Cardiff University School of Social Sciences

Exploring the role of social workers in suicide prevention

Tom Slater

Submitted for award:
PhD

Year of submission:
2014/5

Funder:
National Institute for Social Care and Health Research (NISCHR) Studentship

Word count:
107,073 (including references and appendices)
87,559 (excluding reference and appendices)

Summary

This thesis explores the role of social workers in suicide prevention. Using a mixed methods approach the research examines how social workers understand, and work with, suicidal individuals in multi-agency and interdisciplinary settings. In my first empirical chapter (chapter five) a secondary analysis of the Adult Psychiatric Morbidity Survey (2007) (*n*=7,403) explores the circumstances under which social workers come into contact with suicidal individuals. Using a multinomial logistic regression it has been possible to establish that substance misuse is associated with social worker contact. This suggests that social workers are having contact with a group at elevated risk of suicide.

The second part of the thesis is based on a series of semi-structured interviews with statutory social workers (*n*=17) (chapters six and seven), service users with a history of suicide attempts (*n*=3) and Community Psychiatric Nurses (CPNs) (*n*=3) (chapter eight). A thematic analysis of the interviews found that although statutory social workers had little or no training in assessing suicide, both service users and CPNs believed that social workers have a vital role in supporting suicidal individuals. Social workers found peer learning to be important as both a source of knowledge and learning, and as a support network.

The findings of this research indicate that social workers have particular expertise in taking a holistic approach to suicide assessment and prevention. The Approved Mental Health Professional (AMHP) role is also felt to give social workers a strong knowledge of the legal issues that underpin working with this vulnerable group. However further research into the contact between social workers and suicidal service users and the assessment of suicide is necessary. The findings of this thesis have implications for practitioners, policy makers and researchers.

Dedication

For Christina Mary Slater with all my love; may you finally have found peace x

Acknowledgements and thanks

First and foremost my thanks and gratitude must go to my supervisors, participants and funder (the National Institute for Social Care and Health Research – NISCHR). Without the cooperation of the social workers, community psychiatric nurses (CPNs) and service users this research would not have been possible. Thanks to all those who gave up their time and took part in the research.

A special thanks to my supervisors Jonathan Scourfield and Katy Greenland. It is only with their diligent, patient and thoughtful assistance that I have been able to undertake and complete this work. They have been generous with their time and have proven to be excellent counsel both with this work and wider issues. I am very grateful to both of them for all their support and assistance.

Similarly Trevor Jones, my progress reviewer for the duration of my time as a doctoral student, has provided me with useful advice and input. His kind words of encouragement combined with his insightful questions have helped me to craft the thesis more effectively.

Vicky Parkin and Elizabeth (Liz) Renton have kindly dealt with my constant queries and have always worked hard to ensure that all the doctoral students are well supported in their work. Thanks to both of them for the tireless work they do behind the scenes.

The social work lecturers and support staff at Cardiff University for all the assistance and guidance. Through your support and teaching I have developed the skills needed to undertake this thesis. The opportunities to teach and undertake other pieces of work in the department are greatly appreciated.

Erin Roberts has been a source of great support, putting up with my moments of self-doubt and being a sounding board for my work. Thanks for putting up with me during periods of frustration and stress, not sure I could have completed this without your help.

Thanks to Holly, Josh, Lisa and Russell Dobbins, without whom I would not have come to Cardiff or have had the opportunity to take on either my Masters or

Doctorate. Thanks to Holly for always being there when I needed help and for everything that you did to support me.

My own family have been supportive throughout the course of the PhD and have helped me whenever needed. Thank you for being there. A special thanks to my sister for being there to listen and support me whenever needed.

Many thanks to friends and colleagues throughout SOCSI who have supported me and helped me throughout my time in the department; especially to Victoria Silverwood, Suzanne Spooner, Gareth Thomas, Esther Muddiman, Richard Bloor, Louise Roberts, Mengle Zhang, Luke Sloan, Heather Ottoway, Sally Holland, Dolores Davey, William (Aled) Jones and Sin Yi Cheung.

Finally I must also thank my former colleagues in Caerphilly County Borough Council and my current colleagues in the National Society for the Prevention of Cruelty to Children (NSPCC) for their encouragement and support.

Contents

Exploring the role of social workers in suicide prevention i

Declaration ii

Summary iii

Dedication..... iv

Acknowledgements and thanks v

Contents vii

List of figures and tables xiv

Chapter 1 - Introduction 1

Chapter 2 – Understanding suicide 5

2.0 - Introduction 5

2.1 - Literature review strategy 5

2.2 - Suicide – What constitutes suicide? 7

2.3 – Explanations of suicide 10

Sociological explanations of suicide 10

Psychological explanations of suicide 11

Biological explanations of suicide 12

Lay explanations of suicide 13

2.4 - Suicide as a health and social care issue – what should social workers know about suicide? 14

2.5 - Suicide prevention 17

School-based interventions 18

Risk identification 18

Restriction of access to means of suicide 19

Psychosocial treatments 20

Pharmacology and lithium 21

Helping the bereaved 22

Social work interventions 22
2.6 - Conclusion 25
Chapter 3 – Social work and suicide prevention 27
3.0 – Introduction 27
3.1 - What is social work? 27
Who do social workers work with? 28
What do social workers 'do'? 31
Social work as a welfare profession 33
The social worker-service user relationship 36
Summary 38
3.2 - Interdisciplinary and multi-agency working 39
3.3 - Social work and suicide prevention – What do we know?.....41
3.4 – Attitudes to suicide in other professions 46
3.5 – Conclusion 48
Chapter 4 – Methodology, ethics and access.....50
4.0 - Introduction 50
4.1 – Methodology.....51
Nature of the research and suitability of research methods and theoretical relevance of chosen methods 53
Why conduct secondary analysis of a general population survey (relative merits and limitations)? 53
Why interviews? 55
Making triangulation work 57
Reliability and validity or credibility and dependability? 58
Summary 62
4.2 – The 'foreshadowed problem' 63
Through the looking glass – My personal experience of suicide.....63
Negotiating roles – Social worker versus researcher 64
Reflection on researcher identity – my personal and professional journey through the research data collection and analysis 66

Summary 68

4.3 – Ethics 69

The Research Ethic Committee (REC) – effective safeguard or bureaucratic leviathan? 69

Confidentiality versus duty of care 70

Informed consent 71

Exclusion and inclusion criteria 72

Data Protection 74

Ethical issues in the field (situated ethics) 75

4.4 – Gaining Access 76

4.5 Sampling and data analysis 77

Data Analysis 80

4.6 - Conclusion 84

Chapter 5 – Under what circumstances do social workers come into contact with suicidal individuals? 85

5.0 - Introduction 85

5.1 - Context 85

5.2 - Method 87

Data set selection 87

Data set information and sampling technique 89

How has the data set been previously used? 89

5.3 – Question 1: Can a significant relationship be identified between suicide and social worker contact? 90

5.4 - Question 2: Under what circumstances do social workers come into contact with suicidal individuals? 92

Question 2 - Selection of dependent variables 92

Question 2 - Independent/predictor variables 93

Question 2 – Model fit 100

5.5 – Findings 102

Question 2 - Introduction 102

Question 2 – Findings: Non-significant independent variables (part 1).....103

Question 2 – Findings: Suicide attempts (part 2) 104

Question 2 – Findings: Social worker contact (part 3). 107

Question 2 – Findings: Social worker contact but not suicidal, and suicidal, but no social worker contact (part 4) 108

Question 2 – Summary of findings. 110

Chapter 5.6 - Conclusion.....111

Chapter 6 - How social workers understand suicide and the social worker role in multi-agency and interdisciplinary working 114

6.0 - Introduction 114

6.1 – How do social workers understand suicide and suicidal behaviour?.....116

Suicide as a multi-faceted issue.....116

Social factors 117

Biological and psychological factors 119

Suicide as an inevitable act 121

Formal training in suicide prevention 125

Initial social work training 125

Continuing Professional Development (CPD) 126

Approved Mental Health Professional (AMHP) Training.....130

Informal learning 131

Summary 135

6.2 - What approaches to assessment are currently used by social workers? To what extent does research evidence impact on the practice of social workers in this context?.....135

Types of assessments 136

Assessments under the Mental Health Act 139

Asking the question….....142

Summary 143

6.3 - Conclusion 143

Chapter 7 – Interviews with social workers: What role(s) do social workers have in suicide prevention? 147

7.0 – Introduction 147

7.1 – What roles are currently played by social workers in suicide prevention? Do social workers have a distinct role in suicide prevention, or has the increase in multi-agency working blurred the roles of different professionals? 148

7.2 - Social work diversity 148

7.3 - Multi-agency and interdisciplinary working 153

7.4 – What sorts of social care provision are available to suicidal service users and what is the nature and frequency of their engagement with these services? 160

7.5 – How are social workers supported when working with suicidal service users? 165

7.6 – Conclusion 171

Chapter 8 – The role of statutory social workers in suicide prevention: Community Psychiatric Nurses (CPN) and service user perspectives. 175

8.0 – Introduction 175

8.1 - The Community Psychiatric Nurse (CPN) perspective on the role of statutory social workers in suicide prevention 177

8.2 - The CPN perspectives on social workers in interdisciplinary and multi-agency settings 177

8.3 – The CPN perspective on the role(s) social workers play in suicide prevention 183

8.4 – The CPN perspective on the approaches used by social workers in their work with suicidal people 187

8.5 – How do suicidal people perceive the role of social workers in suicide prevention, particularly where the workers are located in multi-agency and/or interdisciplinary teams? 190

8.6 - Service user experiences of suicidality 191

8.7 - Understanding the relationship between statutory social workers and service users with a history of suicidality 197

8.8 - Interventions by statutory social workers in suicide prevention, the service user perspective 204

8.9 – Conclusion 206

Chapter 9 – Conclusion 208

9.0 - Introduction 208

9.1 - Findings 209

RQ 1 – In what circumstances do suicidal people come into contact with social workers? 209

RQ 2 – How do social workers understand suicide and suicidal behaviour? 211

RQ 3 – What approaches to assessment are currently used by social workers and to what extent does research evidence impact on the practice of social workers in this context? 213

RQ 4 – What roles are currently played by social workers in suicide prevention? Do social workers have a distinct role in suicide prevention or has the increase in multi-agency working blurred the roles of different professionals? 214

RQ 5 – What sorts of social care provision are available to suicidal service users and what is the nature and frequency of their engagement with these services? 218

RQ 6 – How are social workers supported when working with suicidal service users? 219

RQ 7 – How do suicidal people perceive the role of social workers in suicide prevention, particularly when situated in multi-agency/interdisciplinary teams? 220

9.2 - Limitations of my research 221

9.3 - Research implications 223

Further research 223

Policy 225

Practice 228

9.4 - Final words 229

References 230

Appendices 274

Appendix A: Search of databases for literature on social workers in suicide prevention and associated interventions.....274

Appendix B: Consent Form for Professional.....276

Appendix C: Consent Form for Service Users 284

Appendix D: Interview schedule 292

List of figures and tables

Figure 1 – Reference category in dependent variable ……...……..95

Table 1 - Validity and reliability or credibility and dependability (adapted from Shenton, 2004)……..…60

Table 2 - Cross tabulation of ‘seen a social worker in the last year’ by ‘ever made an attempt to take own life’……..91

Table 3 - Variables included in model……98-99

Table 4 - Classification table – Model ability to predict cases correctly……101

Table 5 - Significant predictor variables for value (2) lifetime suicide attempt and social worker contact in last year……105

Table 6 – Significant predictor variables for value (4) lifetime suicide attempt, but no social work contact in last year……106

Table 7 – Significant predictor variables for value (3) never having attempted suicide, but have had social worker contact in last year……108

Table 8 – Breakdown of participants……...…115

Table 9 – Search of databases for literature on social workers in suicide prevention and associated interventions…….. ……274

Chapter 1 - Introduction

In 2011, there were 6,045 recorded suicides in the UK (ONS, 2013); over three times the number of deaths from road accidents for that year (DFT, 2012). Suicide is an important area of preventable death (WHO, 2004). Whilst there has been a general downward trend in rates of suicide in the UK over the past fifty years, the recent economic downturn has, unfortunately, led to a rise in the number of suicides in England (Barr *et al.,* 2012) and across Europe (Stuckler *et al.,* 2011). The commitment to reducing suicides in the UK is evidenced by the introduction of national suicide prevention strategies in all of the home nations (Department of Health, 2012; Department of Health, Social Services and Public Safety Northern Ireland, 2012; Scottish Government, 2013; Welsh Government, 2008). These strategies emphasise the multifaceted nature of suicide and subsequently the need for multi-agency responses.

Despite the implementation of suicide prevention strategies, there remains a relative dearth of literature in social work exploring both the role social workers play in suicide prevention and the techniques they use to assist those who are suicidal (Joe and Niedermeier, 2008). Feldman and Freedenthal (2006) have noted a lack of training for social workers in suicide prevention, perhaps indicating a divide in the priorities of policy makers, researchers, and potentially professionals.

The lack of research into the role of social workers in suicide prevention is particularly surprising, given suicide's well-established association with social issues such as deprivation (Whitley *et al.,* 1999), social fragmentation (Rehkopf and Buka, 2006) and unemployment (Platt and Hawton, 2000). Further to this, suicide has also been a topic of considerable sociological intrigue (Stack, 2000a; 2000b). As a discipline focused on promoting the importance of social factors, it is it likely that such discussions would be of great relevance to social workers, yet it is unclear how much social workers engage with these debates.

This gap in our knowledge seems even more surprising, given that social workers have been afforded roles and responsibilities in Mental Health legislation in England and Wales. Approved Mental Health Professionals (AMHPs), previously known as Approved Social Workers (a role exclusive to the social work profession), are instrumental in the process of detaining a person for assessment and/or treatment if they are felt to pose a risk to their own safety or if they pose a risk to others. Social

workers are therefore likely to come into contact with suicidal individuals, but the circumstances of that contact remain largely unknown.

Currently we know little about how social workers understand suicide; under what circumstances they come into contact with suicidal individuals; how they assess and assist suicidal individuals; or even how they perceive their role in preventing suicide. The purpose of this study is to address these concerns. The aims of this study are:

- To gain an insight into how social workers understand suicide
- To describe the role(s) currently played by social workers in suicide prevention

To meet these aims I will address the following research questions (RQs), each of which focuses on a different aspect of the role(s) social workers play in suicide prevention:

RQ 1 – In what circumstances do suicidal people come into contact with social workers?

RQ 2 – How do social workers understand suicide and suicidal behaviour?

RQ 3 – What approaches to assessment are currently used by social workers? To what extent does research evidence impact on the practice of social workers in this context?

RQ 4 – What roles are currently played by social workers in suicide prevention? Do social workers have a distinct function in suicide prevention or has the increase in multi-agency working blurred the roles of different professionals?

RQ 5 – What sorts of social care provision are available to suicidal service users and what is the nature and frequency of their engagement with these services?

RQ 6 – How are social workers supported when working with suicidal service users?

RQ 7 – How do suicidal people perceive the role of social workers in suicide prevention, particularly when situated in multi-agency/Interdisciplinary teams?

In order to address the research aims and answer the research questions, the thesis will be structured as follows: chapters two and three consist of literature reviews of the research available on the role of social workers in suicide prevention. The literature reviews draw on research and information from the fields of sociology, suicidology and social work. In chapter two I contextualise this study amongst the

existing research in the field of suicidology and draw on wider sociological debates. The chapter ends by exploring what existing knowledge we have about the role of social workers in suicide prevention. Chapter three explores the diverse and at times contested nature of social work. Here I explore how interdisciplinary and multi-agency working poses challenges and opportunities for the social work profession: themes that underpin the role of social workers in suicide prevention.

Having identified the gaps in the existing research and wider literature, I set out my research strategy (chapter four). To answer my research questions effectively, a mixed methods approach has been employed, with methods being selected based on how they best address the research questions. Two methods have been employed in this study, taking the form of separate, but theoretically linked studies. In chapter four a methodological overview of my mixed methods approach is provided and ethical issues are discussed. A detailed examination of my primary research methods is also provided.

Chapter five[1] describes a secondary analysis of the Adult Psychiatric Morbidity Survey for England (2007) (*n*=7,403) using a multinomial logistic regression. This analysis explores the circumstances under which social workers come into contact with suicidal individuals. Variables, informed by my literature review, were used to explore what factors were significant in both social worker contact and suicidality.

In chapters six, seven and eight I explore the findings from my primary qualitative research, a series of semi-structured interviews with three stakeholder groups: social workers employed in agencies (i.e. Local Authority Social Services Departments) (*n*=17), Community Psychiatric Nurses (CPNs) who work alongside social workers in Community Mental Health Teams (CMHTs) (*n*=3), and service users with a history of suicidal behaviour (*n*=3). The findings from the social worker interviews are divided between two empirical chapters (chapters six and seven). Through these interviews I have been able to gain an insight into how social workers understand suicide and the training they receive in how best to prevent suicide (chapter six). The services and resources available to social workers to support suicidal service users are examined as well as the effects of multi-agency and interdisciplinary working (chapter seven).

---

[1] This chapter formed the basis for a forthcoming publication; Slater, T. Scourfield, J. and Greenland, K. (2013), Suicide Attempts and Social Worker Contact: Secondary Analysis of a General Population Study, *British Journal of Social Work*, Online advance access.

The perspectives of the CPNs and service users are explored in my final empirical chapter (chapter eight). CPNs working alongside social workers are able to provide an important insight into the tensions and benefits of working with social workers when service users are suicidal. In the second half of the chapter the service user perspective is examined. Here it has been possible to seek a perspective of the role(s) that social workers undertake in suicide prevention from some of those in receipt of their assistance.

Finally in chapter nine, I conclude by bringing together the findings from the different empirical chapters to provide a coherent understanding of the role(s) of social workers in suicide prevention. The limitations of the study and main implications for future research, policy makers and practitioners are also explored.

Chapter 2 – Understanding suicide

> [Suicide is] one of those patently self-evident terms (...) Every adult knows instinctively what he means by it; it is the act of taking one's life…
>
> (Schneidman, 2004:6)

2.0 - Introduction

In order to gain an understanding of the role of social workers in suicide prevention, it is necessary to draw on literature from a range of different fields (sociology, suicidology, and social work). To do this, I have divided my literature review across two chapters (chapter 2 and chapter 3). In this chapter, I explore the topic of suicide, contextualising my thesis amongst the existing research and exploring the current knowledge available. My strategy for reviewing the literature is also to be found in this chapter. In chapter three, I examine what constitutes social work and what knowledge exists about the role of social workers in suicide prevention.

This chapter is divided into six parts. The first part (section 2.1) sets out my strategy to reviewing the literature. In the second part (section 2.2), I problematise the concept of suicide and explore the variability of the concept. In the third part (section 2.3) the different explanations of suicide (sociological, psychological, biological and lay person) are examined. In section 2.4 I explore suicide as a health and social care issue, before discussing how suicide can be prevented in section 2.5. Finally, in section 2.6, I explore the strategies and techniques for preventing suicide.

2.1 - Literature review strategy

Before I start to review the existing literature, it is necessary to set out my approach to conducting the literature review. Exploring the role of social workers in suicide prevention required me to engage with literature from the fields of sociology, social work, and suicidology. Texts, such as The International Handbook of Suicide and Attempted Suicide (Hawton and van Heeringen, 2000) and the International Handbook of Suicide Prevention: Research, Policy and Practice (O'Connor *et al.,* 2011), were identified to explore the wider literature and to contextualise my work amongst the existing body of research.

After this background reading, a series of specific searches were conducted. Search engines such as Google Scholar and Zetoc were used to look for terms such as ‘social work suicide’, ‘social work and self-harm’ amongst others. Various combinations of phrases and words were used. This was repeated at different points in my research so that new publications could be identified. Relevant journals (such as the British Journal of Social Work, and Suicide and Life Threatening Behaviour) were also identified. These provided information on contemporary research from relevant research fields. As themes started to emerge from the data, I revisited the literature and expanded my literature review as necessary.

A subsequent systematic search of principle databases, including Applied Social Sciences Index and Abstracts (ASSIA), Embase, Psychinfo and Social Care Online was undertaken to specifically look at suicide and social worker intervention (see appendix A). These searches covered a series of different time frames and geographical areas. The result of these searches have been incorporated into chapters 2 (specifically 2.5) and 3. These searches returned a high number of false positives with returned results displaying items that were of no relevance to the topic area. For example, searches using the term prevention often returned results looking at how social work practice in a variety of different areas can aid with the prevention of numerous social ills. Refinement of the search terms and the search parameters (i.e. time frames, geographical location, etc.) helped to improve the quality of the searches although the frequency of relevant articles remains highly limited.

It was not within the scope of this study to conduct a systematic review of the relevant literature. Further to this, the reader is advised that the coverage of the relevant literature is not exhaustive, as it was not the primary purpose of the study. The focus of the review has been the role of social workers in suicide prevention, primarily in the context of the UK. No attempt has been made to systematically evaluate the methodology of the evidence referenced. However, literature from other regions and nations has been included where it was felt it helped to evidence wider trends, for drawing contrasts between the UK and other nations, or where limited evidence exists in the UK context.

As indicated in the introduction it has been necessary to engage with literature from a variety of disciplines and on a great range of topics. Some literature, such as the historic overview of suicide, has been used to help contextualise and situate this

study amongst the wider literature. The diversity of the literature reviewed means that some topics receive limited coverage.

In part of my literature review I draw on an existing systematic review to help structure my work. Scott and Guo's (2012) review of intervention strategies for the World Health Organisation (WHO) was used to guide my discussion on this issue. The relative merits and limitations of their approach are not discussed in this review instead it simply served as a structure to discuss the existing body of literature. Where I have expanded on their work I have made this clear although it is important to recognise that I have not submitted the additional studies to the same rigorous review.

In summary this chapter and the next (chapter 3) provide the findings from my literature review. I have not undertaken a detailed systematic review of the literature and have not submitted the research to any form of robust methodological evaluation. Literature has been explored and used as they became pertinent to my research.

2.2 - Suicide – What constitutes suicide?

As indicated by Schneidman (2004) at the beginning of this chapter, it might seem strange to discuss what might seem to be a self-evident concept, however under closer scrutiny this term is not straightforward. Durkheim, (perhaps the most well-known sociologist to explore the topic of suicide) uses the example of a person suffering from delusions walking off a great height (1897, reprinted 2002). This act, he contends, would not constitute a suicide, but might be better understood as a tragic accident. Similarly, a person who continues to smoke after being told that doing so will lead to their death might not be considered to be suicidal. To define the act of suicide as the taking of one's life is therefore too broad a definition. How then are social workers (or anyone else) to understand suicide? What, if anything, distinguishes suicide from any other death? How do social workers understand suicide? What can social workers do to prevent suicide? Through the course of this chapter I will examine these questions, starting with a historical perspective.

The etymology of the term suicide is contested. Schneidman (2004) suggests that the word suicide was first used by Walter Charelton in The Oxford English Dictionary of 1651. Others such as Palmer (2008) have drawn on Alfred Alvarez's (a British poet) claims that 'suicide' was used even earlier by Sir Thomas Browne's Religio Medici in 1642 and is derived from the Latin words 'sui, of oneself, and caedere, to

kill; in other words to kill oneself' (Palmer, 2008:11). In antiquity there are multiple accounts of individuals taking their lives, from Socrates's use of hemlock (399BC), to Nero's suicide after the burning of Rome (68AD). Williams (1997) has suggested that at various point in antiquity, the act of taking one's life could be linked to issues of honour. Well known examples include Roman aristocrats taking their lives to save the honour of their family name and to prevent further retribution. Daube (1977) highlighted multiple terms in both Greek and Latin for describing the act of taking one's life: the implication being that such an act can have multiple connotations. For example, distinctions were made between those taking their life as a result of ill health and those doing so after being ordered so by the state.

With the rise of Christianity across the Western world, attitudes slowly shifted from a relative tolerance to a more punitive stance. Building on the notion of suicide as a form of self-murder and therefore prohibited under the Ten Commandments[2], the Council of Orleans outlawed suicide in AD553. This position in England changed again during the 16th Century with the Reformation of the church. Rather than blaming the individual, external supernatural factors were seen to be at fault. For example the Devil was increasingly seen as driving people to take their lives (Williams, 1997). Such attitudes were themselves ultimately challenged by the Enlightenment, and the discourse of religion for understanding suicide gave way to notions of 'madness' (Williams 1997).

Slowly, through a shift in attitudes and gradual legal reform, suicide came to be understood as non-criminal behaviour. In 1961, the common law principles that technically criminalised suicide were removed by the Suicide Act. Subsequent and ongoing debates around the criminality of suicide now focus not on those undertaking the act, but rather those who assist them through euthanasia or assisted dying[3]. Debates around euthanasia continue in both professional (Schildmann and Schildmann, 2013; Seale, 2006) and public arenas (R (Nickleson v Ministry of Justice [2012] EWHC 2381).

