Liverpool and Birmingham. Written, informed consent was given by all participants prior to the start of each group after the information sheet was read aloud. A minimum of two members of staff facilitated each group to ensure the groups ran smoothly and that support for participants was available at all times should it be needed. Facilitators were all female and included a study team researcher (authors XXX and/or XXX) as well as a RDA researcher and involvement lead (an XXX researcher with previous experience of the CJS). All facilitators were experienced qualitative researchers with previous experience of conducing focus groups.

Prior to the discussions, each group began by agreeing basic ground rules (e.g., not talking over one another, giving everyone the opportunity to talk) and took part in a simple ice-breaker task with all in attendance introducing themselves. The study team also provided some context to the wider study and why the research was being conducted.

Each group was facilitated with the aid of a semi-structured topic guide. This was developed based on the literature as well as learning from previous phases of the larger study, with input from service users and XXX. The topic guide explored service users' general experience of suicide and self-harm in the CJS and key relationships in this environment, the process of risk identification, examples of good practice, barriers to suicide prevention and thoughts on improvements to risk management and care. Although questions and prompts in the topic guide were used to keep discussions focused, the discussions were allowed to flow as naturally as possible and at the direction of participants. The discussions ranged between 60 and 90 minutes and were audio recorded by two encrypted Dictaphones. Field notes were taken by facilitators who were not leading the discussion to aid in reflexivity and the data analysis process

Refreshments were available to participants throughout the discussions and travel expenses were reimbursed. No support was required by participants during or after any of the focus groups, but all received a follow-up call by RDA the day after the group had taken place to ensure their wellbeing. In addition, information sheets and debrief forms also contained signposting for further support if required.

Data analysis

All group recordings were transcribed verbatim and anonymised by administrative support at RDA. Thematic analysis was chosen as appropriate because it is a well-established and flexible research tool for describing, analysing, and reporting themes and patterns in data (Braun & Clarke, 2006).

Data was analysed inductively and recursively in accordance with Braun and Clarke's (2006) recommended stages for good quality thematic analysis. Firstly, the third author (BJD), an independent, external researcher who had qualitative expertise (that had not been involved in data collection) familiarised himself with the data by reading and re-reading the interview transcripts and noting down on paper initial thoughts and ideas. These interesting features of the data were then coded systematically across the data set, using the software NVivo (QSR International, 2015). Codes were then collated into potential themes by gathering data from each code relevant to the potential theme. As a method of quality control and to ensure consistency, the themes that had been created were then reviewed collaboratively with the first and second authors (i.e., the researchers present during data collection). This took the format of a collective analysis session to check themes were reflective of both the individual coded extracts and the overall data set; this included reflection on the field notes gathered during the focus groups. Finally, individual themes and the overall final narrative of the analysis were refined and clear definitions and names for

each theme generated by the first three authors, which were supported by specific excerpts from the data.

Reflexivity

There are some issues worth reflecting on that may have had bearing on the planning, conduct and reporting of the focus group discussions. Whilst recruitment of service users via existing networks and forums within XXX ensured participants had the appropriate lived experience and were supported at all stages of the research, it is also possible that this existing connection factored in their decision to participate and the reflections they shared. In addition, the groups were facilitated by experienced suicide and qualitative researchers so there were likely expectations on what might come up which may have influenced how questions were phrased and followed up. This will perhaps have been somewhat mitigated by more than one member of staff conducting the groups and the fact that the team were able to reflect on each discussion before the next. However, it is important to acknowledge the presence of more than one researcher and those external to XXX may well have affected what participants were willing to disclose.

Ethics approval

The study had ethical approval from the XXX

Results

Three themes were created: 1) The importance of staff knowing my history, 2) Being treated as an individual and 3) Being able to express vulnerability. Quotes are provided to provide context and meaning of the themes.

Theme 1: The importance of staff knowing my history

This theme centered around the importance of prison staff knowing an individual's history from the very beginning of their sentence, or period on remand. This included prior awareness of an individual's suicide/self-harm risk before they arrived. Participants across all focus groups felt that existing processes available for the assessment and prevention of self-harm/suicide were insufficient within the CJS. This included talking about the importance of early mental health assessment:

> *When you're at the police station, you should be spoken to by psychiatric services, and psychological services. That's where the assessment needs to happen.* (Men's focus group No. 3)

It was felt that communication between services, particularly between prison and mental health services, needed to be more efficient in order to aid risk assessment. Male participants in one focus group said that prisons had insufficient information available regarding the suicide/self-harm histories of individuals, although this information is highly relevant to assessing risk:

> *Crisis teams, intervention, being seen and sectioned for seven days and all that information that's meant to be in your care plan and you're arriving at reception in a prison and they don't know.* (Men's focus group No. 3)

Participants in all the focus groups felt that assessment of suicide and self-harm risk at prison reception could be more thorough:

I don´t think it´s easy to say how that person was feeling before they attempted to take their own life. They´re already at that place when they go through those gates, so I think there has to be a more in-depth assessment done. (Women's focus group)

If you've got say 19 inmates coming in, if it takes you all night to assess them, assess them properly. (Family focus group)

You know, they don´t look at your history like. All they look for is the badness you´ve done. You´re getting locked up. (Men's focus group No. 2)

Male participants thought that thorough risk assessment should include prisoners being directly asked about suicide and self-harm at reception:

I think they need to ask you immediately before they put you behind the door…they need to highlight them kind of things from the beginning. (Men's focus group No. 3)

All participants suggested that openness from people in prison could be encouraged by actively discussing suicide and self-harm and having a conversation about what support was available. To enable this to happen, participants felt that prison staff needed more awareness training to be able to understand and identify risk:

The staff should be trained. They shouldn't just be getting anyone filling these jobs. (Family focus group)

They´re [staff] not trained for that. They can´t see it. They think we´re just naughty or we´re just being bad and they shut the door on you. (Men's focus group No. 1)

Participants in the women's focus group also felt that awareness training needed to extend to people in prison, to empower them to understand and manage risk:

I genuinely think there needs to be more adequate training for everybody. Not just the officers but for the girls [female prisoners] as well, who want to get involved. (Women's focus group)

Theme 2: Being treated as an individual

This theme primarily explored the feeling of deindividuation whilst being in prison and how this linked to experiences of suicide and self-harm. Throughout the focus groups, conversations tended to move towards the need to be treated as an individual, and how support and treatment in prison needed to be person-centered. Some positive experiences were also described. Male participants in two focus groups described good experiences they had had in custody, and how this was able to contribute to a conducive atmosphere in which difficult conversations about thoughts of suicide and self-harm could then be explored:

And it was just feeling I was treated like a human being Call me by my first name, they name me [name], what's your name [name given], and it's just a completely different atmosphere. (Men's focus group No. 3)

He was just completely different. Mr [name], he was like, he´d just sit there and listen to you. See what you needed and what he could do for you. (Men's focus group No. 2)

There was, however, an overall perception amongst participants throughout all of the focus groups that they were *not* being treated as individuals in prison. Instead, it was felt that a collective 'prisoner' label existed and that individual identities had been removed. This made it extremely hard then to discuss suicide and self-harm:

> *You´re just a number and you´re not a name. Your name goes as soon as you go in there. You´re just not nothing anymore.* (Women's focus group)

> *I used to say, they started to call me X* and I said, 'I'm not X*, I'm Mrs X*, that's my name, Mrs X*'.* (Family focus group)

The family group also discussed the issue of prisoners not being seen as individuals, feeling that staff focused on the procedural aspects of their role with limited time to speak to prisoners about suicide and self-harm issues:

> *Dinner, open up, shut the door, end of story. They don't talk to you, they don't talk to you as a human being.* (Family focus group)

One participant in the women's focus group remarked that support for self-harm was not individualized, and the same interventions were provided:

> *It´s like when I did start the self-harming…they offered me a [distraction] pack and I looked at it and I said, ´what´s one of them? ´a tinkerbell f**king colouring and a bracelet. ´honey, i´m f**king 27, not f**king 7. How´s that going to stop me self-harming?* (Women's focus group)

Theme 3: Being able to express vulnerability

This theme involved participants' desire for human connection, and the difficulties of expressing vulnerability or asking for help when feeling suicidal within a prison environment. Feelings toward the support systems in place were mixed and lack of trust was a concern. Some male participants felt that their individuality had been removed through imprisonment and the expression of vulnerability was difficult. However, the importance of human connection in preventing both suicide and self-harm was evident throughout focus groups. A perception of a 'them and us' culture compounded difficulties in expressing vulnerability:

> *Well, when I was in prison, I was like, feeling suicidal, I just wouldn´t tell them* [staff]*...it´s something you don´t do when you´re in prison.* (Men's focus group No. 2)

Male participants and those in the family group described general prison culture as being non-conducive to expressing vulnerability, leading to problems with the disclosure of information regarding risk:

> *The thing is, you don´t want to be on suicide watch, because you get mugged off* [made a fool of]*, classed as vulnerable, and you get even more aggro* [aggression]*...so you wouldn't ever tell anyone.* (Men's focus group No. 2)

In addition to prison culture, one male participant described the physical environment as a barrier to developing enough trust to share vulnerability with others:

> *There are very little opportunities or spaces within that environment to connect with another person and honestly share your vulnerabilities, because it´s often taken as a weakness.* (Men's focus group No. 1)

Consequently, all participants recognized the importance of support being provided by a neutral source. Voluntary sector support and peers with lived experience were frequently highlighted:

> *You need a third party that´s no connection to jail. No connection to courts. No connection to the police. Nothing, a third party, lived experience.* (Women's focus group)

Male participants talked about their experiences of having been supported by fellow prisoners:

> *He [prisoner] helped me… I opened up to him one night. You sort of just lie on the bed and talk through the pipe [air vent] and I was telling him and he helped me. He sort of got me out of it. Of all people. Padmate next door.* (Men's focus group No. 2)

Discussion

The present study aimed to explore the views on what the CJS can do to help and improve services for people who are suicidal while in this system. Thematic analysis revealed three main themes. The first of these themes – *staff knowing my history* – is consistent with well-established and persisting difficulties with the transfer of information within the criminal justice pathway, from police stations, through courts and into prisons (Samele et al.,

2018). Lack of information in specific cases may be part of an overall picture that leads to harsh individual judgments being made, particularly when this is combined with deficiencies in training and sub-cultural approaches to self-protection and coping amongst prison staff (Kenning et al., 2010; Walker et al., 2017).

The second theme – *being treated as an individual* – is consistent with a large body of pre-existing sociological literature which describes what happens when normative individual behavior dissipates within larger groups (Vilanova et al., 2017). People in prisons, who are detained, are particularly vulnerable to these institutional effects and, therefore, it is necessary to ensure that stringent safeguards are in place to ensure that their rights are not overly eroded (Forrester & Piper, 2020). Older people in prison may particularly struggle with issues relating to self-esteem and identity (Haesen et al., 2018), and it is likely that wider issues relating to the concept of de-individuation are on a continuum with, and related to, issues regarding staff desensitization, with lack of resources and support (Walker et al., 2017; Marzano et al., 2012).

The third theme – *being able to express vulnerability* – can also be a problem in desensitized prison systems in which self-harm and suicidal emotions are minimized (Sweeney et al., 2018). It may reflect wider problems in the provision of support for staff working in prisons (Walker et al., 2017), although for some prisoners the provision of peer support can have a beneficial role to play (South et al., 2016).

It is important that the findings from this research contribute to improved methods for managing suicide risk within prisons, given persistently high rates in the general community, and even higher rates in prisons and the wider CJS (ONS, 2020; Phillips & Roberts, 2019). From a clinical perspective, it is apparent that people in the CJS want and need to be treated as individuals, and that such treatment forms a substantial gap in their present experience. While it is encouraging that this remains a key part of the English strategy to prevent suicides

(HM Government, 2021), concerns regarding the delivery of a person-centred approach in prisons persist. In a recent review of the Assessment, Care in Custody and Teamwork (ACCT) process, numerous issues were identified that were broadly consistent with the findings of our research: staff struggled to find sufficient time to fully engage with prisoners in addition to their other duties, meetings were often not multidisciplinary or organized as they should be, additional training was thought necessary, and prisoners were concerned about lack of confidentiality (Pike & George, 2019). While it is clear that this strategy is an ongoing piece of work, it will be important to understand how prison and healthcare staff can be better brought together through joint meetings to help with the provision of integrated care, to therefore ensure that people in prison are managed optimally.

Strengths and limitations

A notable strength of this paper is the inclusion of men and women with prison experience, and inclusion of families of those who have been in prison, unlike previous qualitative studies in this area. This provides snapshot insights from across the prison population. Further, the purpose of qualitative research is not to generalize from the results, but to transform and apply them to similar situations in other contexts (Polit & Beck, 2004). It is important to note that this interpretation is only one of many possible interpretations and the findings in this study should be viewed as one voice in a continuing discourse.

The study may be limited by its retrospective design. Time elapsed since being in the prison could have influenced what participants recall about their experiences as they are no longer actively experiencing self-harm and suicidal thoughts in the prison context. A level of member checking was used in the study as the XXX were provided with details of the findings to feedback on as appropriate, but this could have been conducted in a more structured and detailed manner. Further the diversity of the sample could be improved as the

XXX completed to ensure recruitment was appropriate and these participants were 'known' service users, used to taking part in XXX research and not necessary representatives of service users more widely. If the study was undertaken again if may be useful to include prisoners while they are incarcerated too as their experiences may differ notably than ex-prisoners. It should also be noted that the family group were difficult to recruit too, and this is worthy of future research.

Recommendations

Arising from this research, we make four core recommendations. The first relates to improved connections across teams, with clinicians working in different parts of the CJS to promote continuity of care and the quality of information flow. This is in keeping with existing recommendations within the Corston (2007) and Bradley (2009) reports and they should now be fully implemented.

Our second recommendation is to mitigate institutional deindividuation effects by ensuring and prioritizing the provision of reflective inquiry amongst staff groups, to enable institutions to become more therapeutic in their overall approach and therefore more likely to consider each prisoner as an individual. Our third recommendation is the development and use of key individual relationships to help ensure that people are treated as individuals, with safe spaces in which they may be able to reveal vulnerabilities.

Finally, we recommend that brief self-harm/suicidal ideation interventions should be fully embedded across the CJS, with trained professionals available to support this. This could include consideration of safer self-harm strategies, the learning of tailored relaxation and/or distraction techniques and the creation of individualized suicide/self-harm safety plans.

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