The complexity of suicide as a concept can also be seen in the official reported rates of suicide. How deaths are recorded and categorised varies greatly within and across nations, making it difficult to compare data. For example, Cantor (2000) draws attention to Australia where eight different systems for recording deaths exist

---

[2] The sixth of the Ten Commandments being 'Thou shalt not kill'.
[3] Euthanasia will be used as the preferred term from this point.

across the various territories and states. The recording of suicides is therefore far from straightforward. In the UK, coroners' courts[4] are charged with investigating and categorising deaths. All decisions must be made on the premise of being beyond 'reasonable doubt', requiring an open verdict to be returned where there remains any doubt. This means that coroners have a large degree of autonomy in deciding when a death is a suicide or not, and has led to open verdicts being regularly counted as suicide (Linsley *et al.,* 2001; Salib, 1997).

Understanding and defining suicide is further complicated by the complex and blurred relationship between suicide, parasuicide, and deliberate self-harm (DSH[5]). Parasuicide refers to a self-injurious act which has all the characteristics of suicide but does not result in death (the intentionality of the act is not important). DSH is a self-injurious act with no intention of death. There is a complex relationship between DSH and suicide (Kerkhof, 2000). DSH can be considered distinct from suicide but there is also evidence of a strong relationship between DSH and suicide (Hawton *et al.,* 1999; Zahl and Hawton, 2004; and Cooper *et al.,* 2005). Foster, Gillespie and McClelland (1997) estimated that just over half of those committing suicide have a history of self-harming. There are also high levels of parasuicides that precede suicide: for every one suicide there are an estimated twenty to thirty parasuicides (Maris *et al.,* 2000). It is important to note that the relationship between DSH and suicide is a contested issue with some suggesting that self-injury is a maladjusted coping mechanism devoid of any thoughts of death (Adler and Adler, 2011). Skegg (2005) also reminds us that self-harmers are not a homogeneous group. The motivation, methods and meaning attributed to self-harming behaviours can be hugely variable.

In summary, the attitude of Western society to suicide has swung between being punitive and moderately tolerant (Williams, 1997). The meaning of suicide and the way that we record it varies dramatically across time and culture. What we are able to take from this short overview is that suicide is understood through the culture of a society. Society ascribes meaning to the act of suicide, interpreting it differently as social ideas change; so how then do social workers, or anyone else, make sense of suicide?

---

[4] Fatal Accident Inquiries in Scotland.
[5] DSH will be used as the preferred term throughout the thesis.

2.3 – Explanations of suicide

Suicide has benefitted from the ongoing interest of multiple disciplines over a protracted period of time (Giddens, 1966:276). Sociologists, psychologists, biologists, psychiatrists and others have contributed to the discussion with varying levels of convergence and divergence. In order that we might understand how social workers comprehend suicide, it is necessary that we briefly engage with some of these different accounts.

Sociological explanations of suicide

The sociology of suicide has a long history with Durkheim's work (1897, reprinted 2002) often seen as having an enduring legacy (Stack, 2000a; 2000b). Using official statistics, Durkheim examined why rates of suicide varied between nations. His work was characterised by a desire to 'extend scientifically rationalism to human conduct' (Thompson 1982:35) in line with the objectivist tradition of sociology. Viewing social actors as largely passive to external social institutions and social norms, Durkheim focused on two tenets: (i) social integration and (ii) moral regulation (Thompson 1982). Suicides, he reasoned, could be categorised into four distinct typologies: (i) Anomic suicide: a lack, or sudden loss, of social norms (moral confusion); (ii) Egoistic suicide: an a estrangement from social networks; (iii) Fatalistic suicide: an act of an individual who feels confined by the social norms and unable to effect change; and, (iv) Altruistic suicide: a suicide compelled out of a sense of duty towards a group or society (Durkheim 1897, reprinted 2002).

Durkheim's work relied on official statistics that can be problematic (Douglas, 1967). Rather than focusing on social 'rules', as Durkheim did, Douglas (1967) and those following (Atkinson, 1978; Baechler, 1979) have examined the process of how suicide is given *meaning* whether by coroners or anyone else. By examining rich text data (such as diaries and suicide notes), Douglas examined the complexity of suicides. Suicide, he argued, can only be understood through the subjective sense-making of those undertaking the act. External factors, while very real, are interpreted and negotiated by the individual who then responds to these events. Douglas (1967) provides examples of how some suicides can become an expression of atonement, whilst others are characterised by a desire for revenge. Suicides therefore are not just external labels ascribed to the act, but also have subjective *meaning* to those undertaking the act.

Atkinson (1978) provides an alternative approach to understanding the meaning of suicide. Through the use of conversation analysis, Atkinson examined how coroners had pre-existing ideas about what they felt constituted a typical suicide. This affected the factors that they considered and how they interpreted the information available in making a verdict. Essentially, Atkinson established that coroners (and all those party to the process) would construct a narrative of what they believe had happened and contrast this with their own ideas about what they believed constituted a suicide. For example, a coroner (or a social worker) might look for factors that they think are associated with suicide, such as depression. If these factors are present then they may come to believe that a death is a suicide: if they are not present then they are less likely to reach a suicide verdict.

Douglas (1967) and Atkinson (1978) show suicide to be *interactional* in nature; it is a meaningful act that is subjectively interpreted both by those seeking to end their lives, and those left behind. The meanings given to the act of suicide are influenced by wider social phenomena, such as pre-existing beliefs about the morality and nature of suicide, but ultimately they are uniquely personal narratives.

Within the sociology of suicide we are able to see a clear distinction in approaches of the positivist and interpretivist traditions; the former being concerned with a *causal explanation* of suicide and the latter concerned with understanding the *nature* of suicide. The divide between causally *explaining* suicide and *understanding* the nature of suicide has proven particularly divisive amongst sociologists, but other perspectives of suicide also jostle with the sociological accounts.

Psychological explanations of suicide

Early psychodynamic approaches within psychology drew heavily on Freud's work on the 'death instinct' (1920, reprinted 2010), which frames suicide as a form of internal aggression. Suicide is seen as a result of melancholy where we are unable to satisfy the super ego, the moral component of our psyche. Suicide is therefore an expression of moral anguish; in essence it becomes an expression of our internal moral conflict and aggression.

More recently, Williams and Pollock (2000) suggest that there are six factors for understanding suicide: impulsivity, dichotomous thinking, cognitive rigidity, problem-solving, autobiographical memory, and hopelessness. The feeling of *hopelessness* in particular has been found to affect problem-solving: those experiencing such feelings often struggle to identify and engage with problem-solving tasks (Schotte, *et*

al., 1990). Williams and Pollock (2000: 89) suggest that we would do better to conceptualise suicide as a 'cry of pain' because such a model would bridge the divide between suicide and non-fatal suicide attempts. Using the construct of 'escape potential', Williams and Pollock (2000) suggest that less "serious" suicidal behaviours (i.e. "attempted suicide") are an attempt to create escape routes (i.e., when people believe that there is little chance of escape). Conversely "more serious" suicides (i.e. "completed suicides") are undertaken when someone feels defeated. Escape routes can take many forms depending upon the individual's situation: social workers might have some role to play as escape routes.

Thus far I have divided explanations of suicide into two groups, sociological and psychological. This crude division does not represent how interconnected the various explanations for suicide can be. Giddens (1966) has attempted to marry the work of Durkheim and Freud. In what is arguably a forerunner of what was to become his Theory of Structuration (1984), Giddens emphasises the interdependency of agency and social structure. He suggests that Durkheim is correct to assert the importance of social structure, but argues social actors are autonomous reflexive beings (i.e. they are more than just a reflection of social structure).This autonomy takes the form of Freud's ego and super-ego, that is to say the 'rational' parts of the mind that manage the instincts or drives of the id, and the cultural rules that help to govern our behaviour. In making this link between sociological and psychological explanations, Giddens is emphasising the need for dialogue amongst different fields of inquiry, a point that those researching suicide from a biological perspective have also come to recognise.

Biological explanations of suicide

Building on an observed increased susceptibility of familial suicide amongst separated twins (Statham *et al.,* 1998), it has been suggested that some genes are strongly associated with suicide (Roy *et al.,* 1997). This does not mean that a single gene is 'responsible' for suicide, but rather that having particular genes may increase a disposure towards suicide. Roy *et al.,* (2010) stress that while links can be found between genes and suicide, genes are greatly affected by environmental factors. They suggest that traumatic life events (especially in early childhood) affect the stress functions which in turn affect whether genes become 'active'. Genes are therefore linked to suicide, but they do not determine behaviour: they are themselves affected by wider psychological and biological factors.

While great advances are being made in the field of genetics, other biological factors such as the effect of serotonin (Baldessarini and Hennen, 2004) are also associated with suicide. Post-mortem studies of those who have killed themselves have highlighted changes in the prefrontal cortex which result in lower serotonin levels. Lower levels of serotonin can result in impaired decision making and behaviours (Mann and Currier, 2010).

Lay explanations of suicide

The focus so far has been on academic accounts of suicide, but we must also consider what wider public perceptions and understandings of suicide exist. Professional attitudes to suicide are discussed in the next chapter (see chapter 3.4).

We cannot be sure, at this stage, if, or by how much, social workers are engaging with the wider academic debates and so gaining an insight into discourses in the general public might be of great importance. Giddens (1994) discusses how lay and expert knowledge can become interconnected. Lay understandings can come to influence professional practice, as such it is important that public attitudes towards suicide are considered. Essentially these could help inform how social workers understand suicide.

Droogas *et al.,* (1982) noted that suicides are often 'justified' by making reference to the nature of the crisis the deceased was facing. The personal characteristics of the individual were not found to be important in their own right. This assertion that suicides can be 'justified' indicates that there appears to be a need for a death by suicide to be validated by our peers and society at large.

Several different attitudes to suicide seem to exist. Hill (1995) has argued that suicide evokes both pity and outrage in contemporary Western culture, suggesting diversity in understandings of suicide. However, Pompili *et al.,* (2003) suggest that there remains a stigma attached to suicide, that it is in some way abhorrent. These negative views of suicide have previously been linked with religious beliefs (Bill-Brahe, 2000), that is to say suicide is characterised as a 'sinful' act. Other discourses view those completing or making an attempt to end their lives as engaging in a selfish act (Joiner, 2010). Those completing the act of suicide are felt to be 'weak' or unconcerned for the plight of the bereaved.

Negative attitudes to suicide can extend to the survivors (i.e. the relatives and friends of the deceased). Cvinar (2005) discusses how relatives and friends also need to contend with a sense of stigma associated with deaths by suicide. Further to

this survivors have to contend with others questioning how they ‘did not notice’ or failed to act to prevent the death. For social workers, anxieties about service user deaths and the potential repercussions can be, as will be discussed in chapters 6 and 7, very real.

One final interpretation of suicide is seeing suicide as a ‘cry for help’ (Nock and Kessler, 2006). This discourse views those who make an attempt on their lives not because they wish to die, but as a way of getting attention or assistance. Here the intentionality of the act as well as its meaning is called into question.

In summary, suicide is a contested issue with multiple, interconnected and at times competing explanations. Sociological, psychological, biological and lay explanations all offer different understandings of suicide. What knowledge social workers have of these debates, and to what extent they engage with them, will be one of the main areas of inquiry for this study:

How do social workers understand suicide and suicidal behaviour?

2.4 - Suicide as a health and social care issue – what should social workers know about suicide?

The multiple perspectives and explanations of suicide illustrate its complexity, but what knowledge of suicide exists to help social workers in their everyday practice? Given that the territory of social work is to work with the vulnerable (Sheldon and MacDonald, 2009), what knowledge might help social workers to identify those at risk of suicide? In this section I explore what issues are commonly associated with suicide and might be targeted by social workers in their practice.

There is a well-established relationship between socio-economic factors and psychiatric morbidity (Kerkhof, 2000). Links have been made between suicide and social deprivation and fragmentation (Whitley *et al.,* 1999; Rehkopf and Buka, 2006), social isolation (Stark *et al.,* 2011), unemployment (Lewis and Sloggett, 1998; Platt and Hawton, 2000) and divorce (Kposowa, 2000). These studies demonstrate two points: first, social factors can have a pronounced impact on suicide and second, the more marginalised and isolated the individual, the higher the risk of suicide.

Rates of suicide also vary dramatically based on religion, ethnicity, sex, age, and mental health. Durkheim focused specifically on the role of religion in moral regulation, noting that Protestant nations tended to have higher rates of suicide than

Catholic nations (1897, 2002). The importance of religion in suicide continues to be explored and is perhaps best illustrated by the near non-existent reported rates of suicide in Muslim nations (WHO, 2011) although the actual rate of suicide might be much higher). Stack and Kposowa (2011) have demonstrated that religion continues to be an important protective factor against suicide. Clearly, this is something that social workers may wish to explore during their assessments.

In contrast to religion, ethnicity presents a more confused picture. McKenzie *et al.,* (2008) observed that South Asian men were at a slightly lower risk compared to White men, while conversely South Asian women were at slightly elevated risk. The variance is however limited and generally does not seem to be a major consideration in suicide.

While ethnicity does not seem to be a strong factor in suicidality, rates of suicide do vary significantly along gender lines. Currently suicide in the UK is the leading cause of death amongst young males (ONS, 2011), although it should be noted that the highest number of deaths occurs amongst males aged forty-five to seventy-four (ONS, 2012). The methods used in the act of suicide are also divided along gender lines, with males using more violent and lethal methods, such as stabbings and hangings: less lethal methods such as overdosing are more common amongst females (Cantor, 2000; Kerkhof, 2000). Likewis this divide is noted by Canetto (1995) who suggests that men tend to adopt more violent techniques when attempting to take their lives. Canetto suggests that those surviving an attempt on their life might feel they are 'unmasculine' to survive an attempt (and hence the term 'failed' suicide).

Other possible explanations lie in the reporting and recording of suicide. Salib (1997), for example, suggests that female suicide is underreported. The comparatively low rates of suicide amongst women stands in contrast to the high levels of parasuicide (Arensmand *et al.,* 2011; Zahl and Hawton, 2004).

Another area commonly associated with suicide is mental health, although there is considerable variation in the relationship between suicide and different mental illnesses. Depression, perhaps one of the mental illnesses most commonly associated with suicide, also provides a confused picture. Cavanagh *et al.,* (2003) conducted a systematic review of psychological autopies to suggest that 91% of suicides had a mental disorder, with majority of these being depression. However, many of those suffering from depression (Rihmer, 2011, suggests 50%) never make an attempt on their own life, and those under treatment are at greatly reduced risk.

Those most at risk have acute depression and/or are also experiencing manic, depressive or psychotic episodes, with up to 15% completing the act of suicide (Rihmer, 2011).

Unlike depression, the relationship between suicide and other psychiatric diagnoses is clearer. Personality disorder and borderline personality disorders (BPD) are often identified by impulsive and risk taking behaviours such as substance misuse and DSH. The association with these behaviours elevates the risk to 10% of those with BPD dying by suicide (Stone, 1990; Paris and Zweig-Frank, 2001). Schizophrenia has also been shown to be associated with suicide. Those with a diagnosis of schizophrenia remain at elevated risk of suicide when contrasted to the general population: 4.9% of those with a diagnosis of Schizophrenia complete the act of suicide (McGirr and Turecki, 2011). Using psychological autopsies (from the UK), Appleby *et al.,* (1999) indicated that a fifth of all suicides by persons under thirty-five were associated with some form of schizophrenia, whilst McGirr and Turecki (2011) suggest that overall 7% of suicides meet the criteria for schizophrenia, as defined under DSM-IV. This, McGirr and Turecki, suggest is considerably higher than suicides in the wider population indicating that schizophrenia is a risk factor for suicide.

Those experiencing certain mental illnesses are at elevated risk of suicide and as such social workers should be aware of this. Similarly substance misuse, and predominantly alcohol misuse, has been identified as affecting the rates of suicide, particularly amongst the young (Rutter and Smith, 1995). Appleby *et al.,* (1999) found that 33% of suicides amongst those aged thirty-five and under had a primary diagnosis of alcohol and/or substance misuse. This is supported by Pridemore and Spivak (2003), who examined the impact of President Gorbachev's crackdown on alcohol in the former USSR. They observed a 40% reduction in the suicide rate during this period and a subsequent rise once the initiative ended. The use of alcohol and other substances raises the prospect of a 'chicken and egg' debate. Are those suffering from suicidal ideation and poor mental health self-medicating or does substance misuse cause suicidal ideation and poor mental health? Clearly there seems to be a link between suicide and substance misuse, demonstrating the need for social workers across the profession (not just in mental health) to have a role in suicide prevention. Exploring how social workers manage these issues in multi-agency and interdisciplinary settings will be of particular interest.

It is clear that certain variables are closely correlated with suicide and some sub-groups are at elevated risk of suicide. Given that the social work mandate is to work with those in need it seems probable that they will regularly come into contact with individuals who have an elevated risk of suicide. So what do we know about the circumstances under which social workers come into contact with suicidal service users? This is a particularly pressing question given that only a minority of individuals are known to have contact with health and social care services in the year prior to death. Pirkis and Burgees (1998) and Appleby *et al.,* (1999) suggested about 40% had contact within the twelve months prior to death. Data from the National Confidential Inquiry into Homicides and Suicides (NCIHS) suggests that only 28% of suicides had been in contact with mental health services in the year prior to death (NCIHS, 2013).

While there appears to be some debate over what proportion of people are coming into contact with support services, it is only a minority of individuals. This raises questions not only about *who* social workers are coming into contact with, but also questions about who they are *not* seeing. Are there any discernible differences between those who are in contact with social workers and those who are not? To explore this issue in greater depth I will address the following question in this study:

In what circumstances do suicidal people come into contact with social workers?

2.5 - Suicide prevention

The increased recognition of suicide as a major social and public health concern has led to new initiatives aimed at reducing instances of suicide. Recognising the multifaceted nature of suicide, national suicide prevention strategies or plans frequently attempt to coordinate multi-agency responses. Finland first implemented a national strategy in 1987 and their model was highly influential on the subsequent World Health Organisation/United Nations guidance issued in 1996, which advises individual nations on how best to implement their individual strategies.

In the United Kingdom, the creation and implementation of suicide prevention strategies are devolved (Department of Health, 2012; Department of Health, Social Services and Public Safety Northern Ireland, 2012; Scottish Government, 2013; Welsh Government, 2008). Each of these strategies focus on prevention and treatment of suicide, and utilise a combination of both targeted (focused on certain high risk groups) and universal (available to all) approaches to suicide prevention (Rose, 1992). Interestingly, however, none of the UK strategies makes explicit use

of the term ‘social worker’ (although it should be noted that few professionals are specifically identified). Instead, more generic terms such as ‘health care professional’ are used (Welsh Government, 2008). There is a clear preference in all of the strategies for multi-agency and interdisciplinary working. What role(s) social workers have in wider prevention strategies is not readily apparent.

Scott and Guo’s (2012) review of suicide strategies for the World Health Organisation identifies five areas of suicide prevention which I have used to structure the discussion which follows. I will discuss which strategies appear to have best evidence of success, and the relevance of different approaches to social workers. In addition to the work of Scott and Guo I have also added two additional sections that they did not include in their study. First I look at the support afforded to the bereaved by suicide. In the final section I provide a brief discussion on interventions that are or might be used by social workers. This is, as previously indicated, the result of my own searches of numerous data bases (see section 2.1)

School-based interventions

Scott and Guo (2012) noted a large number of school based interventions. Mainly aimed at those aged 12-19, these interventions focused on issues such as raising awareness of suicide, encouraging behavioural change and coping strategies. The impact of these interventions has been to enhance awareness and create more positive attitudes towards those making attempts on their lives, but there is no evidence that these interventions have been effective in reducing suicide rates.

Understanding these prevention strategies may not be directly applicable to social workers in the UK given that social workers rarely work in schools. However social workers do have an important role to play in working with children and families and so knowledge of these interventions may help to inform their practice.

Risk identification

Given the large amount of data on factors known to be associated with suicide it is unsurprising that attempts have been made to predict suicide (Goldstein *et al.,* 1991). These attempts have however often failed to do so with any degree of reliability. Goldney (2000) suggests that this is due to three issues. First, the sheer diversity of variables that might be of relevance make it impossible to account for all factors. Second, it can be difficult to distinguish between a parasuicide and an actual suicide (see section 2.4). Finally, the resilience of an individual to life stressors is highly variable, making it hard to assess the point at which a person might reach

crisis. Even within specific groups that traditionally have higher than average rates of suicide (e.g., war veterans), results of risk assessment have been disappointing. Using data from servicemen and women who have committed suicide, Pokorny (1983, 1993) attempted to produce a model that used history to predict future risk. The results were disappointing, with high numbers of false positives and a failure to identify all those who had committed suicide in the sample data. Bagley *et al.,* (2010), in their systematic review, noted that while several studies had claimed effectiveness in reducing instances of suicide amongst groups identified as high risk (i.e. veterans), limited data made such claims hard to verify. They concluded that while some studies did show promise, targeting high risk groups such as veterans did not automatically lead to a reduction in suicide. This led to some commentators such as Goldstein *et al.,* (1991) to conclude that suicide cannot be predicted, based on our current level of understanding.

Despite the problems with predicting suicide, assessments of suicidality do exist. Beck *et al.,* (1979) created what is commonly referred to as the Beck Suicide Ideation Scale (BSIS). This assessment, and others like it (such as Columbia Suicide Severity Rating Scale; Posner *et al.,* 2008), are not identifying groups at risk in the wider population, but rather focus on the individual.

How widespread the use of scales such as BSIS is in practice is unclear, but their existence suggests that they may be a tool available to social workers. What scales/assessments are used by social workers and how effective they are perceived to be by social workers will be a feature of this study.

Restriction of access to means of suicide

Perhaps one of the best known and certainly one of the most widely discussed topics in suicide prevention is that of reducing access to means commonly used in suicide; especially amongst groups with elevated rates of impulsivity (such as those with personality disorders). Critics of this approach have argued that people at risk will simply substitute one method for another. Scott and Guo (2012) suggest that the effectiveness of the intervention depends on the means involved. For example, Shekelle *et al.,* (2009) found that firearms controls had only a marginal effect on the total number of suicides. Essentially people seemed to be switching methods, although some evidence does seem to exist to suggest that firearms restrictions can be a protective factor for some population subgroups (Scott and Guo, 2012).

In contrast to the limited effect of firearms controls, other approaches to reducing access to means appear to be highly effective. Placing barriers on bridges (Bagley, Munjas and Shekelle, 2011), reducing the lethality of respiratory toxins[6], restriction on media reports of suicide, and limiting access to over the counter medication (in particular paracetamol in the UK; Hawton, 2001) were all found to reduce suicide. In many cases a downward trend could be noted in both the particular method and the overall rate of suicide. In the Welsh Government strategy *Talk to Me* (2008), restriction of means is highlighted as being of particular importance. The strategy recommends that those detained should be 'risk assessed and all potential aids to self-harm/suicide... made safe', and that steps should be taken to 'control the environment' (Welsh Government, 2008:47), the latter point promoting structural changes to buildings and infrastructure where possible.

Psychosocial treatments

Psychosocial treatments constitute a broad category of interventions encompassing therapeutic interventions, such as Cognitive Behavioural Therapies (CBT), through to community-based interventions, such as text message or postal circulars. These strategies send messages out to those who are known to have previously have attempted suicide with details of services. The idea is to encourage them to seek support if they feel they are becoming suicidal. These interventions are often conducted alongside pharmacological interventions, making it difficult to establish their independent effectiveness.

Scott and Guo (2012) noted that many of the psychosocial studies explored the effect of case management (e.g. monitoring and facilitating access to mental health services) and therapeutic interventions (e.g. psychosocial and psychotherapeutic treatments). Here the role of case management was seen as two fold; first it enables patients to be monitored, and second it helped them to access mental health services when needed. The effectiveness of these approaches was however felt to be limited, with no statistically significant difference being identified between the control groups and the treatment groups. The use of what we might term low-intensity outreach services such as text, phone and mail circulars was also found to have little or no effect on reducing suicide attempts (Hawton *et al.,* 1999).

[6] This includes switching from coal gas to natural gas (Clarke and Lester, 1989) and the effect of catalytic converters on the toxicity levels of car emissions (Kelly and Bunting, 1998).

In addition to these low-intensity outreach services we need also to consider the impact of the media in suicide prevention. This is of particular relevance to Wales after a cluster of suicides in the Bridgend area in 2007-9 attracted significant media attention (Boyce, 2011). The 'Werther effect' refers to an increase in rates of suicide (or attempted suicides) as a result of media representation of an individual suicide (Pirkis and Nordentoft, 2011), and has driven policy makers to examine how best suicides can be reported in the media. Imposing restrictions on the reporting of suicide is difficult, but voluntary guidelines can be effective. Mann *et al.,* (2005) point to an Australian scheme in 1987 where the media was encouraged to reduce its reporting of suicides on the subway, which led to a drop in instances of this type of suicide by 80% (Etzersdorfer and Sonneck, 1998). Given the exceptional media attention on events at Bridgend, it is no surprise that working with the media is identified as one of the main objectives in the Welsh Government's *Talk to Me* (2008) strategy.

Scott and Guo's (2012) assertions about the limited effectiveness of psychosocial treatments might at first glance make a depressing read for social workers. Caution should be urged however as their findings were based on rates of completed suicide and they did not examine wider suicidal *behaviour*. We know from the work of Maris *et al.,* (2000) that for every one completed suicide there are many more parasuicides. For example, Harrington *et al.,* (1998) used a randomised control trial (RCT) to establish that social worker interventions (in the form of family therapy and home visiting) following suicide bids by children and young people reduced further instances of suicidal ideation.

The impact of parasuicides on a person's well-being and the cost of treating parasuicide are considerable (O'Sullivan *et al.,* 1999; Palmer *et al.,* 1995). Even if such approaches do not reduce the rate of suicide, they are likely to have a more general impact on individual and social wellbeing. What specific techniques are used by social workers and how effective they perceive them to be will be explored in chapters 6, 7 and 8.

Pharmacology and lithium

Lithium was noted by Scott and Guo (2012) to be particularly effective in reducing instances of suicide amongst those suffering from mood disorders. Highlighting the work by Cipriani *et al.,* (2005), who reviewed the use of lithium in 32 Randomised Control Trials (RCTs), it was concluded that incidents of suicide DSH were lower amongst the lithium treatment groups (Scott and Guo, 2012). While lithium appears

to be particularly effective, it is not the only pharmacological approach that has been effective in suicide prevention. Although not included in the Scott and Guo review, Isacsson *et al.,* (1996) observed that in Sweden there was a drop in suicide which coincided with the introduction of anti-depression medication (such as selective serotonin reuptake inhibitors).

Clearly pharmacology, and more specifically lithium, can be effective in the treatment of suicidality. Social workers are not medically trained and are so are unable to prescribe or assist in the administering of medication. However, they can still encourage service users to take their medication and seek medical assistance for service users when needed. Exploring how social workers practice alongside health care professionals in administering these interventions raises questions about what roles social workers play in preventing suicide in interdisciplinary/multi-agency settings.

Helping the bereaved

One form of intervention given only scant consideration by Scott and Guo (2012), but is highlighted as part of the *Talk to Me* (Welsh Government, 2008) strategy, is that of increased assistance to those bereaved by suicide. This includes supporting families and communities in the aftermath of a suicide. While it might be argued that it is not strictly part of suicide prevention (in that a suicide has already occurred), it might serve to improve understanding of suicide and promote others to seek help. Local authorities and health boards are given lead roles in providing support in these instances, and as such social workers may have a role to play.

Social work interventions

The interventions discussed in Scott and Guo's (2012) review have focused on those with the best evidence base. What emerges from their review is that many of the best validated interventions are those that would not be utilised by social workers. For example, social workers are unlikely to provide pharmacological advice or effect change to built environment (such as installing nets under bridges). While this provides a useful context for understanding how suicide is best prevented, it does not help us to consider the types of interventions that may be used by social workers. To address this I have provided a brief overview of some interventions that are known to be, or might lend themselves to, being used by social workers.

Drawing on some historical studies van Herringen (2000) discusses how social workers have been incorporated into a number of studies looking at the

effectiveness of multi-agency and interdisciplinary services providing outpatient management. The continued monitoring of service users has been one of the cornerstones underpinning the care in the community programme (Gray, 2010; Hoult, 1986). The effectiveness of such monitoring has been discussed by Tyrer *et al.,* (1995) who noted that the close monitoring of vulnerable psychiatric service users led to low levels of disengagement. Additionally it was noted that this was also accompanied by an increase in hospitalisation.

More recent work by Catty *et al.,* (2002) has challenged this, suggesting that regular home visits and a shared responsibility for health and social care reduced the number of hospital admissions. The reduction in admissions is most effective when service users have previously had high levels of hospital care (Burns *et al.,* 2007). While there appears to be some debate about the effectiveness of monitoring in the reduction of hospital admissions, there does seem to be consensus that such an approach can improve engagement with service users who have acute psychiatric conditions. The importance of this approach to intervention is discussed further in chapters 7.4 and 8.2. In order for social workers to monitor service users they need to be well versed in risk assessment and intervention. The central importance of this skill for social workers is discussed further in chapter 3.3.

However, monitoring service users is not the only form of intervention utilised by social workers. Petrakis and Joubert (2013) discuss how an assertive brief psychotherapeutic intervention can greatly aid social workers, and was found to have a significant effect on the psychosocial presentation of service users with suicidal ideation. Similarly, Das *et al*., (2007), reporting on a study in India, observed that interventions delivered by social workers were able to reduce incidents of suicide in young males by focusing on crisis intervention, cognitive therapy and problem-solving skills. While both of these studies focused on specific models that were being validated under stringent settings, it seems social workers might be utilising some forms of psychotherapeutic intervention in the course of their work.

Shaw (2012), in her overview of harm-minimisation, discusses how techniques such as ‘no self-harm’ contract (non-legally binding) and substitution methods can be employed by professionals from a range of backgrounds. The ‘no self-harm’ contract focuses on setting conditions on both the service user and practitioner, outlining their behaviour and expectations. These contracts will often have agreements that the service user will not harm themselves for a given time frame.

The substitution method mentioned by Shaw focuses on minimising harm by substituting harmful activities for non-harmful ones, such as replacing the taking of pills with sweets. Behaviour modifying approaches have been used to manage both DSH and suicide (NICE, 2004). However, Pengelley *et al*., (2008) have noted that this approach is largely underused by professionals. The use of such approaches will be discussed further in chapters 6, 7 and 8.

Summary

In summary, it has been established that multiple approaches have been taken to preventing suicide with varying degrees of success. The two strategies that seem to be most effective are those reducing access to means of suicide and pharmacological approaches (lithium considered particularly effective in cases of mood disorder). Reducing access to means is largely achieved through changes to wider infrastructure, an area where social workers are likely to have little or no role. Instead, social workers are more likely to be providing therapeutic and case management styled interventions. These interventions were noted by Scott and Guo (2012) to be of limited use in reducing instances of suicide, but they may play a wider role in reducing suicide-related behaviours. Gaining an insight into how social workers assess and support service users might help us to understand how such approaches might be improved to help prevent suicides more effectively. Subsequently I will endeavour to address the following two questions in this study.

What approaches to assessment and intervention are currently used by social workers in their work with suicidal people?

What sorts of social care provision are available to suicidal service users and what is the nature and frequency of their engagement with these services?

One final point to consider when examining interventions is the right of the state to intervene in what is arguably a uniquely personal decision to take one's own life. Statutory social workers, being empowered by the state, are at the forefront of this debate. Jenkins and Singh (2000) draw parallels with road safety strategies, suggesting that suicides, like road deaths, are preventable and should be addressed in much the same way. They illustrate how road safety employs structural changes, educational campaigns and emergency services planning to reduce road deaths.

The rather practical justification proffered by Jenkins and Singh (2000) perhaps sidesteps the more complex ethical questions that are likely to plague social workers. With the introduction of the Mental Capacity Act 2005, there is now a legal

framework underpinning the idea that a person's capacity to make an informed choice is both issue and time specific. What is unclear is how issues of capacity are managed in relation to suicide: in instances where a person has the capacity to make an informed choice, social workers seem to face an ethically difficult choice: to support the rights of the individual to make their own decision versus their desire to preserve life. This question also relates to debates about euthanasia. Understanding how issues of capacity translate into suicide prevention, and how these are navigated by social workers in practice, will help us to gain an insight into how social workers understand suicide and their preventative role.

2.6 - Conclusion

Suicide is, as has been discussed, a historically and culturally derived concept with various sociological, psychological, biological and lay explanations. How social workers engage with these debates and what knowledge they use to inform their practice is, as will be discussed in the next chapter, largely unknown. We have seen how numerous factors such as deprivation, mental illness and other issues have been linked to suicide. In the next chapter, I examine how some of these factors are common both to suicide and the service users with whom social workers engage.

The field of suicidology is divided between those who seek to *explain* suicide, through examination of its 'causes', and those who wish to *understand* suicide as a social phenomenon (Stack, 2000a; 2000b). As will be discussed in the next chapter, Pritchard (2006) urges social workers to adopt a holistic approach to understanding suicide by drawing on the biological, psychological and social explanations of suicide. To explore how social workers understand and engage with the different debates, I will not attempt to define suicide. Instead I will ask social workers, and service users, to self-identify instances of suicide. This will allow me to explore what knowledge social workers use to inform their practice and understand suicide.

In reviewing the literature, it seems that the field of suicidology is dominated by a heavily positivist epistemology. In one of the concluding chapters of the *International Handbook of Suicide Prevention*, Hjelmeland and Knizek discuss future research in the field of suicidology, noting an 'almost completely unilateral focus on *explanations* [original italics] of suicide' (2011:603). This, they argue, is due to a reliance on predominantly positivist epistemologies. Going forward, they believe a greater emphasis should be placed on the *understanding* of suicide. To achieve this they advocate a mixed methods approach with both quantitative and qualitative methods

being employed to answer different questions. This will, as is discussed in chapter 4, be the approach taken in my own work.

During the course of this chapter the following research questions have been identified (these are expanded upon in the next chapter):

How do social workers understand suicide and suicidal behaviour?

In what circumstances do suicidal people come into contact with social workers?

What approaches to assessment and intervention are currently used by social workers in their work with suicidal people?

What sorts of social care provision are available to suicidal service users and what is the nature and frequency of their engagement with these services?

Chapter 3 – Social work and suicide prevention

> [Suicide] is one of the persistent anxieties in the field: if we fail to meet the needs of our clients and miss the danger signals, then suicide can be the outcome.
>
> (Pritchard, 2006:181)

3.0 – Introduction

In chapter one it was noted that previous research had generated only scant information about the role of social workers in suicide prevention (Joe and Niedermeier, 2008; Feldman and Freedenthal, 2006). This stands in some contrast to the wealth of knowledge showing the association between various social issues and suicide (Whitley *et al.,* 1999; Rehkopf and Buka, 2006; Platt and Hawton, 2000). The purpose of this chapter is to explore in more detail what social work is and what is known about the role social workers play in suicide prevention. To do this I have divided the chapter into four parts.

In the first part of the chapter (3.1), I examine debates about the nature of social work, exploring who social workers assist and which other professions they work with. Second (section 3.2), I examine the opportunities and challenges posed to social workers through multi-agency and inter-disciplinary working. Third (section 3.3), current research into the role of social workers in suicide prevention is explored. In the final section (3.4) I examine how other relevant professionals have experienced working with suicidal people.

3.1 - What is social work?

Sheldon and MacDonald (2009:3) have suggested that the territory of social work 'is the poor, abused or discriminated against, neglected, frail and elderly, mentally ill, learning disabled, addicted, delinquent, or otherwise socially marginalised up-against-it citizen in his or her social circumstances'; essentially those who might be said to be 'in need'. Yet, as Sheldon and MacDonald discuss, who might be said to be in need has varied across time, social work is often not the sole preserve of social workers. As Thompson (2000) notes everyone from teachers and nurses, through to carers and charity workers claim *to do* social work, so what do we mean

by social work and how are social workers different from any other public service profession?

To explore social work in more detail, I have divided this section into three parts. In the first part, I explore the evolution of the profession, focusing on how it developed, who social workers work with, and the types of organisations in which social workers operate. Second, I examine what social workers do, first by examining the contested nature of the social work profession, and second by highlighting some of the tasks that are associated with contemporary social work practice in England and Wales[7]. Finally I discuss some wider theoretical conceptualisations of welfare professionals, specifically notions of professionalisation are problematised.

Who do social workers work with?

Social work has been described as 'the newest profession' (Younghusband, 1981), which has evolved from historical notions of welfare. In their overview of the history of social work, Sheldon and MacDonald (2008) suggest that the medieval and nineteenth century Poor Laws sought to provide assistance to the 'worthy poor', often in the form of workfare. The premise here was that those worthy would be given assistance, but they would also have to work for this help. Workhouses are perhaps the best known example of a workfare approach to welfare provision. During the latter part of the nineteenth century, organisations such as the National Society for the Prevention of Cruelty to Children and Barnardos were founded. It was also during this period that the first social worker degree course was established at Bristol University in 1896. Despite some minor changes in the first half of the nineteenth century, it was not until the massive social upheaval of two world wars that significant change occurred in the provision of welfare.

The creation of the welfare state after the Second World War (based largely on the Beveridge Report of 1943) focused on the five giant evils[8]. The post-war Labour government introduced major new welfare state institutions such as the National Health Service. Despite this, social work was, as Harris points out, 'an afterthought' (Sheldon and MacDonald 2008:268). For example, the Children Act of 1948 was largely a reaction to the Monckton Enquiry (1945) which advised all Local Authorities to create Children's Committees to safeguard children. Other pieces of legislation,

---

[7] Please note that my primary research is conducted in Wales, but my secondary analysis uses data from England. The reasons for this are provided in chapters 4, 5 and 6.
[8] Squalor, ignorance, want, idleness, and disease.

such as the National Assistance Act 1948, did however help to give some clarity over relationship and remits of health services and social work/care. Local authorities became the main mechanism for the provision of social care during this period. Social workers during this period provided interventions directly, helping with forms, arranging housing, amongst others.

It was not until the Seebohlm Report of 1968 that Social Services Departments were mandated, prior to this local authorities were largely free to meet their duties with whatever structure they preferred. Harris (2008) asserts that this helped to cement a common social work identity, citing the establishment of the British Association of Social Workers (BASW) in 1970. Governments of this period also sought to further clarify the role of social work as a profession with new legislation such as the Chronically Sick and Disabled Persons Act 1970. During this period, social workers were encouraged to work in the community providing interventions directly with service users.

During the 1980s and 1990s, political and economic change led to a fundamental shift in the shape of the welfare state. The Conservative governments of the 1980s and 1990s adopted a neo-liberal approach to economic development, bringing market principles to welfare provision. Private companies and third sector organisations were increasingly incorporated into welfare provision through the creation of internal markets in the health and social care sectors. For example Galpin (2009) referring to the work of Burnham (2001) suggests that the relationship between the public sector, private sector and third sector (i.e. charities) is increasingly permeable with services being provided by a mix of service providers. Since the 1980s there has been a shift in the types of work being undertaken by social workers. Rather than directly providing interventions, social workers have increasingly become ‘care-coordinators’. Increasingly, the primary roles of the social worker have been assessment, crisis-management, and arranging and managing packages of care. In the area of mental health, the impact of community care policies led to a wholesale shift in how services were provided. The use of large psychiatric institutions gave way to care in the community (Lewis and Glennerster, 1996). The role of social workers shifted away from being providers of care, to more of an assessment and case management role (Galpin and Bates, 2009), a point emphasised by the NHS and Community Care Act 1990 which focuses on the need for detailed assessments and care plans.

At the same time as the rise of case management social work there was also a separate drive towards increasing professionalisation (Payne, 2001). A profession is, according to Evetts (2003), a special, or privileged, occupation often characterised by eligibility or entry criteria, such as specific qualifications. A further discussion of social work as a profession is provided in the coming sections.

The professionalisation of social work has continued under the subsequent Labour and Coalition governments and amidst the process of devolution. As a result of the Care Standards Act 2001 and the Regulation of Care (Scotland) Act 2001, all of the home nations now designate social work as a protected title. Formal qualifications and registration with appropriate national bodies are now necessary for practice. For example in Wales, social work courses are regulated by the Care Council for Wales, a body that all social workers must register with.

The process of devolution raises new challenges to social workers in the UK, as policies and legislation become increasingly diverse. An example of this can be seen with the introduction of the Mental Health (Wales) Measure 2010. This Wales-only legislation affords additional rights to those accessing selected services in Wales, such as the right to self-refer back to secondary mental health care services after discharge. The impact of devolution is however still very much in its infancy but as Scourfield *et al*., suggest 'looked at on a global level, the similarities between social work in Wales and England are very obviously so much greater than what separates them' (2008:54).

What we are able to establish from this extremely brief outline of social work in England and Wales is that social change has always impacted on social work, creating and shaping it into a public service profession. The provision of support by wider society to 'deserving' groups is not a modern phenomenon, but the level, form and those deemed worthy of support varies over time.

Social work has evolved from providing assistance to those deemed *worthy* of support to those *in need* of assistance. Social workers now focus on the needs of service users rather than making moral judgements. Those in need can vary markedly from children through to the elderly, those with mental illness to those in financial difficulties. Many of those who might be said to be in need would include some who are at elevated risk of suicide; for example, in chapter 2 those with certain mental illnesses (McGirr and Turecki, 2011; Paris and Zweig-Frank, 2001), substance misuse issues (Pridemore and Spivak, 2003; Appleby *et al*., 1999), and

those that are socially excluded or isolated are all at risk of suicide (Stark *et* al., 2011; Kerkhof, 2000)

Clearly social work would not have emerged in its current form without changes in the relationship between the social and private worlds in which people live. The changing role of the state in our everyday lives symbolises changes in where these social and personal worlds meet. The notion of a universal government-run welfare state providing health and social care would have been unthinkable in the Victorian era largely because it would have been seen as a gross violation by the state in private affairs. Without this wider change in what we accept to be public (that is to say social) issues, social work as a profession would likely have emerged as a very different creature (Harris, 2008; Marston, 2004; Rose, 2000).

In this section I have examined how social work has evolved as a profession and highlighted the groups that social workers assist in the course of their work. The profession has undergone significant change over the last century moving from largely unregulated charity work to a regulated profession often acting as an instrument of the state. As Sheldon and MacDonald (2009) suggest, social workers do work with those in need. However, the perceptions of who constitutes being in need varies across time. Essentially, we can see that social workers have a social mandate to work with those society views as requiring assistance. In what follows it is important to consider what social workers do to assist those in need.

What do social workers 'do'?

We can see that social workers have a mandate to work with those considered to be in need of assistance, and that these are a diverse and changing group of people. What do we know about what social workers do to assist those in need? Payne (1996:17) suggests that 'everyday practice does not require us [social workers] to think about and define the purposes of social work'. While Payne is undoubtedly right on one level, his comments still fail to give us any more idea about the nature of social work as compared to other professions.

Webb and Wistow (1987) explored the nature of social work and suggested that it can be viewed in three different ways; as a force for social change; a force for social control; and a force for maintenance of the current social structure. While these categories might be deemed a little crude, they are useful for highlighting some of the competing demands placed on social work. We need only to look at Humphries (2004) to see that these debates remain an active part of contemporary social work.

Arguing that social workers have become complicit in implementing immigration policies that she feels are largely incompatible with the values of social work, Humphries advocates the need to adopt a more critical perspective that encourages social change rather than acting as a form of social control.

Humphries seems to implicitly suggest that social work is homogeneous in nature with the profession as a whole being seen as at fault. Payne (1996) suggests that we should not see social work as a homogeneous entity. Instead three competing perspectives are outlined by Payne: Individualist reformist – social work 'as an aspect of welfare services to individuals in society'; Socialist Collectivist – social work as empowerment 'promoting co-operation and mutual support'; and reflexive-therapeutic – social work 'facilitating personal growth and self-realisation' (Payne 1996:2).

Taking a slightly different approach, Fish and Coles (1998) suggest that social work is a profession ‘tormented by incompatible views of professionalism’ (2000:9). They argue that social work is divided by two conflicting knowledge bases. The first is a ‘technical’ base which emphasises the use of applying theory in practice and draws on quantitative scientific approaches; and the second a ‘professional artistry’ where theory is derived from practice and understanding rather than prescriptive techniques. The contested nature of the social work profession might at first seem disconcerting, but it might simply reflect the changing mandate of social work: social workers are working on the areas that bridge the public and private spheres, areas that are constantly being negotiated (Gray, 2010).

The diversity of the social work role might be indicative of a plethora of approaches to how social workers understand, assess and intervene with suicidal service users. Similarly, service users may also have different ideas about the roles social workers fulfil. During the course of this thesis I will examine how different perspectives on the nature of social work translate into the role social workers play in suicide prevention.

Despite the complexities surrounding the nature of social work, we are able to gain some insight into the sorts of tasks undertaken by contemporary social workers from legislation, policy, and wider research. Seddon *et al.,* (2010) discuss the introduction and implementation of the Unified Assessment in adult services across England and Wales. Their work clearly highlights the importance of formal assessments as part of everyday practice in contemporary social work. Part of these assessments is to validate the needs of the service user against eligibility criteria (section 47 of the National Health Service and Community Care Act 1990). Working in partnership with

service users, social workers create (or facilitate) care plans that meet the needs of service users based on their individual needs. These care plans often require social workers to refer to, and at times commission, services. For example, a social worker might identify a service user to be at elevated risk of suicide and put in a support package such as a crisis team (a team that works on an intensive basis for short periods of time during a crisis). The crisis team would provide direct assistance to the service user and feedback to the social worker. The social worker would then need to work with the crisis team to determine how long this intervention should last and what further support packages might be needed.

In summary, social workers are charged with working with vulnerable and marginalised groups and are therefore well placed to come into contact with those at risk of suicide. The risk factors associated with suicide seems to have a lot in common to those being in need of social work assistance. However we have yet to explore the social worker-service user relationship. Before exploring this relationship it is first important to conceptualise social work as a welfare profession and examine issues of legitimacy and power.

Social work as a welfare profession

So far the focus has been on the nature of social work and discussions about who social workers seek to assist in the course of their work. We have seen that social workers have a mandate to work with those considered to be in need of assistance. In the last section it was suggested that social work had been professionalised over the past century but how are we to understand this concept? This section will briefly explore social work as a profession and outline some of the complexities associated with this.

As previously indicated, social workers do not have a monopoly on claiming *to do* social work, or to put another way they are not the only caring profession (Thompson, 2000). Nursing, probation, teachers, youth workers and others can all lay claim to being caring professions, but what is a profession?

For Abbott and Wallace (1990) professions are characterised by privileged knowledge bases, a centralisation of expertise, the erection of social boundaries around the profession, specific qualifications for entry, specialist training and mechanisms for self-policing. This definition does however raise the question, how do occupations become ‘professional’?

To become a profession requires legitimacy from those in receipt of services/support and wider society (Foucault, 1979). This legitimacy is not easily achieved, and even when granted not all professions are given equal standing. For example, nursing is seen as having a subservient status to other medical professions (Wallace and Abbott, 1998; Abbott and Wallace, 1990). The strive for legitimacy has been complex for social work, partly due to debates about the role of social work in society.

From a feminist perspective social work has struggled to gain legitimacy as a profession, primarily due to wider discourses of caring as being 'women's work' (MacDonald, 1995; Walby, 1989). Essentially social work has been viewed as a female orientated activity of providing support to those in need. Consequently, attaining legitimacy has been slow and complex due to gendered conceptualisations of care.

Social work has also faced challenges to its legitimacy from the publicity resulting from incidents such as child deaths (Ayre, 2001; Warner 2014). Whether the result of individual or systemic failures, the legitimacy of social work is called into question. The impact of this is to question the 'professional' status of social work (Leigh, 2014).

Implicit in the concept of legitimacy is the power that is imbued in 'professionals'. Evetts (2003) discusses how occupational power can help service to justify and reinforce the legitimacy of a profession. This power manifests itself in two ways. First, social workers come to embody the power of the organisations in which they work. That is to say they exercise functions on behalf of local authorities and other organisations. Second, social workers have power in the legitimacy of the social work professional status. By this I mean that social workers have tasks that only they can undertake. These include tasks such as conducting certain assessments or exercising certain powers. In terms of mental health, social workers can become Approved Mental Health Professionals (AMHPs) who have specific functions that they must undertake that can ultimately determine if a service user is detained against their will.

Power is thus a complex issue for social workers, particularly in the areas of mental health or child protection. Social workers are expected to empower and promote the rights of service users so as to enable them to make their own decisions (Care Council for Wales, 2001). Equally they also have a duty of care towards those they work with and the public as a whole (Care Council for Wales, 2001). The status of

‘professional’ has, in some situations, been construed as a barrier to working in partnership with service users (Hugman, 1998); a theme that will be discussed further in the next section.

The politics of power in professional identity has led to what is perhaps one of the most fundamental objections raised by feminists and service user groups alike. Such criticisms arise from professionals’ ability to exercise power through their position as ‘experts’ (Evetts, 2003). In formalising knowledge and placing boundaries, or criteria, to entering the profession, a divide is created between those who have the professional status and those that do not. Further to this it can also formalise and limit the ways that someone becomes a professional.

Freidson (2001) suggests that professionalism affords ‘occupational control’ over a given area or topic, whereby the given profession is able to create a monopoly of what is considered legitimate knowledge or skills. This subsequently reinforces the perceived legitimacy of the given profession. In this way the concept of expertise can be created and reinforced (Housley, 2003).

Yet the process of professionalisation is not without its merits. Fournier (2000) has argued that professionalisation can mean more autonomy, collective bargaining (for economic, political or social gain), a strong sense of identity and ideology. However, McClelland (1990) argues that the more positive aspects of professionalisation are more likely to occur when the drive for professionalisation occurs ‘from within’ rather than ‘from above’. Essentially this means the form of professionalism attained is not what it might have looked like if the respective profession had developed organically.

In summary the concept of social work as a profession raises challenges for social workers, who are obligated to balance the need for the legitimacy of their profession both in the public consciousness but also in relation to other professions. Further to this, social workers must carefully balance the powers they have whilst also being mindful to work in partnership with others so that the legitimacy of social work as a profession is not undermined. In the next section the complexities of how social workers assist those in need is discussed further. Exploring how these different aspects of professionalisation are enacted in the role of social workers in suicide prevention will be unpicked further in my empirical chapters.

The social worker-service user relationship

Thus far I have attempted to identify who social workers assist, explored the nature of social work and have discussed social work as a profession. What has not yet been discussed is the interaction between social workers and service users, that is to say those who social workers assist in the course of their work. Here, I will briefly explore the complexity of the social worker-service user relationship to help provide an understanding of the nature of contemporary social work practice, and to inform the later empirical chapters.

The relationship between social workers and service users often goes far beyond the 'normal customer boundaries' (Chamberlain and Jenkinson, 2014:15). The ability of social workers to develop a positive relationship with service users is regularly identified as being of paramount importance to 'good' social work practice (Murphy *et al.,* 2012; Ruch *et al.,* 2010). However, these relationships can take many forms and are complicated by issues of power inequalities, competing demands, capacity, notions of expertise, partnership, empowerment and self-determination. So what do we mean by relationship?

Relationships in social work and social care have been conceptualised in multiple different ways ranging from Biestek's (1957) classic concept of the casework relationship through to Trevithick's (2003) discussions of psychosocial relationship-based social work. Despite the diverse conceptualisations of the social worker-service user relationship a common feature is the 'bridge' that this relationship creates between the two parties (Sudbery, 2002). In short, positive relationships can help social workers to assist service users whilst also allowing them gain an insight into the service user's world.

However, these relationships need to be 'deep' (Ferguson, 2005: 791) in order to move beyond surface level understanding. Superficial understanding of service user situations and a lack of a 'healthy scepticism' (Laming, 2009) can lead to information being missed or social workers being 'overly optimistic' about their service users (Munro, 2011).

It seems that social workers must try to develop positive relationships with service users but must do so while remembering that these relationships have a purpose. The social worker-service user relationship is inherently bound up with issues of power. As previously indicated, social workers as professionals are often operating in situations of power imbalance, with service users being the less enfranchised

party. In order for this power imbalance to be overcome, contemporary social policy in the UK (Turner and Balloch, 2001), and more specifically in Wales under the new Social Services and Wellbeing (Wales) Act 2014, must embrace partnership working. Tunnard (1991) notes that partnership working is characterised by (i) a mutual recognition that both parties have something to contribute, (ii) that power is shared equally and (iii) decisions are jointly made.

The second of Tunnard's (1991) points about the equal sharing of power as a fundamental part of partnership working is potentially highly complex when looking at the role of social workers in suicide prevention. Social workers, according to the Code of Practice for Social Care Workers in Wales (Care Council for Wales, 2001), must promote the rights of service users whilst also protecting them and others from harm. This does however raise questions about what happens when the two come into conflict. In instances where service users wish to end their lives how do social workers balance the rights of the service user to choose to end their life, versus the need to protect them from harm?

The right to choose to end one's life is bound up with notions of self-determination. Self-determination is concerned with whether a person 'is psychologically able to make decisions, has the power to do so, and is not prevented or directed otherwise' (Spicker, 1990: 222). However, as Cook and Jonikas (2002) suggest a person with a profound mental illness can often lack self-determination. Where a mental illness or a substance addiction interferes with a person's comprehension their ability to make informed decisions is likely to be impaired. Suicide is, however, not necessarily the result of a mental illness, or of substance misuse and addiction (see chapter 2).

The complexity of the issue is arguably made more difficult by discussions about euthanasia, or right-to-die. For example, McCormick (2011) discusses how self-determination is seen as an important narrative of both social work and right-to-die movement. Despite the complexity of this issue Feldman and Freedenthal (2006) have noted that there has been a lack of dialogue and training on how to manage issues of self-determination in such instances; a topic that is discussed further in my empirical chapters.

In instances where a service user is suicidal, the power imbalance in the service user-social worker relationship is acutely skewed. Further to this, the imbalance of power further detracts from the service user's self-determination: they are no longer able to make decisions free from intervention. As previously discussed, the Mental Health Act(s) (1983/2007) make provisions for a person who appears to be suffering

from a mental disorder that presents a risk of harm to themselves or others to be detained for treatment. This presents a complex dilemma for social workers, as they must constantly balance the power afforded to them with the need to promote the rights of service users to self-determination.

One approach to redressing the power imbalance is to empower service users. That is to say to provide them with information and support that lets them make decisions and affords the ability to have control and independence where possible (Dolgoff, *et al.,* 2011). However, it is not something that is easy to achieve.

Pease (2002) argues that empowerment is often, perhaps ironically, described as something that is done to people. Hartman (1992) and Healy and Meagher (2004) take this further, suggesting that as professionals social workers are experts, and this expertise inherently carries power that can undermine the empowerment of service users. Further to this, Sola (1996) has pointed out that the focus on empowerment at the policy and managerial level has actually been disempowering as it can be targeted in such a way as to create an illusion of equity.

In summary, the relationship between social workers and service users is complex and requires both parties to constantly renegotiate their positions over time (Tunnard, 1991). These (re)negotiations encapsulate issues of power, listening to one another and managing a whole host of wider external demands. Yet relationships need not be so complex as to be fundamentally problematic. For example, Bower notes that a 'thoughtful and emotionally receptive stance' to service users can have 'therapeutic value' (2005:11). In terms of suicide prevention, social workers find themselves in the unenviable position of promoting the rights of service users whilst potentially also restricting their rights if they are felt to present a danger to themselves. This tight-rope walking is complex, and as will be discussed in the empirical chapters, raises very real challenges in practice.

Summary

This section has explored the nature of social work and issues of professionalisation, culminating in the discussion of the service user-social worker relationship. In doing so, it has become apparent that social workers often come into contact with populations who are at an elevated risk of suicide (such as those with mental health issues of substance misuse). Despite this, they have to negotiate the social worker-service user relationship, balancing the need to promote the rights of service users with the need to protect them, and others, from harm. Issues of self-

determination combined with wider discussions about the legitimacy and power of social work as a profession have highlighted the complex web of factors that impact on the practice of social workers. How these manifest themselves in helping to prevent suicide will be examined further in my empirical chapters. Gaining an insight into service users' perspectives on the service user-social worker relationship will need to be explored further, and as such, I will be addressing the following research question:

How do suicidal people perceive the role of social workers in suicide prevention, particularly when situated in multi-agency/interdisciplinary teams?

It is important, however, to remember that social workers do not work in isolation. Working across different agencies and with other disciplines is, as I will now explore, an issue for social workers.

3.2 - Interdisciplinary and multi-agency working

To understand how social workers conceptualise their role in suicide prevention, we also need to consider that social workers rarely work in isolation. Driven by the belief that interdisciplinary working can bring together different ways of thinking and practising creating a more holistic approach to, decision making and service delivery (Housley, 2003), contemporary reforms of welfare services have placed great emphasis on interdisciplinary working. The diverse nature of social work means that social workers operate with a range of other disciplines, such as the police and health professionals. Interdisciplinary working can take multiple forms (Atkinson *et al.,* 2002). The degree and nature of contact between social workers and other professionals will vary based on a multitude of different issues ranging from what area of practice they work in (e.g. Children's Services, Adult Services) through to personal working relationships between particular individuals.

In this study, Community Mental Health Teams (CMHTs) are of particular importance in understanding the role that social workers play in suicide prevention (as will be discussed in chapters 6, 7 and 8). CMHTs are jointly run between local authority social service departments and NHS services. As such they are multi-agency in nature and have multiple disciplines embedded in them. For example, social workers, Community Psychiatric Nurses (CPNs), occupational therapists, physiotherapists, psychiatrists, and psychologists are all represented in CMHTs. Social workers in CMHTs are therefore negotiating interdisciplinary working on a daily basis. In contrast, social workers in children's services are less likely to have

other professionals situated in their team (although they are likely to have regular contact with police officers and various health professionals). The nature and frequency of contact between social workers and other professionals therefore varies based on what area of practice social workers occupy.

For interdisciplinary working to be effective, any barriers between disciplines need to be overcome (Housley, 2003). By acknowledging barriers between disciplines, Housley (2003) draws our attention to the specialist and privileged knowledge bases of different professions. Yet as Thompson (2000) noted, many other professions profess *to do* social work. What do social workers and other professionals see as the knowledge base of social work? What implications does this have for the role that social workers play in suicide prevention?

Interdisciplinary working can be complicated by multi-agency issues. Multi-agency working refers to working across organisations while interdisciplinary refers to specialist *knowledge bases* held by different professions. With the rise of Community Mental Health Teams (CMHTs) in the 1990s, multi-agency and interdisciplinary working have become commonplace for social workers in mental health (Morris, 2008). Social workers in CMHTs will often share physical working environments, resources, and in some instances might even have integrated management structures.

Concerns have been raised about the challenges (from both interdisciplinary and multi-agency working) posed to professional identities both for social workers (Bailey and Liyanage, 2012; Nathan and Webber, 2010), and other professions such as CPN (Robinson and Cottrell, 2005). Social workers may be torn between the need to work with other professionals, and yet maintain a strong sense of self-identity, a point articulated by Golightley:

> The most important contribution that you can make as a social worker, is to manage to work alongside your health colleague to provide a joint approach, yet retaining the essential and unique features of social work
>
> (Golightley, 2008:103)

Golightley sees the potential danger to social work as a loss of its unique features. These features include a holistic approach to assessment and intervention and a focus on the social needs of service users (e.g. exploitation, social isolation, parenting needs, substance misuse, etc.). A holistic approach for Golightley means that social workers consider all aspect of a service user's life (e.g. physical health,

mental health/illness, social situation/relations, housing, etc.). This approach stands in contrast to a traditional medical model where the service user's health needs are somaticized and not seen in context of other needs (Beresford, 2002; Engel, 1977).

While multi-agency and interdisciplinary working poses challenges for professionals it is important to note that the effect of these approaches also impacts on service users. MacDonald *et al.,* (2002) discuss how the service users are integral to understanding effective interdisciplinary working and that their perspective can improve the effectiveness of such approaches. Gaining service users perspectives of multi-agency and interdisciplinary working in suicide prevention will be included in the course of this research.

In summary, to understand the social worker role in suicide prevention, we need to gain an insight into how workers perceive and make sense of their role and how this may be different to other professionals. This requires an examination of how they negotiate conflicting perspectives on the nature of social work and also how they manage interdisciplinary and multi-agency working. It seems probable that given the numerous and competing demands placed on the social work identity, we will find that the social worker task in responding to suicide prevention is far from homogeneous. It is also possible that the unique features identified by social workers may differ from those advocated by non-social workers. Seeking the perspectives of those with whom social workers practice, both other professionals (such as CPNs) and service users will be covered in the scope of this study. As such the following research questions will be addressed in the course of this thesis:

What roles are currently played by social workers in suicide prevention? Do social workers have a distinct role in suicide prevention or has the increase in multi-agency working blurred the roles of different professionals?

3.3 - Social work and suicide prevention – What do we know?

In chapter 2.5 I discussed some of the interventions and techniques that have, or might be, employed by social workers to prevent suicide. In this section I examine what is known about social workers and suicide prevention more generally. As previously indicated, Joe and Niedermeier (2008) have highlighted the relative lack of published research in social work journals addressing the topic of suicide and effective interventions that might be used by social workers. This is surprising given that until 2007 social workers had a unique role in detaining a person under the

Mental Health Act 1983 (as amended by the Mental Health Act 2007). Since 2007, the previously exclusive role of Approved Social Worker has now been opened up to other professions and has been renamed the Approved Mental Health Professional (AMHP). Social workers with this status are instrumental in the process of a person being assessed and possibly detained to a secure psychiatric setting. So what information do we have about the role of social workers in suicide prevention? In this section I will discuss my findings from the searches of various databases (as indicated in chapter 2.1) and wider reading.

Joe and Neidermeier (2008) in their review of literature noted that much of the research available focuses on explanatory knowledge focusing on issues of risk for suicide and attempted suicide. This literature has much in common with the literature discussed in chapter 2 and will not be repeated again here. What appears to be lacking are details about what social workers do to prevent suicide and how best to intervene.

Despite the lack of articles identified by Joe and Neidermeier (2008), we do know that social workers are likely to have contact with suicidal individuals. Jacobson *et al.,* (2004) in their survey of mental health social workers in the US noted that the majority of them had contact at some point with suicidal service users. Additionally Sanders *et al.,* (2008), again surveying social workers in the US, reported that 32-34% of social workers had a service user complete the act of suicide and a further 50-90% (depending on area of work) had worked with suicidal service users. Clearly it seems that social workers have an important role to play in preventing suicide.

Studies looking at the role that social workers can play in preventing DSH and suicide prevention are not new. For example, he comments on some historic studies focused on DSH and suicide that have incorporated social workers (Deykin *et al.,* 1986; Hawton *et al.,* 1981; Gibbons *et al.,* 1978; Chowdhury, 1973). These studies help to identify some types of interventions that can be employed by social workers and also illustrates the importance of multi-agency working. What we are able to establish from studies such as Hawton *et al.,* (1981) is that social workers are able to work as part of wider multi-agency and interdisciplinary teams to provide and test interventions focused on suicide prevention.

The formation of CMHTs in the 1990s has often been used as an example of the neo-liberalisation of the health and social care sectors (Onyett, 1998). As Onyett (2003) notes, their formation started under the Conservative governments of the early to mid-1990s and was continued during the New Labour governments of 1997

onwards. Onyett (2003) suggest that their implementation caused a considerable amount of discussion, with advocates suggesting how such working can improve outcomes for service users, as well as improving efficiency and reducing costs. These claims have, however, been refuted by Malone *et al.,* (2007) who suggested that many of these supposed benefits have little or no evidence. Further to this, others have suggested that economics actually determine the composition of the teams, rather than the teams being tailored to meet the needs of service users (Evans *et al.,* 2012; Barr and Huxley, 2002). Interestingly, while there has been considerable debate about the relative merits of CMHTs, Simmonds *et al.,* (2001) has suggested that CMHTs have been associated with fewer deaths from suicide.

However, we still know little of the roles played by social workers in preventing suicide within these multi-agency and interdisciplinary teams. One possible role highlighted by Jacobson *et al.,* (2012) was the importance of gate keeping. Jacobson and colleagues examined how training could assist social workers acting as gatekeepers in mental health services. They found that training could improve social worker knowledge and efficiency when dealing with suicidal cases. However, no attempt was made to examine the impact this had on rates of suicide.

Despite the importance of training on suicide prevention Feldman and Freedenthal (2006) found that social workers often receive limited formal training in how to manage suicidal behaviour. However, it is important to note that the informal training, or peer learning, and tacit knowledge do not appear to have been considered by Feldman and Freedenthal. As will be demonstrated in the empirical chapters, this informal learning (Eraut, 2000) can be of great importance (see chapter 6.1).

The lack of training is even more concerning given that suicide has been identified as an issue of professional anxiety for social workers. Ting *et al*., (2011) examined US social workers working with suicidal service users and noted that they were more likely to suffer from stress and secondary trauma. Further to this Ting *et al*., (2006) have noted the emotional impact of service user suicides on social workers. This led to issues of stress and concerns about professional competency amongst the bereaved professionals. The fear and impact of service user deaths is a topic that will be discussed further in my empirical chapters (see chapters 6 and 7).

Further to this, Stack (2001) provides what is perhaps the only data on this topic to suggest that social workers have an elevated risk of suicide, something he attributes to social workers being client-facing professionals (Labovitz and Hagedorn, 1971).

Many of the other professions that were found to be high risk were medical professionals (e.g. doctors and vets) who are likely to have access to more lethal means (i.e. medication). As already indicated, reducing the means to access can reduce suicide rates. Social workers are unlikely to have access to such lethal means but they are most certainly client facing professionals. The lack of previous research into the rates of suicide amongst social workers means that we are, at the current time, unable to draw any meaningful conclusion on this issue.

The dearth of research specifically addressing the role of social workers in suicide is echoed in the relative absence of suicide in social work textbooks, Pritchard's (2006) text being a notable exception. Pritchard advocates a bio-psycho-social understanding of mental health and suicide. Essentially Pritchard is encouraging social workers to consider biological, psychological, and social factors when conducting their assessments and when arranging packages of care. Pritchard suggests that social workers need to be aware that to prevent suicide it is important to understand an individual's needs and presenting problems. These problems might range from housing issues, through to periods of acute mental ill-health. Service users are experts on their own lives and recognising this in exploring their individual situation is essential to assisting them. Further to this, being aware of these problems and understanding factors commonly associated with suicide (e.g. alcohol/substance use) can help social workers assess suicide effectively and to tailor interventions.

While Pritchard is writing about mental health social work, the presenting problems he discusses are issues that could come to the attention of many social workers with service users. In chapter 2 (sections 2.3 and 2.4), it was established that many of the issues associated with suicide (such as deprivation, unemployment, divorce, etc.) are problems faced by many service users that social workers are trying to assist.

Despite the limited information about the role of social workers in suicide prevention we do have a wealth of knowledge on risk management in social work more generally (Hothersall and Mass-Lowit, 2010). It seems likely that many of the skills used to manage risk in other areas would likely lend themselves to suicide prevention. Contemporary society is characterised by risk (Beck, 1992; Giddens 1994) and social workers are often working with the most *risky* groups, such as those who are at elevated risk of suicide. However, risk assessment and

management is an inexact art (Lipshitz and Strauss, 1996) meaning that social workers often have to work with uncertainty (Stalker, 2003).

Further to this practitioners often lack the time to undertake detailed assessment (Webb, 2006). This combined with a move towards empirical forms of risk assessment that can lack rich contextual information (Kemshall *et al.,* 1997) to help inform decisions making the assessment and management of risk more complex. Issues of risk and uncertainty in the role of social workers in suicide prevention will be discussed in my empirical chapters. As we shall see in chapters 6 and 7, risk assessment of suicide is a complex task.

Pritchard (2006) suggests that the quality of the relationship between the social worker and service user is central to both assessment and intervention. To do this effectively Pritchard emphasises the importance of adopting a holistic approach in assessments and interventions, much like Golightly (2008). Being aware of how wider issues such as housing or financial problems can impact adversely on a service user's wellbeing can mean that social workers are better able to identify issues and better support those they work with. Specifically, Pritchard highlights the need to be aware of the importance of working closely with family members. Social workers must work not only with the individual, but also with wider social networks to support service users effectively. For example, family networks and friends are more likely to have regular contact with service users and so any change in the mental health of a service user might first be observed by a family or friend. Being able to build relationships with these informal support networks can help social workers to work with service users and provide assistance at the most appropriate time.

Having a relationship with the families and friends of service users is important in supporting those bereaved by suicide. Mitchell *et al.,* (2005) have noted that those bereaved by suicide are themselves at elevated risk of future suicidal behaviour. Interestingly, several studies have explored how social workers can assist those bereaved by suicide (Craig, 1977; Sheperd and Barraclough, 1979; Dransart, 2013). Professional assistance as part of the sense making process for survivors has been strongly advocated (Dyregrov and Dyregrov, 2008), suggesting that social workers can be of great assistance during these difficult periods. Supporting survivors could in effect be helping to reduce future suicidal behaviour.

One final finding from this search of the literature on social workers and suicide prevention was the considerable attention that has been afforded to wider discussions about the role of social workers in euthanasia, or assisted suicide (Miller

et al., 2004; Csikai, 1999; Smokowski *et al*., 1996). Some of this literature might help us to understand the challenges of balancing issues of capacity in decision making and wider ethical discussions about the right to die it is predominately focused on issues of palliative care. As such, this literature, while interesting, arguably identifies a different group of service users with a different set of needs and ethical considerations.

In summary, there appears to be relatively little existing research into the role of social workers in suicide prevention, but we are able to gain some insight into the potential roles that social workers might have in assisting suicidal service users. Supporting the families of those bereaved by suicide, adopting a holistic approach to assessment, and having an awareness of the multifaceted nature of suicide (the biological, psychological and social factors) all appear to be associated with social worker roles in suicide prevention. At the same time, however, we know little about how social workers understand suicide or what knowledge they draw on to inform their practice. Examining whether social workers draw on the experience of peers in keeping with Fish and Coles (1998) concept of artistry, or, more formal professionalised versions of learning as in Fish and Coles (2000) technical base, will be addressed in later chapters.

We know little about any specific assessments or interventions being used by social workers to support suicidal service users. There is also some limited evidence to suggest that social workers are themselves at elevated risk of suicide. Understanding what support, if any, social workers receive after the death of a service user might further enhance our knowledge of the role social workers play in suicide prevention. Hence my final research question will be:

How are social workers supported when working with suicidal service users?

3.4 – Attitudes to suicide in other professions

In chapter 2.3 lay explanations of suicide were discussed. Here I build on this by exploring what knowledge we have of other professions' attitudes to suicide. It is clear that little is currently known about the role played by social workers in suicide prevention or their attitudes to suicide. This stands in contrast to those working in the medical professions. Herron *et al.,* (2001) surveyed general practitioners, trainee psychiatrists, community psychiatric nurses, and accident and emergency staff (A&E). Their findings indicated that medical staff working, or training, in mental health had more positive attitudes towards suicide (compared to their colleagues

who had no training or experience of mental health), whilst those in more physical health roles often held more negative attitudes towards suicide and those who had attempted to take their life. The findings of Herron *et al.,* are consistent with earlier studies such as Goldney and Bottrill (1980), suggesting continuity over time in attitudes toward suicide amongst the medical professions.

The negative attitudes towards those deliberately self-harming (DSH) (with or without intention of death) have also been discussed by Palmer *et al.,* (2007) who noted that self-harmers were often seen as 'time wasters'. Particularly negative attitudes have been noted towards those who repeatedly presented (Clarke and Whittaker, 1998), and/or who were often felt to be 'attention seeking' (McAllister *et al.,* 2002). Essentially people are often deemed, relatively, to harm themselves to get attention or assistance from professionals (Warm *et al.,* 2003).

Worryingly these negative attitudes have been associated with increased rates of poor quality care and missed opportunities for further intervention (Allen, 1995). As discussed in chapter 2.2 we know that those with a history of DSH are at an elevated risk of suicide and that for every suicide there are estimated to be between twenty to thirty parasuicides (Mann *et al.,* 2005). This means that opportunities for intervention (e.g. after presentation for medical assistance) are possibly being missed.

Negative attitudes towards suicide in the medical professions are not just reserved for patients. Center *et al.,* (2003) discuss how historically physicians who have disclosed having suicidal thoughts have been treated in a punitive manner, essentially discouraging physicians from seeking help. Those medical professionals who admitted to having mental illness and/ or suicidal thoughts were likely to be subject to professional conduct panels which would often look at penalising the professionals rather than considering how they might be supported. Whether similar attitudes exist in the social work profession remains unclear. Consequently, Center *et al.,* call for a cultural shift in how the medical profession supports those who are experiencing mental illness and suicidal thoughts.

The negative attitudes of some medical professionals towards suicide are not the only understanding of suicide that we need to consider. Glaser and Strauss (1964) suggest that medical practitioners use professional distance as a strategy to reduce occupational stress. They conducted an ethnography of an emergency room (the equivalent of an A&E unit in the UK) and noted that the physicians maintained an emotional detachment from their patients. They highlight that if a physician became

too emotionally invested in their patients then the emotional strain would impair their ability to assist effectively. The high levels of stress experienced by social workers, particularly in children's services (Tham, 2007; Tham and Meagher, 2009) and mental health (Evans *et al.,* 2006), suggest that social workers, like their medical colleagues, may also need to maintain a professional distance in their work. What is not clear is whether, like medicine, different areas of social work display differing attitudes to suicide.

3.5 – Conclusion

The role of social workers in suicide prevention is, as Joe and Neidermeier (2008) assert, an under-researched topic. We know that social workers can play a role in supporting survivors (Craig, 1977; Sheperd and Barraclough, 1979; Dransart, 2013) and that social workers have specific roles (i.e., Approved Mental Health Professional) under the Mental Health Act(s) (1983/2007). This role is unique in so far as those with AMHP status may, with appropriate medical practitioners, detain a person for assessment and/or treatment if they are a risk to themselves or others. We also know that social deprivation, social isolation, and substance misuse are closely linked to suicide (Whitley *et al.,* 1999; Rehkopf and Buka, 2006). These issues are factors that social workers are likely to address during the course of their practice.

Despite this, we know very little about how social workers understand, assess, or assist suicidal service users. There is also no clear data available on the circumstances under which social workers come into contact with suicidal service users. Adding to the complexity, we must remember that while social work is a protected title many other professions profess *to do* social work (Thompson, 2000). Social workers have a mandate to work with those *in need* (Sheldon and MacDonald, 2009) in a holistic approach (Golightly, 2008). Yet the diversity of different roles within social work and the contested nature of suicide indicate that more than one approach to understanding and preventing suicide is likely to exist. How much the different 'professionalisms' (Fish and Coles, 1998) of social work impact on the role(s) social workers play in suicide prevention will be examined.

In this study I draw on the experiences of social workers employed in statutory service (i.e. local authorities). This is not to diminish the work being done by those social workers working in the voluntary and private sectors, but has been done for the practical reason that local authorities are the largest employers of social

workers. Although the social workers in this study are all employed in statutory posts this does not mean that they will all have the same beliefs and understanding of suicide. I interviewed social workers from different areas of practice, such as children's services, older person's teams, physical disabilities, community mental health teams and other areas of practice. Exploring how social workers from different areas of practice understand and seek to prevent suicide will be explored in this study.

In reviewing the existing literature and research from the fields of social work, suicidology, and sociology it has been demonstrated that little is currently known about the role of social workers in suicide prevention. Also indicated is that the field of suicidology is dominated by quantitative approaches. In contrast, UK research on social work is almost exclusively qualitative in nature (Research Assessment Exercise, 2008). The next chapter will explore how to bridge the divide between social work and suicidology to address the following research questions (RQs):

RQ 1 – In what circumstances do suicidal people come into contact with social workers?

RQ 2 – How do social workers understand suicide and suicidal behaviour?

RQ 3 – What approaches to assessment are currently used by social workers? To what extent does research evidence impact on the practice of social workers in this context?

RQ 4 – What roles are currently played by social workers in suicide prevention? Do social workers have a distinct role in suicide prevention or has the increase in multi-agency working blurred the roles of different professionals?

RQ 5 – What sorts of social care provision are available to suicidal service users and what is the nature and frequency of their engagement with these services?

RQ 6 – How are social workers supported when working with suicidal service users?

RQ 7 – How do suicidal people perceive the role of social workers in suicide prevention, particularly when situated in multi-agency/Interdisciplinary teams?

Chapter 4 – Methodology, ethics and access

4.0 - Introduction

This chapter details the methodological rationale for the research as well as explaining the ethical issues that needed to be negotiated. Through this chapter I explain my decision to use two different methods to address the research questions set out in chapter one. I will briefly summarise my research method before outlining the structure of this chapter.

My research uses a mixed methods approach to understand the role of social workers in suicide prevention. First, I conducted a secondary analysis of the Adult Psychiatric Morbidity Survey (2007) (*n*=7,403) looking at the circumstances under which social workers come into contact with suicidal individuals. Details of the variables, analysis and findings are located in chapter 5. I will discuss related issues over the application of quantitative tools, such as the pros and cons of secondary analysis and the use of mixed methods, in this chapter.

Second, I understook a series of semi-structured interviews with statutory social workers (*n*=17) (chapters six and seven), service users with a history of suicide attempts (*n*=3) and Community Psychiatric Nurses (CPNs) (*n*=3) (chapter eight). I employed a combination of purposive and snow-ball sampling and used thematic analysis to explore the role of social workers in suicide prevention. Details of the method, sampling strategy and approach to analysis are included in this chapter.

The chapter is divided into five sections. In section 4.1, I set out my rationale for the use of two methods. I explore the different approaches that have been taken to mixed methods, and explore some of the ontological and epistemological issues that are commonly associated with mixed method designs. After establishing the rationale for using a mixed methods approach I then explore the two composite methods specifically focusing on how the two components interact with one another.

In section 4.2 I explore how my personal exposure to a suicide was negotiated. While my research is not autobiographically informed, I cannot discount the importance of specific personal experiences to the research process. The impact of the research on me as the researcher is also discussed.

Section 4.3 explores the process of gaining ethical approval and more general ethical issues in my research. The perceived and actual ethical dilemmas encountered are discussed, as well as the process of attaining ethical approval from the National Health Service (NHS) Multi-centre (Wales) Research Ethics Committee (MREC). Reflections on issues that arose in the field and how they were managed are also explored.

In section 4.4 I outline how I obtained access to local authority social services departments and NHS health boards. I discuss the fragmented and variable process of gaining access to local authorities and the contrast between health and social services in approving access.

Finally in section 4.5 I set out my sampling strategy and approach take to my qualitative data analysis. The rationale for my quantitative data analysis can be found in chapter 5. The details of the quantitative analysis are inextricably linked to the method itself, making it conceptually problematic to disentwine the two.

4.1 – Methodology

In chapter two it was noted that much of the existing suicide research has utilised quantitative methods (Stack, 2000a; 2000b); that is to say, drawing upon objectivist approaches to understanding the social world. The lack of qualitative methods has been lamented by Hjelmeland and Knizek (2010; 2011), who acknowledge that despite some excellent qualitative studies inspired by the work of Douglas (1967) and Atkinson (1978), there appears to have been little attempt to incorporate more qualitative methods into the field of suicidology. In contrast, the field of social work in the UK is dominated by qualitative perspectives that emphasise a constructivist understanding of the social world (Research Assessment Exercise, 2008). My research into the role of social workers in suicide prevention sits across these two epistemological fields and so consideration needs to be given as to how the research will be situated and justified. Equally it is vital that I select methods based on their appropriateness to answer the research questions.

An obvious solution to redressing the above divide between suicidology and social work would be to adopt a mixed methods approach. However mixed methods are contested, complex, and varied in nature. Tashakkori and Creswell (2007) note that for the last three decades there has been considerable debate about how qualitative and quantitative approaches might be effectively integrated. The issue according to Bryman is about what constitutes ‘genuine integration’ (2007:8). This relates to the

point at which integration takes place in the research process: is integration necessary from the planning and collection stage of research, the analysis, or at some other point? Is the end project more than the sum of its individual (qualitative and quantitative) parts? Or should these different methods be used independently of one another to answer individual research questions?

Bryman (2007) suggests that many of the debates surrounding mixed methods treat qualitative and quantitative methods as separate domains. Redfield Jamison (2000:20) refers to the divide between qualitative and quantitative perspectives as the 'Maginot lines', a reference to the formidable (if ultimately futile) fortified defences constructed by the French in the inter-war period. Fundamentally, Redfield Jamison contends that conceptualising these perspectives as divided is unhelpful. Instead, we would do better to acknowledge that the two perspectives offer different interpretations of the social world; quantitative methods predominately focus on explanations that emphasise social structure, while qualitative perspectives emphasise social agency.

As Giddens (1979) suggests, structure and agency do not exist in isolation from one another. Instead of viewing agency and structure as polarised concepts, Giddens suggests that they are better conceptualised as a duality, with structure providing rules and resources which are used by social actors in their everyday lives. By reflexively using these rules and resources, social actors reconstitute social structure, thus forming a duality. In the case of social workers in suicide prevention, we need to be able to examine both the context of contact between social worker and suicidal people (social structure), and also gain an insight into how social workers understand and work with suicidal individuals (social agency).

While Giddens correctly asserts that the 'Maginot Line' of social sciences serves to unnecessarily divide researchers, he does not provide much insight into how we should be researching the social world in practice. An obvious solution would be to 'triangulate' different methods to explore different aspects of a given issue. For example, in the first part of this study I examine the context under which social workers come into contact with suicidal individuals through the secondary analysis of a general population survey. I then proceed to explore how social workers understand and support suicidal service users through a series of interviews with CPNs, service users and social workers.

Denzin suggests that triangulation is 'the combination of methodologies in the study of the same phenomenon' (1978: 291). Denzin (1978) suggests that there are two

typologies of triangulation, ‘within-methods’ and ‘between’ or ‘across’ methods. The former is primarily characterised by repeated validation within a given method, such as rephrasing the same question in the same survey and cross-validating the responses between the questions. The later, and more preferable in Denzin’s opinion, is the combination of two or more methods with the relative limitations of one method being compensated by the strengths of the other. For methods to be effectively triangulated Denzin contends that we need to consider four factors: (i) the nature of the research and the suitability of particular methods; (ii) theoretical relevance of chosen methods; (iii) internal and external validity; and (iv) researcher reflexivity in relation to the methods used. I will use these points to help guide my discussion over the coming pages.

Nature of the research and suitability of research methods and theoretical relevance of chosen methods

Given the limited research into the role of social workers in suicide prevention (Joe and Niedermeier, 2008) this study has, as indicated in the introduction, two broad aims: (i) to gain an insight into how social workers understand suicide and (ii) to describe the role(s) currently played by social workers in suicide prevention. The breadth of these aims combined with the diverse research questions invites the use of multiple methods or methodological eclecticism (Hammersley, 1996). Essentially methods have been selected that best suit the research questions posed (O’Byrne, 2007).

The selection of methods also requires the researcher to be conscious of the context of their research. Some methods are not practical and cannot be employed. As previously indicated secondary analyses of a general population survey and interviews have been selected in this research over other methods for reasons that I will now explore.

Why conduct secondary analysis of a general population survey (relative merits and limitations)?

The first of my research questions (in what circumstances do suicidal people come into contact with social workers?) is focused on contextualising contact between social workers and suicidal people. Being able to contrast those who are suicidal and in contact with social workers against other groups (e.g. those who are suicidal but do not have any contact with social workers), we are better able to explore the variables affecting this contact. This is best achieved through a large sample

population where key variables (such as sex, age, etc.) have been recorded, such as survey data. As such my first question is best understood through an objectivist ontology, utilising quantitative methods.

Using secondary data, as Dale *et al.,* (1998) argue, carries both limitations and opportunities. Perhaps the most obvious limitation is that the aims and priorities of the original researchers may not directly correspond to those doing secondary analysis. As such, the questions asked, the way they are phrased, and what responses are provided are predetermined. In the case of the Adult Psychiatric Morbidity Survey 2007 (APMS07), the focus was on psychiatric morbidity as a whole: suicide and social worker contact were a small part of the wider study. Subsequently, they were not given the same prominence that they would have been given if I were collecting primary data.

The lack of input in the shape and structure of the research also has implications for the use and analysis of data: for example, ethical dilemmas about appropriate data usage and the representation of participants. Secondary analysis will often mean that data are being explored in ways that were not originally envisaged when it was compiled. This raises issues around informed consent (Murphy and Dingwall, 2007; Renold *et al.,* 2008; Boden *et al.*, 2009). In the case of the AMPS07, participants were advised that all identifiable information would be removed and the data would be made available for secondary analysis through the Economic and Social Data Service. This however means that participants have little knowledge of how data might be used after the original study. For example, there is a risk that data might be used to make spurious claims. Such misuse of the data is unfair on the grounds that it misrepresents the participants and is also an abuse of another's work. In relation to my own work, I have been very open about both the methods employed and the limitations of my analysis in exploring the topic area.

These limitations should not, however, preclude the use of secondary data. Bryman and Crammer (2011) discuss how secondary data can present researchers with access to large scale, high quality data at little-to-no expense. Yet the use of secondary (and more specifically secondary quantitative) data remains a scarcely utilised resource in social work research in the United Kingdom (Maxwell *et al.,* 2012). In terms of my own research, I would not have been able to obtain such a large sample with the limited time and resources available; nor would I have had the resources to undertake a multi-staged randomised sample. By using secondary

analysis I have been able to build on the work of others in a way that is transparent, yet innovative in this study context.

Why interviews?

In contrast to my first research question, the subsequent questions (two to seven) explore social worker, service user, and CPNs 'subjective meanings, attitudes, and beliefs' (Smith, 2009:115). Survey data would not effectively allow us to explore how social workers *understand* suicide, or what CPNs feel about the role(s) social workers have in suicide prevention. Here a constructivist ontology is needed with qualitative data exploring the subjective social world of the participant.

There is, as Denzin and Lincoln (2011) point out, a plethora of different methods available that provide an insight into the subjective meanings, attitudes, and beliefs of participants. Focus groups were briefly considered as a potential method, but issues of how to maintain confidentiality and practical issues of implementation made such a method unviable. Discussing experiences of suicide and suicide prevention could be emotionally challenging; there was a risk that participants would not want to discuss their experiences if they could not be guaranteed confidentiality. In a focus group I would have had little control over what information participants disclosed, making it hard to ensure confidentiality.

On a practical level it would also be problematic to get busy professionals to attend a focus group. The crisis nature of many areas of social work (primarily children's services and mental health) often means that the professionals can be called away at very short notice. For example, one of my interviews with a Children's Services social worker was interrupted half way through due to an urgent matter. The interview had to be adjourned to a later date. Trying to get a group of professionals together therefore would, potentially, have been very challenging.

More ethnographic approaches (e.g. observations of social work teams) were also discounted, as the relatively low prevalence of both suicidality and completed suicides might have yielded limited data. I might have been with a team for some time without seeing any instances of suicide prevention in action. It would also have committed me to working with a limited number of teams from a few areas of practice, and the perspective of some areas of social work practice might have been missed. Ethical and legal boundaries around how much I might be able to observe would also have posed a challenge.

Documentary analysis of service user mental health case files[9] was also considered. It was envisaged that this might be a third component of the research. However, it transpired that a lack of continuity in record keeping, both within and across organisations, combined with some ethical concerns raised by the NHS MREC[10] meant this part of the project was unfeasible. The time and resources required to undertake this component of the study proved to be beyond my means.

Many of the issues raised in discussions of these methods have focused on practical issues of implementation or access, as opposed to any complex discussion of the relative merits of the methods themselves. My rationale for doing so is to illustrate that while a method might be theoretically viable, implementing the method and ethical issues can render the method redundant.

In contrast to the other methods highlighted, interviews lend themselves well to this research. For example, it was possible for me to work around the commitments of my participants and to interview them in locations that were convenient to them. As well as being practically viable, interviews also allowed me to develop 'a deeper understanding' (Shaw and Gould, 2001: 144) of their subjective world.

Interviews are, as Burgess reminds us, 'a conversation with a purpose' (1984:102); they provide participants with the opportunity to 'tell the story in their own words' (Decker and van Winkle, 1996:27). Essentially they provide research participants an opportunity to 'unfold the meaning of their experiences' (Kvale and Brinkmann, 2008:1). They provide an insight into the subjective meanings of the world that is constructed by the participant.

While the interview offers the participant the opportunity to tell their story, it is not a one way process; both interviewer and interviewee enter into a relationship (Rubin and Rubin, 2005). Interviews are co-constructed between the interviewer and the interviewee, with the interviewer helping to steer the interviewee through their journey. As such, interviews require the interviewer to actively listen to the interviewee and have:

---

[9] This was part of the original research proposal.

[10] The main requirement of the NHS MREC was for Caldicott Guardians, or social services equivalents, to review my work to ensure that I was not misrepresenting or misusing the data of deceased service users. After consultation with Local Authorities it transpired that no Caldicott Guardians (or equivalents) exist in their services.

> A respect for what people say, and a systematic effort to really hear and understand what people tell you.
>
> (Rubin and Rubin, 2005:17)

I adopted a semi-structured approach to interviewing. Semi-structured interviews offered an effective compromise between the lack of flexibility within structured interviews, and the risk that the interviews might quickly go off topic with open interviews. I used an interview schedule[11] which outlined topics for discussion and possible questions (Kvale and Brinkman, 2008). These topics and questions were to act as prompts and were not to structure the interview. It was not essential for all of the topics and questions highlighted in my schedule to be used in every interview, and some topics/questions became unsuitable in a couple of interviews with social workers because of the emotional sensitivity. The order in which issues were discussed also varied depending on what the interviewee said. An example of one of the topics (training on suicide) and questions used in interview schedule is given below:

Training:

- Have you received any training to help you identify, assist and/or treat service users?
- Was it helpful?
- What further training or support would you like, if any?

In chapter 3.3 it was established that we know little about the role social workers play in suicide. Further, Feldman and Freedental (2006) have noted that social workers receive only limited training. Being able to explore not only what training they have received, but also what they felt about training was therefore identified as an area of inquiry. The interview schedules for social workers, CPNs and service users were tailored for each group, as the topic areas and wording of questions needed to be suitable for each audience.

Making triangulation work

A pragmatic selection of methods runs the risk that different components of the research become misaligned resulting in disjointed research. The researcher does, as Denzin (1978) points out, need to be reflexive about their methods throughout the

[11] A copy of my interview schedules can be found in Appendix D.

research process and not just at the planning stages. However, Denzin (2014) also discusses how over the past forty years there has been considerable debate about what constitutes effective triangulation and suggests that it has been redefined to meet changing needs. I will not endeavour to explore the extent of these debates in this work but will instead set out my own approach.

As has been discussed already I have used two different approaches to explore different aspects of the role of social workers in suicide prevention. I have clearly identified that the quantitative component of my study looks at the context under which social workers come into contact with suicidal service users, while the qualitative component examines how social workers understand and assist those who are suicidal. The interaction between the two components takes place at three points. First, and perhaps most evident at this stage, is the design of the project. The lack of previous research meant that it was necessary to design a project that would allow me to capture data on a range of topics. To do this it was necessary to use multiple methods.

Second, the findings from the secondary analysis were being formulated at the same time as I was undertaking my primary data collection. The findings from secondary analysis were fresh in my mind during my primary data collection allowing me to build on these findings. For example, issues related to substance misuse identified through the secondary analysis were also raised by participants during interviews, and were further unpicked to provide greater clarity on the identified relationships.

Finally, and arguably most important, the two come together interactively in my discussion of the findings. Where relevant I have identified continuity in the findings across the respective methods. In chapter nine, I bring together all my findings and address each of the research questions in turn. This is arguably the main point at which an analytical integration between the two methods is displayed. In summary, my approach to triangulation was primarily to explore different aspects of the role of social workers in suicide prevention. Where common themes were identified by both approaches, they have been commented on.

Reliability and validity or credibility and dependability?

Ensuring the quality of research and making this apparent in the reporting of results is a task incumbent on all researchers. Details of reliability, generalizability and validity for the quantitative component of my study (i.e. the secondary analysis) are

discussed in the next chapter. In this section discussions about the reliability and validity of this study as a whole, and the primary data, are explored.

Being able to appropriately demonstrate that a given piece of work is of sufficient rigour is a universally accepted component of any research. It is necessary that the researcher be able to demonstrate that their research is valid, that is to say it measures what it was intended to measure, and reliable, that is, the extent to which results are consistent over time or over a wider population. However, in line with the methodological divide identified earlier in this section, we find that how this rigour is conceptualised and understood is highly variable. Seale (1999) suggests that in the case of qualitative research, it is often understood in terms of trustworthiness; although he acknowledges that this is a contested concept. This he argues is achieved in a manner quite different to that of validity as advocated by positivists.

Building on this, Shenton (2004) drawing on the work of Guba (1981), suggests that positivist framings of reliability and validity do not lend themselves to qualitative data. However it is possible, he suggests, to reconceive or 'translate' the concepts and form a new framework for verifying quality research that is primarily qualitative in nature. Table 1 on the next page is adapted from Shenton (2004:64).

While the research design utilises both quantitative and qualitative methods I have chosen to primarily shape the coming discussion on 'validity' using Shentons interpretivist framing. The reasoning for this is that this section focuses on my primary qualitative data and so lends itself towards this approach.

Denzin and Lincoln (2005) have suggested that research findings be 'credible' through peer review of the data, or by having the participants review the findings and verify that the researcher has correctly interpreted what was said or done (otherwise known as respondent validation). This approach while commendable was not practical within the scope of this study. Bringing together social workers, health professionals and service users to discuss the results would have been impractical and may have undermined the confidentiality of participants.

Despite this by selecting three distinct groups of participants and social workers from a range of different areas of practice it was possible to triangulate the different accounts through the coding process. As Shenton (2004) notes, having multiple stakeholder groups means that it is possible to check the credibility of concepts and comment on any similarities and differences. As will be discussed in the coming

chapters, there is some continuity between the findings of my primary and secondary data analysis.

Table 1 – Validity and reliability or credibility and dependability (adapted from Shenton, 2004)

Positivist framing	Purpose	Interpretivist framing
Internal validity	To verify that the study has measured or explored what it was intended to.	Credibility
External validity/generalization	The degree to which the findings can be applied to wider groups or populations.	Transferability
Reliability	How reliable are the results over time? For positivists this would be repliciability.	Dependability
Objectivity	How might the researcher's personal history, experience and ideas impact on the research?	Confirmability

Another approach advocated by Lincoln and Guba (1985) is to adopt a methodology that has previously been used and to avoid making any alterations. This approach does however assume that the adopted approach is itself 'credible'. In terms of this study the relative lack of previous inquiry into the topic area rendered this approach problematic. It would have been possible to draw on studies into other areas but it would also have been necessary to make alterations so as to render the approach appropriate for the topic area. In doing so it is likely that any attempt to improve credibility would have been negated.

In a slightly different vein Silverman (2000) suggests that previous studies can however help to verify the credibility of a study by examining how congruent the results are with wider studies. While comparatively little research explicitly focuses on the role of social worker in suicide prevention, a considerable body of work from the fields of suicidology and social work can be utilised. In the reporting of my

results I have drawn on wider literature to verify my findings and demonstrate congruence with the existing research, in doing so I hope to demonstrate credibility (or internal validity).

In relation to transferability (or external validity) caution is urged in how far the findings can be applied to other situations or 'generalized' (Lincoln and Guba, 1985). Gomm *et al.,* (2000) suggest that the provision of pertinent contextual information can help others to determine if the circumstances described in the data are similar to those being experienced by others. Where the contexts are felt to be similar then the findings are likely to be transferable. While I have endeavoured to provide some contextual information this has been limited by the need to maintain the anonymity of my participants. As such, careful consideration should be given to how far the results can be transferred or generalised. Further to this it is important to note that this is an exploratory study and the themes highlighted would greatly warrant further enquiry.

Thus far we have considered the credibility and transferability of this research but we also need to consider its dependability. As Shenton (2004) notes, those using a positivist approach would consider the reliability of a study, that is to say the degree to which a study can be replicated to validate the findings. However, from an interpretivist perspective, the social world is in a constant state of change meaning that the phenomenon being studied is likely to change between different pieces of research (Marshall and Rossman, 1999). Interviewing the same participants a second time will necessarily invite them to provide different responses from those in their first interview. Even if the same questions are asked, the participants are likely to have reflected on their previous statements and possibly modified their points. Further to this they are also likely to have experiences in between the studies that might have affected their ideas.

Despite this, the methods and approach employed in any study should be made apparent so that any shortcomings can be identified. Shenton (2004) argues that transparency of the research design, data collection and clear evidencing of the findings can all aid in making the dependability of research apparent. In terms of my own study I have, through the course of this chapter, explained my methodology and have provided a copy of the interview schedules used to guide my conversations with participants. In the coming chapters I have endeavoured to evidence my findings in a way that will convince the reader that they are informed by and accurately reflect the content of my interviews.

Finally we arrive at confirmability which, according to Shenton (2004), is characterised as the interpretivist equivalent of objectivity. Confirmability for Shenton means that findings should reflect the informants 'experiences and thoughts and not those of the researcher's 'characteristics and preferences' (2004:72). Validating how this has been achieved is, however, difficult. In an effort to partially redress this I have considered my previous experiences, both personal and professional, of suicide and have reflected on my journey throughout the process of data collection and analysis as outlined next in section 4.2. In making this apparent to the reader, and reflecting on this throughout the process, I hope to have kept the focus on the content of my data and not my personal characteristics and preferences.

The validity and reliability of the quantitative component of my study is discussed in the next chapter. This has been done as some of the issues around the validity of the study are linked to the method of analysis which is itself embedded in the results and their interpretation. The interconnected nature of the methodology and data identification, selection, and interpretation makes it impractical for these to be separated.

It is important that the quality of my research and any apparent shortcomings are readily acknowledged. My use of multiple methods raises challenges for understanding the credibility of the work. In the course of this section I have provided details of how I have sought to ensure that my research is transparent through the provision of copies of my interview schedules. I have also provided information on how I have sought to maintain the credibility, transferability, dependability and confirmability through cross validation of different interviews and drawing on existing relevant research. In the next section I reflect on my positionality that is to say the researchers journey where I discuss my personal and professional experiences of suicide and reflect on them in relation to the research.

Summary

In summary, given the divide in the types of data needed to answer my research questions, I have used two distinct methods, one quantitative and one qualitative in my research. In chapter 5, I describe the secondary analysis of existing data using a multinomial logisitic regression. In chapters 6, 7 and 8 I present analysis of a series of interviews with three populations: social workers (n=17), service users (n=3), and Community Psychiatric Nurses (CPNs) (n=3). In my interviews I explore the remaining six research questions. By doing this I am able to utilise methods that best lend themselves to answering different research questions. Inevitably, this

means that different approaches to data collection and analysis take place; it is in the interpretation of the results that the two come together.

4.2 – The 'foreshadowed problem'

My research is not autobiographical and as such my own narrative is largely absent from this thesis. However we all:

> rely on presuppositions about the world, few of which we have subjected to tests ourselves, and none of which we could fully and independently test.
>
> (Hammersley and Atkinson, 2003:16)

These presuppositions can be problematic as they can be the very subject of study, an issue described by Malinowski as the 'foreshadowed problem' (1922:8). In order that I might be able to make the familiar strange and the strange familiar, I have reflected on my own experiences and examined how they may impact on my role as a researcher.

Suicide has been a strong narrative in my life, both personally and professionally; the personal dimension being the experience of my own mother's suicide, and the professional dimension being my experience working with suicidal service users as a social worker. Subsequently, I find myself in the position of being a double insider; that is to say a person who has experience of the matter under study in two ways. I will discuss each of these in turn, examining (i) the nature of these experiences and their potential impact on my role as a researcher and (ii) how these experiences were negotiated in the course of the research.

Through the looking glass – My personal experience of suicide

My mother's suicide had a profound impact on my understanding of suicide. Her struggle with bipolar disorder over the course of a twenty year period was marked by at least five attempts to end her life. These attempts occurred throughout my childhood and I grew up in a household where discussions about mental health and suicidality were commonplace. The experience of my mother's suicidality made me address the topic of suicide, forcing me to forge my own ideas about the 'causes' of suicide and its prevention.

In conducting the research there was much that seemed familiar to me, but equally much that challenged my preconceived ideas and experiences: both the familiar and

the unfamiliar were to prove problematic. My own experiences at times resonated strongly with the accounts of my participants, but at other times they stood in stark contrast. The risk of being overly familiar with my data posed the possibility of 'going native' (Fuller, 2004), running the risk that important information might not be identified. To help mitigate this risk I regularly revisited the data and reflected on the content.

Equally, unfamiliar narratives that challenged my own perceptions and ideas were, at times, difficult to engage with. The close proximity of the research topic to my own experiences inevitably raised the prospect of an emotional toll on me. Fincham *et al.,* (2008) noted that research into suicide can have an emotional impact on researchers. My experiences of being bereaved by suicide only served to heighten this risk and as such, the need for me to be emotionally aware in my own research was paramount. While topics were at times challenging, the research data were sufficiently removed from own experiences as to not be emotionally distressing.

As a final note on this point I readily acknowledge that my personal experiences of suicide and understanding of the topic are not necessarily any more valid than anyone else's. Others who have been bereaved, or have survived suicide attempts, may have very different narratives from my own.

Negotiating roles – Social worker versus researcher

In addition to my mother's suicide, I also had to consider how my status as a social worker might impact on my research. As a qualified social worker with some limited experience in children's services, I am a member of the professional group that is the focus of my study. This posed both challenges and opportunities for the research.

As a social worker I am bound by various codes of conduct, such as the Care Council for Wales Code of Practice (Care Council for Wales, 2001). Embedded in these codes is a duty to promote the wellbeing of service users and to protect their rights. Simultaneously, I am also subject to researcher codes such as the Code of Ethics for Social Work and Social Care Research (Butler, 2002). These codes have much in common such as protecting individuals from harm, but there is also the potential for conflict.

Examples of potential conflict were present in my research in two ways. First, as a researcher the purpose of my interviews was to elicit information from my participants, but as a social worker interviews might also be therapeutic in nature,

possibly offering some form of counselling. It was necessary during my interviews to make sure that participants were clear that the interviews were not designed to be therapeutic in nature. Second, confidentiality is managed differently by these two roles. As a social worker, a disclosure of substance misuse might warrant further interventions or a referral to other agencies. The same information for a researcher might be seen as an insight into the perspectives of the participant, and would be unlikely to be referred unless in extremis. This is not to say that there are not occasions when researchers should breach confidentiality (this is a topic discussed in section 4.3), but the threshold level at which confidentiality is breached would be different (Wiles *et al.,* 2008; Al-Shahi and Warlow, 2000).

Bogolub (2010) and Bloor (2010) have suggested that social work research in particular needs to meet a higher ethical standard than other research. Specifically, Bogolub states:

> for social work researchers, it is not enough to create new knowledge. Social work research is guided by the ethical principle of beneficence, and social work researchers are also obligated to bring about good.
>
> (Bogolub, 2010:10).

Bogolub and Bloor appear to allow little room to consider the complex relationship between researchers and participants. For example, research participants may not wish the researcher to champion their cause if this also compromises the confidentiality of their data. Bogolub and Bloor might be accused of failing to problematise the concept of what constitutes ‘good’. Bovin and Schmidt’s (2009) work on acupuncture and fertility treatment highlights that there are multiple levels of good and harm, some of which are more transparent than others. Using the example of the placebo effect she correctly asserts that concepts of ‘good’ and ‘bad’ can pull in different directions; an intervention may not be doing any good in its own right, but the belief in it is sufficient to have a positive impact.

In the case of suicide prevention we might draw parallels with a service user being given medication to help improve their mood. This medication may be well received by the service user and have a positive impact on their mental health. However a failure to help the service user address their mounting debt may mean the medication has limited impact in the long-term. The service user has been provided with assistance which might be seen as ‘good’, however if other issues are not addressed, the benefits of such assistance might only prove to be temporary.

Bogolub (2010) and Bloor (2010) also seem to be constructing a divide between social work researchers and other researchers. This seems to be doing other social science researchers a disservice. As we shall see in the next section, ethical scrutiny and reflections on ethical considerations are fiercely debated concepts. To assume that one profession holds a monopoly on what is 'good' is disingenuous in the extreme. It fails to recognise how social science researchers and social workers have much in common. For example, D'Cruz and Jones (2004) discuss how social workers regularly conduct interviews in a way not dissimilar to researchers. The skills of getting people to tell their story is something that is common to both professions. For myself, I felt that I was not there to advise or assist my participants. Instead it was my role as a researcher to listen to what they said, and to use this to develop and further our knowledge of the role of social workers in suicide prevention.

The blurring of roles between social worker and researcher also manifested itself in my knowledge of the language of social work. This proved to be a great advantage when securing access, recruiting participants, and when conducting interviews. For example, the acronyms, abbreviations, and professional terms used by social workers were readily known to me, making it easier to converse with participants and to put them at ease.

My social worker status also assisted me during my efforts to gain access to a hard to reach, closed profession. For example, during one meeting with a local authority there was a direct challenge to my status as a 'researcher'. In the course of this meeting I was asked if I was 'a professional' (by which they meant 'a social worker'). The tone of voice and the bluntness of the question indicated that only a fellow practitioner would be able to understand social workers. Holdaway's famous study (1982) of the police force illustrates how being a 'member' of a profession can be vital in gaining access. The ability to state that I was a qualified professional meant that I was able to allay fears that I was *other* and gain access. This might also account for the willingness of many to participate in the research, and their apparent frankness during interviews.

Reflection on researcher identity – my personal and professional journey through the research data collection and analysis

Thus far I have explored my personal and professional identities in the form of foreshadowed problems 'locating' myself in the research. However, it is also necessary that I reflect on my personal and professional journey throughout the

process of research data collection and analysis. As has been previously noted, the research at times was emotionally challenging presenting me with a need to carefully consider how my own experiences might impact on both the collection and analysis of my data.

It is, as Heidegger (1962, reprinted 1996) notes, impossible to approach a topic with a blank canvas. Inevitably every person will perceive a given phenomenon in a unique way that is framed through his or her prior experiences, understanding and background. Yet determining how our subjectivity influences our data collection and analysis is, however, a complex task (Finlay, 2002). By being reflexive we are, to varying degrees, able to gain an insight into the impact on the collection and analysis of our data.

In terms of the interviews, that is to say 'conversations with a purpose' (Burgess, 1984), my line of questioning, body language and even the inflections in my voice will have impacted on the responses of my participants. In the collection and subsequent analysis of my interviews I was conscious that during my interviews with professionals I readily defaulted to using terminology and acronyms. In doing so I was able to converse with professionals in a language that we were both familiar with. However, in doing so I potentially risked not unpicking the meaning behind terms being used. For example, terms such as 'commissioning care packages' could have been discussed in greater depth by probing more into the process of commissioning and the experience of doing so.

To help me refine my approach and reflect on how my previous experiences were affecting my data collection I would listen to previous interviews before conducting the new ones. In doing this I was able to refine my approach and examine how my own previous experiences were impacting on my data collection.

As discussed my status as a social worker did however greatly aid me in gaining access. However, this presents the added risk of 'going native' (Fuller, 2004), or rather, becoming too closely aligned with my participants. To help address this I regularly reflected on my actions endeavouring to make the familiar strange.

Perhaps inevitably the process of collecting and analysing data on a topic where I have personal experience did prove challenging. As noted by Fincham *et al.,* (2008) the topic of suicide is an emotionally charged issue that can be difficult for the researcher. During the collection of my data some of the concepts and ideas raised by professionals and service users were challenging. For example, during a

conversation outside of an interview a professional not participating in the research opined that suicide was necessarily a 'narcissistic selfish act'. This was a challenging discomforting assertion to hear given my own personal experience.

While I endeavoured to ensure that my personal feelings were not apparent to those being interviewed, I am conscious that it is possible that my thoughts and feelings may have had an impact on my analytic work. I did not disclose my personal history with participants as I was concerned that if I did then this might impact on their responses.

However, my experiences of being bereaved by suicide did allow me to empathise with social workers when discussing their experiences of service user suicides. These were at times highly emotive for my participants, and while I did not disclose my experiences, I was able to reflect on my feelings and use this insight to help guide the conversations in a sensitive manner.

In analysing my data I was conscious that I needed to keep the impact of my own personal and professional experiences to a minimum. I sought to draw on wider literature, and as will be discussed, develop a coding scheme that allowed me to carefully validate any emergent themes. It was necessary to recognise where my own thoughts and feelings ran contrary to the data and record this in a research diary.

My journey through the research was at times challenging, both emotionally and professionally. Making the move from practitioner to researcher, whilst also managing personal experiences, required me to carefully consider my actions both in the field and in analysis. As Anderson (2008) notes, reflexivity requires us to carefully consider the lenses through which we see the world. It is a constant process that requires us to constantly consider our positionality and question our take for granted assumptions.

Summary

In summary, while my own narrative is largely absent from the chapters that follow, I readily acknowledge that my 'voice' is inevitable, both in the text in general and the 'presentation of the voices of one's respondents within the text' (Hertz, 1997:xi-xii). By reflecting on my own 'presuppositions about the world' (Hammersley and Atkinson, 2003:16) I am able to 'locate' myself (Firestone, 1987 quoted in Denzin and Lincoln, 2000:183) to some extent and make this apparent to the reader.

4.3 – Ethics

Suicide is a sensitive topic and as such due consideration was given to the ethics of the research strategy being employed. Ethical considerations start prior to entering the field and continue long after we have written up our findings. It is an ongoing process with new issues arising all the time and points being constantly renegotiated. Over the coming pages, I first discuss the process of obtaining ethical approval, before providing a discussion of the main ethical issues that needed to be negotiated in this study.

The Research Ethic Committee (REC) – effective safeguard or bureaucratic leviathan?

Ethical approval was obtained from the Wales National Health Service (NHS) Multi-centre Research Ethics Committee (MREC). Approval from an NHS REC/MREC was necessary for me to interview NHS staff and conduct research on NHS properties (in England and Wales mental health services are joint ventures between the NHS boards/authorities and social services departments situated in local authorities). The multi-centre REC was selected because the focus of the study is a minority group within a minority group (that is to say those who are suicidal and have social worker contact). To maximise the potential sample population, a large geographical area covering two health boards and multiple local authorities was originally selected[12]. An MREC, being able to give ethical approval for multiple NHS organisations, was therefore appropriate.

The experience of gaining MREC approval required me to engage with pertinent discussions about the merits and ethics of my research. The main ethical issues in my research including MREC recommendations are discussed below. Many of the ethical considerations of the study focus on my semi-structured interviews, however, where relevant, ethical issues around the use of secondary data analysis (i.e. the quantitative component of my research) are also discussed. The main ethical issues are given below and will be discussed in turn:

- Confidentiality versus duty of care
- Informed consent
- Exclusion and inclusion criteria

---

[12] One health board and three social service departments eventually participated in the research. MREC approval was sought at the same time as access was being negotiated.

- Data protection
- Ethics in the field

Confidentiality versus duty of care

Speaking to people about their experiences of suicide can be emotionally challenging. As such, there was a need to provide an environment where participants could talk openly in the confidence that the issues they discussed remained confidential. Equally, however, I have an ethical duty to ensure that my participants do not come to any harm by engaging in the research. The British Sociological Association (2002) for example, makes specific reference to the need for a researcher to promote and safeguard the welfare of participants where necessary. To do this it may, for example, be necessary for outside help to be sought in instances where a person becomes unduly distressed, thus jeopardising confidentiality. This was a matter of particular concern where my participants were also service users with a history of suicide attempts.

It is important to stress that there is no evidence that talking about suicide increases the risk of a person becoming suicidal. The ASIST programme, advocated by the Welsh Government 'Talk to Me' (2008) strategy, promotes actively asking in appropriate circumstances if a person is suicidal. This does not mean that a person would not still become distressed recalling their experiences. It seemed likely that some participants might become upset discussing their experiences, but this did not mean that they would become unduly distressed. The line between being upset and unduly distressed is not easily quantified, but has been discussed by Hollway and Jefferson (2000). They suggest that distress may not be harmful to participants and in some circumstances may be beneficial to participants as they get the chance to explore their thoughts and feelings.

To help balance the competing demands of confidentiality and duty of care, service users were asked to provide contact details about their general practitioner and/or their CMHT link worker. The information sheets provided to the service users notified them that this information would be used to contact these professionals for support in the eventuality that they became unduly distressed. Participants would be told of any need to breach confidentiality prior to any referral being made. There was also the added protective factor that the service users were being recruited by social workers, who were often their case worker. The MREC further requested that a formal protocol be written to explain the process for deciding to breach confidentiality: specifically that I would initially notify my supervisors, before

contacting the relevant services, and then would remain with the service user until some assistance was available. I would also contact the relevant services over the course of the preceding week to check on the welfare of the service user. In the event, this did not prove necessary during the course of data collection.

My interviews with social workers and CPNs also raised the possibility that they may become distressed. Here, however, support would readily be available as the interviews took place in the social work offices, meaning that their colleagues and managers could be called upon in the event that they became unduly distressed. The MREC raised concerns about the language used to explain confidentiality on the information sheets. They felt that it was not made sufficiently clear that a breach of confidentiality would take place if misconduct were uncovered. As such the wording for this was amended to emphasise this point. Again this did not prove necessary during data collection.

Informed consent

Consent is an on-going process that does not start and end with the signing of a consent form but must be continually negotiated and reconstituted throughout the research process (Atkinson *et al.,* 2003). Homan (1991) reminds us that no participant can ever be completely informed about participation in research, as research inevitably changes and evolves as it progresses. Despite this, the focus of the MREC was on the documentation for the project. As previously indicated, they provided some useful advice on the wording of my documents, but there was no suggestion by them that consent was an ongoing process.

To ensure that participants were as informed as possible, consent forms were completed in duplicate and at more than one stage of the process. When a person first expressed interest in the research, they signed an initial consent form to say that they were happy for me to contact them. A further consent form was also signed at the point of interview, and the confidentiality clause and purpose of the research were also stated verbally at the start of each interview. My contact details (phone number, email and address) were highlighted on all documents, and wherever possible I attended the team meetings of professionals. This meant that I was able to present my work, and clarify any issues with potential participants directly. This was particularly important because I was dependent on social workers to recruit service users. Once a social worker passed the details of the service user to me, I spoke to the service user to arrange a location and time for the interview. At this stage service users were able to ask questions. There was also an inevitable time

delay between agreeing to participate and the interviews taking place, giving participants time and opportunity to reflect on participation.

The main issue with any form of consent is that of redressing the inevitable power imbalance between the researcher and the researched (Homan, 1991). To make my consent forms as accessible as possible, I attempted to get service user organisations to comment on both my research design and documentation. One of these organisations declined to participate and the other advised that they would only be able to assist once REC approval was granted. This would have meant going back and forth between the REC and the service user organisation and therefore was not possible in practice. Appendix B provides a copy of my consent form for professionals and Appendix C for service users.

It was also necessary to consider informed consent for the quantitative component of my research (i.e. the secondary analysis of an existing data set). Those participating in the original study would have been advised that their data would be made available for others to use, albeit in an anonymous form. However it is unlikely that they will be aware of the nature of these studies. The implications of this are that participants might not have been so willing to participate if they knew that the data was being used for certain topics, such as suicide. While I was not able to redress this issue, I needed to be sensitive about how I used that data and how I represented the participants in my findings.

Exclusion and inclusion criteria

Setting the limits of the research was vital to ensure that the project did not become too broad or unmanageable. For example, social work is, as was noted in chapter 3.1, a diverse profession meaning that if I had not specified statutory social workers there was a potential for the scope of the research to be become too broad and diffuse.

Equally, however, too stringent eligibility criteria would have served as a barrier to recruiting participants. If, for example, I had restricted the study to just focus on social workers who had experienced the death of a service user in the last three years, then it is unlikely that I would have been able to recruit many participants.

Establishing the eligibility criteria for social workers and other professionals was relatively straightforward. For social workers, they had to be employed in a statutory role with experience of working with service users who they believed to be/have

been suicidal. For health professionals, they had to have had experience working alongside social workers with suicidal service users in multi-agency settings.

The complications and primary ethical issues arose when clarifying the eligibility criteria for service users. The criteria were set as follows:

- All participants were to be aged eighteen years or older.
- The service user should have had a history of suicidal behaviour or attempted suicide.
- Anyone who appeared to lack the capacity (Mental Capacity Act 2005) to make an informed decision on participation in the study would not be permitted to participate.
- The social worker (or referring professional) had to be satisfied that the service user did not pose a risk to my welfare or safety.
- Anyone who continued to be subject to sections S35, S36, S37 or S41 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) could not participate.
- Anyone who was under a Community Treatment Orders (CTO) or equivalent could not participate.

The requirement for participants to be aged eighteen years of older was a practical decision that was made to avoid any issues with consent. Those under the age of eighteen are still classed as children under the Children Act 1989 and so are still subject to parental responsibility. Gaining consent for parental responsibility would have added more complexity to the research process. Further to this it is unclear how willing a REC would have been to me undertaking research with vulnerable young people.

The second criterion, a history of suicidality, was very much reliant on the interpretation of the recruiting social worker. They were determining what cases were being approached, but also whether they felt a person was suicidal or not. This raised the possibility of selection bias by social workers, but without their assistance any identification of potential participants would have been impossible (this is discussed more in chapter 6.1.

Asking social workers to verify that they had no reason to doubt that the service user had capacity to make an informed choice on participation was important in upholding the rights of service users/participants. If someone lacks capacity to make a decision on participation they cannot give informed consent. This would be unfair

and potentially exploitative. While capacity is time and issue specific, I determined that social workers should not be approaching individuals whom they knew to have issues with their capacity. Similarly it was important that the referring practitioner did not include those who had a history of behaviour that might have posed a significant risk to my own safety.

The last two points were less problematic as they were easily identifiable issues. It was straightforward for the social worker to check the records and establish whether the service user was currently subject to any of these conditions. The rationale for excluding individuals subject to these various conditions was more practical than ethical in nature. The sections highlighted under the Mental Health Act(s) (1983/2007) are primarily court powers, making Ministry of Justice or Home Office approval necessary. This would have added another layer of approval and slowed down access. Similarly those subject to a Community Treatment Order are under the care of a responsible clinician who would also have to be identified and approached prior to any interview.

Data Protection

The Data Protection Act 1998 introduced new safeguards for the collection and storage of personal information that have implications for researchers. All information must be kept securely and should be processed only for the purposes for which it was originally collected.

On the first of these points (keeping data securely) the MREC proved to be very helpful: pointing out that my original plan for social workers to email me participant information was not secure. Emails between social services departments and the university would not be secure. It was agreed that the documents should be sent by post. However, this was later complicated when a Data Protection Officer at one of the social service departments stated they were unhappy for such information to be sent by post, believing this also to be insecure. They felt that the postal service was unreliable and there was a high possibility that documents might be lost. Frustratingly, they favoured the use of emails. Data protection issues appeared to be largely driven by the perspective and interpretation of individuals and organisational culture. It was finally agreed that a point of contact in the social service department would collect all documents (e.g. participant information) on my behalf, and I would collect any documents by hand.

Beyond this particular issue, maintaining secure storage of documents was relatively straightforward. The office I used for the duration of my research was only accessible by a security door and the locked cabinet where consent forms were stored could only be accessed by me. All other data were stored on the university's secure servers, encryption software was installed on my laptop, and my mobile phone with email and phone correspondence could be remotely wiped (all of these were password protected).

Ethical issues in the field (situated ethics)

The potential ethical issues of my research have been discussed at some length, but thankfully there were only two comparatively minor ethical issues experienced upon entering the field. The first and most challenging ethical issue occurred during an interview with one of the social workers.

One of the social workers interviewed, whom I shall refer to as 'Anna', had two service users who completed the act of suicide in the week prior to my interviewing her. I was concerned about her emotional wellbeing and spoke to her in private about whether she still wished to participate. During this conversation I gave her a copy my interview schedule and advised that she did not have to answer any questions if she did not wish to. Equally her right to take a break or stop the interview at any stage was restated. Anna took some time to consider her participation while I conducted other interviews. She eventually agreed to participate. The emotional strain of the suicides was very evident: at times Anna blinked back tears and at other points she took long pauses. In the course of talking about her experiences Anna remarked that she was '*using* [the interview] *as my debriefing'* and then apologised for doing so. I was aware that talking about what had happened was difficult, but also cathartic for Anna. At the conclusion of the interview Anna and I spent a few minutes chatting and I asked whether she wanted any additional support: she declined and indicated that she was getting a lot of informal support from her colleagues, a point on which I elaborate more in chapter 7.5.

Hutchinson *et al.,* (1994) point out how interviews might feel therapeutic to participants, particularly those with emotionally intense issues. Hollway and Jefferson (2000) have discussed this point and suggest that research interviews can provide a safe environment for participants to emote, which can act as a therapeutic experience for them. However, as pointed out earlier when discussing my status as a social worker, the purpose of my interviews was not to provide counselling to my

participants. While I was careful to listen to Anna, I did not treat the interview as a counselling session and I was clear to point out at the conclusion of the interview which services might be able to offer her support.

The second, very minor, ethical issue arose during the recruitment of social workers and community psychiatric nurses (CPNs). On several occasions I was asked by practitioners if I could provide them with further information about suicide and suicide prevention. This was not something I had expected and it placed me in a dilemma: should I provide the information prior to my meeting to build my relationship with the department, or should I wait until after I had undertaken interviews? To provide the information before might potentially impact on what they said during interviews. Failing to provide this information might have impeded the ability of social workers to prevent suicides. I resolved this issue by explaining that I would happily provide information after the interviews, but not before as I wanted to know what knowledge the social workers currently had about suicide prevention. This explanation was accepted and did not seem to affect recruitment.

4.4 – Gaining Access

Social workers and health care professionals both occupy professional statuses and are situated in statutory agencies with complex bureaucracies. Access to these departments was essential for the recruitment of both social workers and service users. Hayes (2005) notes that this is particularly problematic for social work as each social services department has its own peculiarities and processes.

The first hurdle was identifying gatekeepers who would be able to facilitate access (Schutz, 1976). Identifying a gatekeeper is not an easy task, as it varied in each local authority. After identifying the correct contact, I first wrote to them with a brief letter outlining the study and then followed this up with phone calls and further letters. As a result of this correspondence, meetings were arranged with those empowered to grant or refuse access.

Three local authority social services departments granted access for my study. The format of these meetings varied greatly between each organisation. For example, in one department I had a meeting with the relevant senior manager who then contacted staff directly. As a result of this, participants were identified within the space of a two week period. The other two departments also started with meetings involving only senior managers, but these were followed by meetings with the team managers in the services, and then finally by meetings with each of the relevant

teams. Each department had a different process for reviewing research. One department was content for the service manager to review the project. Another required just the designated data protection officer review the research. Only one of the three authorities had a person designated as responsible for reviewing research proposals.

The lack of consistency in gaining access to social services departments might be attributed to the limited culture of research that exists in social work. This stands in stark contrast to the NHS, where each health board/authority has a Research and Development (R&D) office. These are independent from the REC and are responsible for examining the practical implications of the research on service delivery (e.g. time and cost). Any form of research taking place on an NHS site or utilising NHS staff or resources requires permission from an R&D office. The R&D process is highly prescribed and (like the NHS REC process) utilises the Integrated Research Application System (IRAS) for document submission and stands in some contrast to the generally ad hoc approach of the social services departments. Each site required paperwork to be completed that was specifically tailored to the needs of that site. Getting into contact with relevant NHS gatekeeper was achieved using the contacts in social services departments. Obtaining the relevant permissions was not complex, but identifying the relevant persons and negotiating the extra layers of permission was yet another factor slowing access to the field.

The bureaucratic process of the NHS systems was particularly confusing, but equally the variability of processes within the social services departments was marked. There was, however, generally a very positive response towards the research by both senior managers and professionals across the NHS and social services.

4.5 Sampling and data analysis

In this section I set out the sampling strategy employed in my qualitative primary data. The sampling approach used for the secondary data is discussed in the next chapter. A combination of purposive sampling and snowball sampling was employed to reach three stakeholder groups:

1. Social workers employed in statutory roles (i.e. local authorities)[13].

2. Health care professionals who have experience working with service users in cases where service users have been suicidal.

3. Service users who have been suicidal whilst under support from social workers.

Two of the three target populations identified are professional groups operating within large statutory agencies. Gaining access to privileged or powerful groups presents considerable challenges, as has been noted by Williams (1989) and Holdaway (1982). The researcher is in these situations obligated to work not only with professionals but also within the bureaucracies that can facilitate or restrict access. As has previously been discussed, three social services departments (one children's service and two adult services) in three different local authorities, as well as one NHS health board, agreed to participate in the study. All of these were situated in the South Wales region.

In identifying three groups my sampling strategy was partly purposive in nature. Purposive sampling, a form of non-probability sampling, is where the individuals included in the sample are selected by the researcher using specified criteria (Oliver, 2006). This as Oliver suggests, is a pragmatic approach which is often employed when trying to gain access to hard to reach groups such as professionals. This approach inevitably carries the risk of selection bias with the researcher intentionally identifying people or groups that they feel are important to the study (Emmel, 2013). This may prejudice the study as it may be biased towards the perspective of certain groups. In terms of my own sample, the identified groups were selected based on their relevance to the topic area. In the case of this research, social workers are unsurprisingly the main area of focus, but as Pritchard (2006) reminds us they do not work in isolation. As such, gaining the insight of health professionals who often work alongside social workers in Community Mental Health Teams (CMHTs) was felt to add an additional dimension to our understanding of the role social workers play in suicide prevention. Finally we need to gain the insight of those who social workers are trying to assist (i.e. service users). Their perspective as recipients of care makes them uniquely placed to comment on how the actions of social workers can help, or hinder, those with suicidal thoughts and feelings.

---

[13] Being employed by a local authority meant that the social workers would be qualified and registered with Care Council for Wales.

As indicated, my approach to sampling was not exclusively purposive in nature. After initially identifying the three target populations the selection of participants took on more of a snowball approach (Morgan, 2008). Here information about the study was disseminated through a variety of means and respondents chose to participate. Social workers and CPNs were made aware of the study through emails and visits to team meetings. Some participants were directly recruited through these meetings and others self-nominated to participate after hearing about the study (either through the emails or discussions with colleagues). This approach does, like probability sampling, carry inherent issues and limitations. Berg (2006) has noted that some people, specifically those with more social connections, are more likely to be aware of and potentially participate in research than others.

Further to this, a consideration underlying both probability and snowball sampling is that of the motivation of participants. The decision to participate in a given piece of research can be based on a multitude of reasons, including personal experience, a desire to help others, curiosity of the topic under discussion, amongst other reasons (Emmel, 2013). The sensitive nature of the topic raised the prospect that people might have strong emotional attachments for wishing to take part. Further to this, social workers are often subject to public criticism (Ayre, 2001; Warner, 2014) and may wish to portray their actions and thoughts in a particular way that makes them appear more positive.

However it is difficult to validate the motivation that a participant has for participating in a study prior to interviewing them. It is important to note that even when a participant has a strong or clear reason to participate their contribution can still be valid and informative (Emmel, 2013; King and Horrocks, 2010). As such, all those who met the eligibility criteria and wished to participate were invited to do so.

The issue of possible selection bias was particularly acute for the service users in my study. It was not possible for me to identify service users without the support of social workers. I could not ethically or legally go through social service case files to identify appropriate service users. Social workers were ideally placed to be gatekeepers facilitating access to a hitherto largely unknown and difficult to access group. However, asking social workers to identify and recruit service users raised the possibility of them selecting those who would portray them in a positive light. This should, however, be tempered with the knowledge that service users with a prolonged history of social work assistance are likely to have had multiple social workers. Social services are plagued by high levels of staff turnover (Webb and

Carpenter, 2012; Huxley *et al.,* 2005). As such, even if a social worker identified a case because they felt it showed them in a positive way, the service user's previous experiences with other social workers might have been different. Attempts were made to contact third sector organisations specialising in mental health who might also have been able to identify relevant service users. Unfortunately these conversations did not come to fruition and I was reliant on social workers as the primary gatekeepers for the recruitment of service users.

One final consideration in the sampling strategy was the size of the sample. The degree to which a sample size is 'sufficient' particularly in instances where you are seeking to gain qualitative, that is to say rich, data, remains highly contested (Sandelowski, 1995). Some, such as Charmaz (2004) and Ritchie *et al.,* (2003), have suggested that between 20 and 50 interviews, depending on the scale of the study, are sufficient. These relatively arbitrary numbers do however fail to take into account the importance of issues such as data saturation (Strauss and Corbin, 1990). Saturation, the notion that no new information would be uncovered by further research, does however carry its own problems. Specifically, validating how and when saturation has been achieved is a heavily debated topic (Ritchie *et al.,* 2003; Bowen, 2008). In short, there is no single 'right' approach to sampling but rather a series of different approaches that focus on a wide range of factors ranging from the methodology we use through to the subject matter. Marshall (1996) notes qualitative sampling is often determined by convenience and practicalities. When researching hard to reach populations, such as professional groups, issues of access and time can often be primary factors for determining the size and reach of a sample.

In summary, a combination of purposive and snowball sampling was employed to target three population groups; social workers, health care professionals and service users with a history of suicidal behaviour. Eligibility criteria were devised that helped to target these groups. In total twenty three participants (17 social workers, 3 service users and 3 Community Psychiatric Nurses) participated in interviews. Ideally more CPNs and service users would have been recruited however given the hard to reach nature of the groups in the study it proved difficult to capture a large population.

Data Analysis

There is a plethora of different approaches that might be employed to analyse qualitative data, ranging from conversation analysis (Sacks, 1995) and discourse analysis (Renkema, 2004) through to thematic analysis (Guest, 2012). Ultimately all qualitative research should strive to develop an understanding of the experiences

and associated meanings of those being studied, that is to say their subjective world (Fossey *et al*., 2002). As Denzin and Lincoln (2011) remind us, the purpose of analysis is 'sense-making', the act of taking raw data and distilling the meaning, without losing or corrupting, the context. Selecting an appropriate approach to analysis is as important as the selection of the method itself.

In order to gain an insight into the subjective worlds of my participants I adopted a thematic approach to analysing my data. This approach was chosen as it offers high levels of flexibility which were felt to be important when researching a previously under-researched subject. However, the comparative flexibility of thematic analysis is both a strength and a weakness. Boyatzis (1998) suggests that it does not compel a particular method or even definitive stages of analysis. The advantage of this is that the approach can be adapted to suit multiple methods and the needs of specific studies. However, the lack of definitive clarity over what constitutes the particular approach runs the risk of an 'anything goes' mentality (Antaki *et al*. 2002). The lack of clarity about what constitutes thematic analysis and its implementation has been a matter of some considerable debate (Tuckett, 2005; Attride-Stirling, 2001). It is therefore vital that those using this approach to analysis are transparent about the steps involved so that others can understand what was involved. I have therefore set out my approach as follows.

Thematic analysis essentially requires the researcher to examine their data and inspect it for 'recurrent themes, topics or relationships' (Mills *et al*., 2010). Themes are, as Leininger remind us, the 'bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone' (1985:60). Where incidents related to a theme are observed then the researcher codes or labels the data to help categorise the data and develop an understanding of a given phenomena. By coding data it is possible for information to be easily retrieved enabling the process of theory-building to begin.

Boyatzis (1985) suggests that thematic analysis provides a means of (i) seeing, (ii) finding relationships, (iii) analysing, (iv) systematically observing a case, and (v) of quantifying qualitative data. In making this claim Boyatzis is drawing our attention to two points: first thematic analysis can be used in a variety of different ways with an array of different methods (i.e. observation, focus groups, interviews, etc.[14]); and

[14] Traditionally thematic analysis was primarily used with text based data however it increasingly being applied to other forms of data such as video and audio files.

second, thematic analysis is comprised of a series of stages that require the researcher to read and re-read their data (Rice and Ezzy, 1999) until they have achieved data saturation (Strauss, 1987). Data saturation, the point at which no new information emerges, is however a much debated topic (O'Reilly and Parker, 2013; Ritchie *et al.,* 2003; Bowen, 2008). It is therefore incumbent on researchers to demonstrate that they have achieved this through a transparent methodology and clarity in their results.

In order to achieve data saturation it was necessary to develop a coding scheme that effectively captured the key themes from my data. To assist me with this process and ease the process of coding, the interviews were (with the permission of participants) recorded and transcribed. Nvivo 10 Computer Aided Qualitative Data Analysis Software (CAQDAS) was then used to aid me in my coding. This software allowed me to code my data in an organised way, greatly assisting me during analysis. CAQDAS packages such as Nvivo have been critiqued by Coffey and Atkinson (1996) for obligating researchers to organise data in particular ways, potentially impacting their findings. However more recently Seale (2002) has disputed this arguing CAQDAS can actually improve the analytical rigour over more manual methods. This, he argues, does not detract from the craft of social research, but instead is a tool that assists us. CAQDAS packages are able to assist with the process of analysis however the craft of analysis remains the exclusive preserve of the researcher.

Identification of themes and the codes that underpin them can, as Strauss and Corbin (1990) suggest, be both inductive and deductive. Inductive themes embody a grounded perspective with themes emerging from the data. In contrast to this deductive themes are based on theoretical constructs that the researcher wishes to explore prior to entering the field. Miles and Huberman (1994) have suggested that while most coding falls into these two broad categories the process of coding is discursive in nature with codes being formed and changing as concepts develop. They argue that most coding has not two but three distinct typologies: (i) descriptive codes that identify specific points such as mention of professions; (ii) interpretive codes that provide context to a given event/situation; (iii) pattern codes, which focus on emergent themes and patterns in the data. In my work I devised a coding scheme that borrowed much from the approach advocated by Miles and Huberman.

My rationale for adopting this tripartite approach to coding the data was that it enabled me to capture information that could be used to explore themes previously

identified in my literature review, whilst also aiding me in identifying new themes. Essentially the three types of codes helped to build on one another with descriptive codes providing basic information that could be explored and developed further through the coding process. The hybrid approach to thematic analysis utilising both deductive and inductive approaches has been previously undertaken by Fereday and Muir-Cochrane (2006).

Coming from a phenomenological perspective, Fereday and Mui-Chochrane used a six stage approach to coding. An important feature throughout their coding process was that of reflexivity, specifically the ability to validate and amend codes by close examination and rereading of the data. Whilst my approach does not specifically embrace the approach advocated by Fereday and Mui-Chochrane, it did however pass through a series of stages that I will now briefly summarise.

Stage 1 – Descriptive codes – Data were coded to identify information such as profession or a reference to method of suicide. A multitude of descriptive codes were identified and then linked and built on in the subsequent stages to build a detailed understanding of the phenomena being explored. This was initially informed by my literature review and subsequent additional codes were developed as themes emerged from the data.

Stage 2 – Interpretive codes – By reading through of the data with a copy of the descriptive codes at hand it was possible to start identifying the 'context' of the descriptive codes. For example, where training on suicide (or its prevention) was mentioned I coded factors such as whether it was formal or information learning. Other codes focused on positive or negative responses to a given issue.

Stage 3 – Pattern code – After the identification of interpretive codes I again re-read the data and looked at the codes identified as interpretive codes. In doing so I was able to identify patterns and emergent themes. An example of this would be the importance of peer learning in social workers' understanding of suicide. This theme encompassed a series of interpretive codes such as, attitudes to formal training experiences, instances of knowledge acquisition in multi-agency and interdisciplinary settings, and the opportunities for formal training.

Step 4 – Validation – After pattern codes had been identified I initially returned to check on my reading of the data and then sought to identify existing literature for comparability. This final stage can be seen in my empirical chapters.

It is important to note that this was an iterative process with me moving back and forth between different stages. Some themes that initially showed promise were later discarded. Conversely an emergent theme could prompt the descriptive codes to help better unpick and validate the theme.

As already noted, the final stages of the quantitative component of my study were being completed at the same stage as my primary data collection was occurring. The findings from the quantitative component of my study, while present in my mind, were used to help explore and validate the issues identified in the qualitative component of my study. An example of this is the topic of substance misuse in suicidality and social worker contact.

4.6 - Conclusion

In this chapter I have explained how my research uses quantitative and qualitative methods to explore the role(s) of social workers in suicide prevention. The methods have been selected to provide data that will best answer my research questions. My research is comprised of two separate case designs; the first a secondary analysis of an existing data set (the Adult Psychiatric Morbidity Survey 2007) and the second, a series of interviews with social workers (n=17), service users (n=3) and CPNs (n=3).

The emotionally sensitive nature of suicide means that ethical considerations were of paramount importance in this study. Gaining approval from the NHS MREC was a convoluted, but helpful experience. Balancing the need to maintain confidentiality and a duty of care was a potentially difficult topic, but thankfully proved not to be an issue during data collection. Considering my own experiences of suicide helped me to consider how I related to my data. My own voice is largely absent from the narrative of my analysis. However it is hoped that making my own experiences apparent ensures that my work is as transparent as possible.

In the next chapter I present the first of my two case designs, a secondary analysis of the Adult Psychiatric Morbidity Survey 2007, to examine my first research question: under what circumstances do social workers come into contact with suicidal individuals?

Chapter 5 – Under what circumstances do social workers come into contact with suicidal individuals?

5.0 - Introduction

In this chapter I will use the Adult Psychiatric Morbidity Survey 2007 (APMS07) to explore the contexts under which social workers come into contact with suicidal individuals[15]. A multi-nomial logistic regression will be used to answer the following two questions:

1. Can a significant relationship be identified between suicide and social worker contact?
2. Under what circumstances do social workers come into contact with suicidal individuals?

I will open with a brief contextualisation of the chapter within the wider thesis. I will then explore the rationale for conducting a secondary analysis as well as how and why this data set has been selected. Each of the questions will then be addressed in turn. The chapter will conclude with an in-depth discussion of the findings and implications that this has for the qualitative component of my research and wider research agendas.

5.1 - Context

Previous studies have highlighted that many of those who take their lives have contact with services in the year prior to their death. For example, Mann *et al.,* (2005: 2065) suggest on the basis of studies in several different countries that 'up to 83% of suicides have had contact with a primary care physician within a year of their death and up to 66% within a month'. Data on contact with mental health services can be found in the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (2011). This inquiry suggests that for England, Scotland

[15] This chapter formed the basis for a forthcoming publication; Slater, T. Scourfield, J. and Greenland, K. (2013), Suicide Attempts and Social Worker Contact: Secondary Analysis of a General Population Study, *British Journal of Social Work*, Online Advance Access.

and Wales, the proportion of people dying by suicide who had contact with mental health services in the year before their death was 23-27% from 1998-2008. As a key constituent of mental health services, social workers are likely to be coming into regular contact with those at risk of suicide.

Further to this, there is increasing recognition that complex social factors are heavily implicated in suicide. For example, it is associated with living in areas characterised by social deprivation and social fragmentation (Whitley *et al.,* 1999; Rehkopf and Buka, 2006). Other issues include personal experience of unemployment (Platt and Hawton, 2000) and relationship breakdown (Shiner *et al.,* 2009). Despite the importance of the social context for understanding suicide, there has been little research into social work with suicidal people and the potential to enhance its preventive role (Feldman and Freedenthal, 2006).

Joe and Niedermeier note the 'relative scarcity of articles' in social work journals 'addressing the development of effective interventions' (2008:523) for suicide prevention. This is cause for concern when social workers are more likely to come into contact with persons suffering from suicide-related problems than many other more 'highly publicized problems like homicide, including child homicide' (Joe and Niedermeier, 2008:508). Further to this, it is estimated that for every successful suicide attempt, twenty-five unsuccessful attempts are made (Maris *et al.,* 2000).

Although most research in suicidology is quantitative (Stack, 2000a; 2000b; Hjelmeland and Knizek, 2010), the opposite is true of social work research in the UK (Huxley *et al.,* 2009a). It would therefore seem appropriate to explore what data sets are available and how these might help to add to our understanding of the role of social workers in suicide prevention.

This chapter will address, in a modest way, this methodological divide, whilst also adding to our knowledge on a greatly under-researched area. The use of archived data sets in the UK for social work research remains a minority activity and these data sets are a greatly underused resource (Maxwell *et al.,* 2012). It is appropriate therefore to explore what data sets are available to enhance our knowledge of social workers' contact with suicidal people.

It is important to emphasise that the purpose of this analysis is not to provide a predictive model of suicidality and/or social worker contact. As discussed in more detail in chapter 2.5, attempts to build such models (e.g. Pokorny, 1983; 1993) have been plagued by poor predictive capability (Goldney, 2000). Goldstein *et al.,* (1991)

note that even with groups known to be at high risk of suicide we are unable to 'predict' suicide. As Schneidman (2004) asserts, it seems that Heisenberg's uncertainty principle applies in that essentially the more we focus on a specific issue (such as the psychiatric histories of those who have completed the act of suicide), the less we know about the effect of other factors (such as socio-economic issues) on suicide and vice versa. The purpose of this analysis is to provide a purely cross-sectional insight into the circumstances under which social workers come into contact with suicidal individuals.

The methodological divide between the fields of suicidology and social work research might go some way to explain the relative dearth of knowledge, as noted by Joe and Neidermeier (2008), on the role of social workers in suicide prevention. This chapter will address this matter whilst also adding to our knowledge of a much under researched area.

5.2 - Method

Previously in chapter 4.1 I discussed my rationale for using secondary data. Here I explain how, and why, the Adult Psychiatric Morbidity Survey 2007 (APMS07) was selected.

Data set selection

The APMS07 was selected after a systematic search of available data sets in the Economic and Social Data Service (ESDS)[16], part of the UK Data Archive. It was a requirement for all studies that they had to have variables on both suicide/suicidality and social worker contact. Trying to find data on both these issues necessarily limited the number of possible studies.

To identify an appropriate data set, the ESDS was first searched for sets with variables addressing social worker contact. This was complicated by the numerous ways that social worker contact might be termed and categorised. For example, only three studies in the ESDS contained the term 'social worker' in the title, and only twelve studies included 'social worker' at any point in their variables. To address

[16] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, based at the University of Manchester, holds data that might also have been pertinent for this study. This data is however primarily focused on medical information. Access to this information is also restricted to clinicians working for NHS Trusts (Mental Health and Neurodegeneration Research Group, 2012).

this, the search parameters were expanded to include terms such as ‘social work’ and ‘social care’.

A second search was then conducted to identify data sets with variables exploring suicidality (terms such as ‘suicide’ and ‘suicide prevention’, etc.). Fifty-four studies were found to use the term ‘suicide’, but only twenty-three had ‘suicide’ appear in a variable. In total, 210 searches were made of the ESDS using the catalogue search option and a further 61 searches were made using the variable search option. When these results of these searches were compiled, eight studies were identified as potentially useful data sets.

Of these eight studies, three (*Focus on Youth Edinburgh Study of Youth Transitions and Crime, Waves One to Four 1997-2001 (ESDS ref. 4800), Mental Health of Young People in Great Britain 2004 (ESDS ref.SN5269), Youth Life and Time Survey (ESDS ref. SN6531)*) were discounted because they focused primarily on children and young people.

Three further studies contained limited data on social worker contact, making it hard to directly look at the relationships between suicide and social worker contact (*Health Survey for England 2008 (ESDS ref. SN6938), Health Survey for England 2007 (ESDS ref. SN6112) and, Welsh Health Study 2009 (ESDS ref. SN6589*)).

One final study (*Predictors of Suicidality: Towards an Integrated Model 2005-6 (ESDS ref. SN5599)*), was found to have pertinent data on both social worker contact and suicidality. Despite this, the comparatively small scale of the study (*n*=267) raised concerns around: (i) how far the findings could be generalised, and (ii) the frequency of social worker contact in such a small sample. As the study is looking at a minority group within a minority groups (that is to say those who are suicidal and have social worker contact), it was felt that the frequency of those who were suicidal and had social worker contact would be very small in such a small scale study. The study would also not have provided any understanding of those who were not suicidal, but did have a social worker (because the focus was on suicidal individuals only).

After reviewing the available data sets, the APMS07 (ESDS ref. SN6379) emerged as having relevant information on both suicide and social worker contact. It is important to note that this data set is for England, whereas the qualitative component of my research takes places in Wales (see chapters 6, 7 and 8). The decision to use an England only data set was made as no data set for Wales with

relevant information was identified. The process of devolution in Wales is leading to increasing divergence between the home nations in the areas of health and social care. For example, the new powers voted for in the 2011 referendum mean that the Senedd has increased powers which it is using to reform areas such as social services; as can be seen through the Social Services and Well-being (Wales) Act 2014. While we must be cautious in generalising the findings from this chapter to Wales, the two nations have much in common in regards to social services (Scourfield *et al.,* 2008).

More information on the data set is now provided, before moving on to explain how the data will be analysed.

Data set information and sampling technique

The principle investigators for the APMS07 are the University of Leicester and the National Centre for Social Research (NatCen). The survey is collated by NatCen and is sponsored by the Information Centre for Health and Social Care. The field work for this survey took place between October 2006 and December 2007. The survey is part of a series of studies entitled *Surveys of Psychiatric Morbidity in Great Britain* which 'aim to provide up-to-date information about the prevalence of psychiatric problems among people in Great Britain, as well as their associated social disabilities and use of services' (ESDS, 2010:9). It is the third survey in the series aimed at adult psychiatric morbidity. The study focuses on those aged over 16 years living in private households in England.

A multi-stage stratified random sampling technique was employed with a total sample size of 7,403. The survey was conducted using computer assisted interviewing (CAPI) software. Where more than one adult lived in a given property, one adult was randomly selected.

How has the data set been previously used?

The APMS07 has a wide range of variables and so has been of great use to both policy makers and researchers. The data set has been used to explore a large array of issues, ranging from relationship between common mental health disorders and employment (Ford *et al.,* 2010); suicidality amongst those with estimated borderline intellectual functioning (Hassiotis *et al.,* 2011); mental health in non-heterosexual populations (Chakraborty *et al.,* 2011); and service personnel populations in England (Woodhead *et al.,* 2011).

The main report of this survey (McManus *et al.,* 2007) briefly discusses suicide and suicidal behaviour using both longitudinal and cross-sectional analysis. The findings of the report are divided into face-to-face and self-completion questions. The main findings are as follows:

- 13.75% of those interviewed face-to-face and 16.7% of self-reporting cases indicated that they had thoughts about suicide in their life time. 0.8% of those in face-to-face interviews stated they had had thoughts of suicide in the last week (McManus *et al.,* 2007:73-4).
- 4.8% of those interviewed stated that they had attempted suicide at some point in their life, with 0.1% having attempted in the last week.
- 4.3% said that they had thought about suicide in the last year (McManus *et al.,* 2007:74).

No studies were identified that used this data set to explore the roles of social workers in suicide prevention.

5.3 – Question 1: Can a significant relationship be identified between suicide and social worker contact?

To answer this question, it was necessary to identify variables that address: (i) social worker contact and (ii) suicide. The APMS07 has 1,754 variables (including some derived variables) ranging from basic demographic information to detailed information on mental health disorders.

One variable[17] asked participants if they had 'seen a social worker in the last year' with responses being recorded in a binary manner (i.e., 'Yes' or 'No'). Only a very small minority of the sample population, 1.8% (*n*=131), had contact with a social worker in the last year.

There were several variables addressing suicide. Two stood out as being of particular relevance: 'attempted suicide in last year', and 'ever made an attempt to take own life'. Initially the first of these two variables was felt to be most appropriate as the relative time frame (twelve months) fitted that of the above social work variable. However a cross tabulation revealed that the frequency of those with social

[17] Two variables directly explored social worker contact in the data set. One of these variables was derived by the original researchers from the other social worker contact variable. This variable was removed because it was little more than a variant of the original variable.

worker contact and attempted suicide in the last year was very low (*n*= 8), making any form of further analysis all but impossible.

In contrast, a cross-tabulation (table 2) using the two variables which were ultimately selected ('seen a social worker in the last year' by 'has ever made an attempt to take own life') led to a rise in the number of cases (*n*=25). While the numbers remain relatively low, we must remember that suicide is an act that only a small minority of individuals undertake and this study is trying to explore a minority group (i.e., those with social worker contact) within this minority group.

Table 2 - Cross tabulation of 'seen a social worker in the last year' by 'ever made an attempt to take own life'.

		Seen a social worker in the last year	
		Yes	No
Ever made an attempt to take own life	Yes	*n*=25 (0.3%) *E* =6.9	*n*=362 (4.9%) *E* =380.1
	No	*n*=106 (1.4%) *E* =124.1	*n*=6899 (93.3%) *E* =6880.9

Using a chi-squared test (x^2=51.553, 1 *d.f.*, *p*=<0.001), we can see that twenty five participants were suicidal and had contact with a social worker, compared to the expected count of approximately seven. Conversely, those who were suicidal and not in contact with a social worker, and those who had contact with a social worker, but were not suicidal had lower counts than expected (*n*=362, *E*=380.1 and *n*=106, *E*= 124.1 respectively). This suggests that social worker contact with suicidal individuals is more prevalent than would be expected by chance. This is consistent with the existing research identified in chapters 2 and 3. In both these chapters, it was suggested that many of the risk factors for suicide (e.g. deprivation, social isolation, etc.) also increase the likelihood of someone having contact with social workers.

The significant result from the chi-squared test indicates that the relationship between suicide and social worker contact would benefit from further analysis. For

example, it would be useful to establish what factors increase or decrease the odds of a person being suicidal and having social worker contact. In answer to the first question, we are able to establish that a significant relationship exists between having social worker contact in the last year and lifetime suicide attempt, but we now need to explore this relationship in greater depth.

5.4 - Question 2: Under what circumstances do social workers come into contact with suicidal individuals?

Despite establishing that a significant relationship exists between social worker contact and suicide, we still have no data on the circumstances under which social workers come into contact with suicidal individuals. To answer this question it was important to first identify what variables exist within the data set that might be of use. In the next few sections I will explore how variables were selected and why a logistic regression was identified as an appropriate model.

Question 2 - Selection of dependent variables

We know that there is a relationship between social worker contact and suicide; what remains unclear are the factors that are important in understanding this relationship. To explore this relationship we need to be able to derive a variable that indicates both suicidality and social worker contact. As established in the previous section, no single variable existed within the data set addressing this issue so it was necessary to create a new variable.

With confirmation from the chi-squared test (that a significant relationship exists between 'social worker contact' and 'ever made an attempt to take own life'), it was logical to merge the two variables already identified into a new categorical variable[18]. The four values of this variable were:

1 – Never attempted suicide and no social worker contact in last year.

2 – Has attempted suicide in lifetime and has had social worker contact in last year.

3 – Has never attempted suicide, but has had social worker contact in last year.

[18] The new variable was referred to as 'Social worker contact with suicidal individuals'.

4 – Has attempted suicide in lifetime, but has had no social worker contact in last year.

Only 0.1% (*n*=11) of the sample population could not be categorised with this new variable. As indicated in table two, the distribution of data in this new variable indicated that the vast majority 93.3% (*n*=6,899) of respondents were not suicidal and had not had contact with a social worker in the last twelve months. Only 0.3% (*n*=25) of respondents were reportedly suicidal and also had a social worker. Yet 4.9% (*n*=362) had been suicidal and not had contact with a social worker, suggesting that social workers are not always coming into contact with those who are in need of assistance. Social worker contact was generally low with just 1.4% (*n*=106) of respondents having contact with a social worker and not being suicidal; giving a total of only 1.7% (*n*=131) of all respondents having contact with social workers. The implications of this are explored in the discussion section 5.5.

So having identified a dependent variable, I established what independent/ predictor variables might be having an effect. Such variables would provide an insight into the circumstances under which social workers come into contact with suicidal individuals.

Question 2 - Independent/predictor variables

The selection of independent variables went through four stages:

Stage 1 – Identifying variables: First it was necessary to identify variables that might be relevant and recode them as necessary. The selection of variables was informed primarily by my literature review (chapters 2 and 3). Where previous research indicated that a particular variable was commonly associated with suicide and/or social worker contact (such as substance misuse, deprivation, etc.) then it seemed appropriate to mark that variable for inclusion.

When multiple variables existed on one topic, or when a variable had a very high number of values, it was sometimes necessary to recode/merge variables. For example, nine variables explored issues of domestic abuse with different types of abuse and time frames. This was merged into one binary variable which simply asked if a person had ever been a victim of domestic abuse. This reduced the number of variables and also made interpretation of results more accessible.

It became clear during the early parts of this process that the APMS07 is predominately comprised of nominal variables, that is, variables where the values

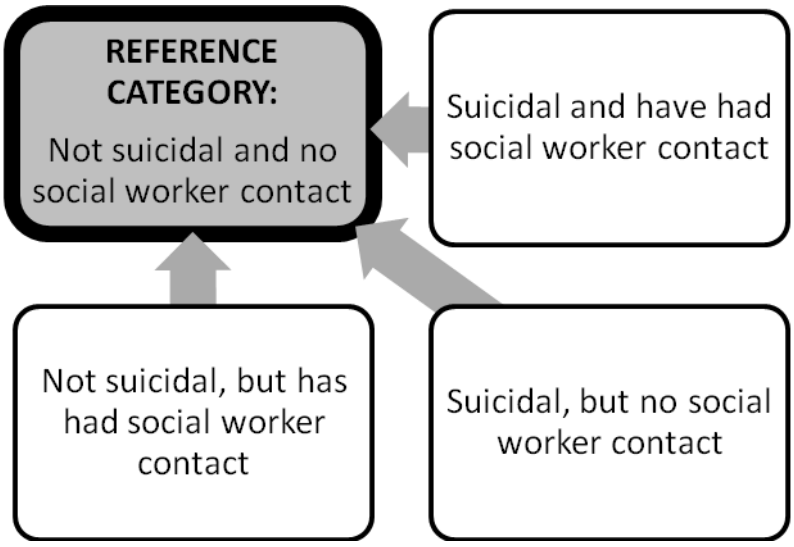
have a limited number of predetermined categories with no hierarchy (e.g. male or female). This means that the data cannot be linear, but are instead definitively grouped as absolute values (such as 0 for male and 1 for female). This impacted on the statistical analyses available: any models that assumed observed linearity had to be discounted. Two viable forms of statistical analysis were identified: (i) log-linear regression, and (ii) logistic regression.

Log-linear regression was ultimately rejected because, as Yang (2010) discusses, it is unable to accommodate as many independent variables as multi-nomial regression. This was an important consideration as my analysis was focused on trying gain an understanding of the circumstances under which social workers come into contact with suicidal individuals. Including more variables meant that more potential circumstances would be established.

Logistic regression provides a method to explore how independent variables affect the probability of a particular outcome (i.e. which value) in the dependent variable. For example, independent variable *A* increases the odds of a case being in value *B* in the dependent variable. The odds ratio refers to odds being made to a reference category. The reference category is normally the largest value in the dependent variable; in this case those who are not suicidal and have not had any social worker contact. Any claim then made about the other three values is in relation to this group.

An example would be if we said that those who are not suicidal, but do have contact with a social worker were twice as likely to have a gambling addiction as the reference category (i.e. those who are not suicidal and do not have contact with a social worker). The graphic on the next page helps to visualise how this relationship works:

Figure 1 – Reference category in dependent variable.



Stage 2 – Missing Data: One potential issue with logistic regression is that it is highly sensitive to missing data; when a case is missing from any variable used in the model the case is removed from the whole model. Therefore the cumulative effect of missing data across variables poses a significant challenge. It was important to check for instances of missing data within each variable and across all the variables included in the model.

To address the issue of missing data, the frequency distribution of the variables was examined to establish levels of missing/invalid data. Six variables were removed due to missing data. Four variables ('tried to get help after attempt', 'tried to get help from hospital/psychiatric service', 'tried to get help from the voluntary sector' and 'tried to get help from community/local authority services') contained 94.8% (*n*=7,018) missing data. This is largely due to these being questions specifically for those who responded as having made an attempt on their life.

The other two variables removed for high level of missing data (91.8%, *n*=6,796 in both instances) were linked to borderline personality disorders. Mehlum *et al.,* (2007) suggest that borderline personality disorder increases the risks of suicide due to impulsive behaviour and a high propensity towards DSH and parasuicide.

There was not a limit set on missing data for individual variables but the cumulative effect was considered. In the case of the variables removed at this stage, we can see that they had excessively high levels of missing data (i.e. 90+). In the final

model, the level of missing data was 15.10% (*n*=1118), meaning 84.90% (*n*=6,285) of the available data were included in the model.

Stage 3 – Testing the relationship: Having used my literature review to help guide my independent variable selection, a Pearson chi-squared test was then used to validate whether a significant relationship could be identified with the criterion variable (i.e., 'social worker contact with suicidal individuals'). The significance level was set at $p<=0.05$, as per convention (Field, 2009).

Two variables, the ethnic origin of the respondent (x^2=15.573, 9 *d.f.*, p= 0.076), and problem or pathological gambler (x^2=1.693, 3 *d.f.*, p= 0.638), were removed due to no significant relationships found between them and the dependent variable. The lack of a significant relationship between ethnicity and dependent variable is not surprising given that other studies have also found that suicide rates are generally stable across different ethnic groups (Neeleman and Wessely, 1999). The removal of gambling was unexpected as it is often associated with issues such as depression (Phillips *et al.,* 1997; Newman and Thompson, 2003).

Stage 4 – Multi-collinearity: Multi-collinearity addresses the amount of correlation between two or more independent/predictor variables. Put simply, it means that you get two variables that are very closely aligned. This can be problematic for two reasons: first, you do not know which measure is actually important, and second, there is not enough variance in the data to make any clear claims between the two (more data are needed).

Where multi-collinearity was uncovered, it was necessary to examine the variables and work out if one or more of the variables should be removed. Identifying multi-collinearity did not mean that a variable was automatically removed. Each case was examined on its own merits and wider literature consulted to help guide my decision. For example, the 'sex of the respondent' showed some collinearity with 'looks after family member, friend or others due to their health or disability'. Given the large body of research (Arber and Ginn, 1995; Dahlberg *et al.,* 2007) highlighting the gendered bias of the 'caring role' this overlap is not surprising. Despite this, it was felt that both variables should remain in the model as previous studies have separately suggested the importance of gender in understanding suicide (Varnik *et al.,* 2008) and the impact of caring on the carer's mental health and wellbeing (Field and Bramwell, 1998).

Similarly ‘drug dependency’ and ‘ever deliberately self-harmed, but with no intention of killing self’ displayed some collinearity. The overlap here might be due to some form of self-medication by those with substance misuse issues. While the rationale for this overlap is not entirely clear, both variables were used in the model as there is sufficient evidence to suggest that both DSH (Foster *et al.,* 1997) and substance misuse (Appleby *et al.,* 1999; Pridemore and Spivak, 2003) are important factors in understanding causes of suicide. Equally, both are issues that fall under the social work remit. In total, a further five variables were removed as a result of multi-collinearity (these can be seen in table 3).

Summary

The APMS07 is comprised primarily of nominal variables. The selection of variables was initially informed by my previous literature reviews and then subject to review based on frequency of missing data, Pearson chi-squared results and multi-collinearity diagnostics. As a result of this process, thirteen variables were removed from the model. The remaining twenty variables are included in the table 3.

In noting that these were all nominal variables, it was also possible to identify that a logistic regression would be the most appropriate statistical tool for exploring these relationships in more detail. The model interpretation and the findings of this model will now be discussed.

Table 3 – Variables included in model.

Variable	Recoded from other variables?	Missing data	Chi-squared	Collinearity diagnostics
Has respondent ever thought of suicide?	Derived from five existing variables.	0.1%	(x^2=1218.739, 3 *d.f.*, *p*= <0.001)	No issues.
Has respondent ever deliberately self-harmed but no intention of killing self?	N/A	0.2%	(x^2=773.161, 3 *d.f.*, *p*= <0.001)	Multi-collinearity identified with Drug dependency (0.56 and 0.59, respectively, in dimension 24).
Sex of respondent.	N/A	0%	(x^2=21.855, 3 *d.f.*, *p*= <0.001)	Multi-collinearity identified with look after family member, friend (0.47 and 0.41, respectively in dimension 20).
Age of respondent divided by quintiles.	Recoded from existing variable.	0%	(x^2=66.229, 12 *d.f.*, *p*= <0.001)	No issues.
Religion	Derived from two existing variables.	0.7%	(x^2=76.503, 24 *d.f.*, *p*= <0.001)	No issues.
Is respondent working or has respondent worked in last 12 months?	Recoded from existing variable.	0.8%	(x^2=82.342, 6 *d.f.*, *p*= <0.001)	No issues.
Defacto marital status of respondent.	N/A	0%	(x^2=178.215, 15 *d.f.*, *p*= <0.001)	No issues.
Has respondent ever been in Local Authority or institutional care prior to the age of 16?	Derived from two existing variables.	0.6%	(x^2=129.373, 6 *d.f.*, *p*= <0.001)	No issues.
Gross personal income by quintiles.	Recoded from existing variable.	14%	(x^2=93.717, 12 *d.f.*, *p*= <0.001)	No issues.
Self-reported health of respondent.	Recoded from existing variable.	0%	(x^2=167.960, 3 *d.f.*, *p*= 0.001)	No issues.
Has respondent ever been a victim of domestic violence and abuse?	Derived from nine existing variables.	0.7%	(x^2=306.341, 9 *d.f.*, *p*= <0.001)	No issues.
Has respondent ever been victim of sexual abuse since age of 16 (and/or in	Derived from six existing variables.	1.1%	(x^2=186.039, 6 *d.f.*, *p*= <0.001)	No issues.

last 12 months)?				
Has respondent ever been victim of sexual abuse prior to 16?	Derived from three existing variables.	1.3%	(x^2=218.458, 3 *d.f.*, *p*= <0.001)	No issues.
Does respondent have a drink problem?	N/A	0.1%	(x^2=32.587, 3 *d.f.*, *p*= <0.001)	No issues.
Is respondent dependent on any drug or not?	N/A	0.6%	(x^2=127.044, 3 *d.f.*, *p*= <0.001)	See above (Has respondent ever deliberately self-harmed but no intention of killing self?).
Does respondent have any money problems?	N/A	0.6%	(x^2=253.299, 9 *d.f.*, *p*= <0.001)	No issues.
Does respondent look after family member, friend or others due to their health or disability?	N/A	0%	(x^2=17.826, 3 *d.f.*, *p*= <0.001)	See above (Sex of respondent).
Does respondent suffer from depression?	Derived from five existing variables.	0%	(x^2=293.026, 3 *d.f.*, *p*= <0.001)	Multi-collinearity identified with Generalised Anxiety Disorder, latter removed from model (0.70 and 0.44, respectively in dimension 11).
Does respondent have any phobia?	N/A	0%	(x^2=263.455, 3 *d.f.*, *p*= <0.001)	Multi-collinearity identified with Social Phobia, Specific Phobia and Agoraphobia, all subsequently removed (0.97, 0.48, 0.52 and 0.59, respectively, in dimension 19).
Does respondent have an eating disorder?	N/A	0.7%	(x^2=51.553, 1 *d.f.*, *p*= <0.001)	No issues.

Question 2 – Model fit

Having identified variables that were to be included and excluded from the multinomial logistic regression, the model was run with the new derived variable, 'social worker contact with suicidal individuals', as the dependent variable.

The model could be evaluated in a number of ways. The Likelihood Ratio Tests indicated that there was a significant (p=<0.001) difference between the 'intercept only' and the populated model. I can therefore use this model with confidence knowing that it furthers our understanding of the dependent variable. The pseudo R^2 suggested that between 18.7% and 41.8% of variance in the dependent variable was explained by the model. Fields (2009) suggests that it is normal to have low values in logistic regression, so the ranges identified in this study appear to be acceptable.

However, when exploring how well the model fitted the data, some issues became apparent. There was a considerable difference in the results between the two tests used to check goodness of fit. The Pearson result was 0.000 indicating that there was a very poor fit between the model and the data. Conversely, the Deviance indicated that the model was an excellent fit (1.000). When this issue was explored in greater depth it emerged that the data was suffering from under-dispersion.

To understand under-dispersion we need to re-examine the distribution of the dependent variable. In table two we saw that most of the participants (93.3% n=6,899) were concentrated in one value of the dependent variable, i.e., not suicidal and no social worker contact. This uneven distribution of data combined with the large number of independent variables meant that when the model was run, many of the possible combinations of variables/values were not populated. In the Hessian Matrix 74.8% of the cells had zero frequencies. Put simply, there were lots of potential combinations of variables/values, but the data was concentrated in a very limited number. This makes it hard for a good fit between the model and the data to be achieved. Subsequently, we must be cautious in making any broad claims about any findings from this study.

The high concentration of data in one value of the dependent variable is also apparent in the model's predictive capacity. In table four, we can see that the model was able to predict 93.8% of cases correctly. This means that in using the independent variables, we could correctly predict which of the four values of the dependent variable a case was from 93.8% of the time. However, we can also see

that that the model is not able to predict all values with the same level of certainty. For example, we can see that the model failed to correctly predict any cases for those who were not suicidal but did have social worker contact. Despite this, we can see that the model is able to give some limited predictive capability for those who are suicidal and do have social worker contact (14.3% correctly predicted) and also for those who are suicidal and do not have contact with a social worker (21.7% correctly predicted). Gaining an understanding of these two groups (exploring how they are similar and how they differ) would greatly enhance our understanding of the relationship between social worker contact and suicidality.

Table 4 – Classification table – Model ability to predict cases correctly.

		Predicted				
		Suicidal and have had social worker contact.	Suicidal, but no social worker contact.	Not suicidal, but have social worker contact.	Not suicidal and no social worker contact.	Percent Correct
Observed	Suicidal and have had social worker contact.	3	5	0	13	14.3%
	Suicidal, but no social worker contact.	1	72	0	259	21.7%
	Not suicidal, but have social worker contact.	0	6	0	75	0%
	Not suicidal and no social worker contact.	0	33	0	5,818	99.4%
Overall Percentage		0.1%	1.8%	0%	98.1%	93.8%

In summary we can see that the under-dispersed nature of the data means that we must be highly cautious in making any wide claims about our findings. Clearly there is a need for more detailed data specifically addressing the central issue of social worker contact and suicidality. But as emphasised earlier, these data do not currently exist. Despite this, the model does provide an insight, albeit limited, into the context under which social workers come into contact with suicidal individuals.

5.5 – Findings

Question 2 - Introduction

Thus far, I have been able to establish that a significant relationship exists between having social worker contact in the last year and lifetime suicide attempt. We know that more people reported having contact with a social worker and having made an attempt on their life than expected (*n*=25, *E*=6.9). Conversely, those who were suicidal and not in contact with a social worker, and those in contact with a social worker and were not suicidal, had lower counts than expected (*n*=362, *E*=380.1 and *n*=106, *E*= 124.1 respectively).

We can also see that despite the issues of under-dispersion, the logistic regression model does provide us with some insight into the circumstances under which social workers come into contact with suicidal individuals. The final stage of the analysis is to look further into the statistics to see why this might be the case. What is it that seems to make people more likely to be both suicidal and in touch with a social worker? This will now be explored.

As outlined earlier, a multi-nomial logistic regression allows us to explore how independent variables affect the probability of a particular outcome in the dependent variable. In the dependent variable, the largest value (in this case not suicidal and no social worker contact) is designated the reference category. Any effect the independent variables are having on the other three values is made in relation to the reference category (see Figure 1). This means that by using this model, we are able to identify how the other three values: (i) suicidal and have had social worker contact, (ii) not suicidal, but have social worker contact, and (iii) suicidal and no social worker contact, differ from that of the reference category. Subsequently, any claims made about an independent variable increasing or decreasing the odds of a particular value are being made in relation to the reference category.

To explain and discuss the meaning of these results, I have broken the discussion down into four parts. First, I briefly discuss the independent variables that were not found to be important/ significant predictors. Second, I examine the two values concerned with suicidality (i.e. has ever been suicidal and having social worker contact[19]; has ever been suicidal but having no social worker contact), commenting on how these are similar and how they differ. In the third section, the two values

[19] Social worker contact from this point on refers to contact in the last twelve months.

exploring social worker contact are explored (i.e. being suicidal and having social worker contact; not being suicidal but having social worker contact). In the fourth section I discuss some apparently contradictory findings which suggest the need for further research. The findings include a number of potential double negatives in the results which are more easily understood when reversed; where this is the case I will make it clear that the results are best understood as double negatives.

Question 2 – Findings: Non-significant independent variables (part 1)

Eight of the variables included in the model were found to be not significant ($p<0.05$) in predicting the dependent variable. This means that within the model they were found to add little predictive capability: they did not enhance the ability of the model to guess correctly which value a case would be in the dependent variable. Despite this, it is still worth exploring some of these variables briefly, as they were found to have significant relationships in the Chi-squared tests. They were also originally selected as a result of previous research that was covered in my literature reviews (chapters 2 and 3).

Interestingly, respondent sex, respondent de facto marital status, alcohol problem, and depression were amongst the independent variables that were found not to be significant. All of these factors have traditionally been strongly associated with suicide and suicide prevention (Palmer, 2008; Kposowa, 2000; Appleby *et al.,* 1999). The reasons as to why these variables were not found to be significant is not clear: it could be a quirk of the data set, but research that might offer some explanations is limited.

For example, the absence of gender as a significant variable might also be understood through what Canetto and Sakinofsky (1998) term the gender paradox. It is known that females make more attempts to kill themselves than males, but they have a lower completion rate; this is often attributed to the more lethal methods used by males (Paykel *et al.,* 1974; Platt *et al.,* 1992). This might be making any clear relationship between suicide and gender problematic.

Similarly having an alcohol problem and marital breakdown are commonplace, particularly amongst high-risk groups such as the mentally ill (Weaver *et al.,* 2003) and prisoners (Singleton *et al.,* 2003). While these factors do pose an increased risk of suicide (Appleby *et al.,* 1999; Kposowa, 2000), they are not as significant as other risk factors such as DSH and suicidal thoughts, factors which are present in this

data set. Similarly, it might be argued that depression is a wide-spread mental health issue but that only a few individuals with depression actually kill themselves.

Having examined the variables that were not found to be significant, I will now explore the results.

Question 2 – Findings: Suicide attempts (part 2)

Tables 5 and 6 give details about the independent variables that were found to be significant predictors of being suicidal, either with (table 5) or without social worker contact (table 6). Each of the values will be briefly discussed, before moving on to a more detailed discussion of the similarities and differences between these groups and what these might mean.

We can see from table 5 (see next page) that three independent variables were found to be significant predictors of the value 'suicidal and have had social worker contact'. Participants who had been suicidal and also had social worker contact were over four times more likely to have self-harmed with no intention of killing themselves (*b* 1.454, *OR* 4.279, p=0.008) compared to the reference group (i.e. not suicidal and did not have a social worker). Similarly, they were more likely to have ever had suicidal thoughts than the reference category (expressed as the double negative of this relationship, (*b* -1.887, *OR* 0.151, p<0.001). Essentially people who have thoughts of suicide at any point (i.e. ever) are more likely to be suicidal and have a social worker than the reference category. Finally, we can see that those with a drug dependency were nearly four times more likely (*b* 1.373, OR 3.948, p=0.22) to have social worker contact and have made an attempt on their life than the reference group.

In table 6 (see page 80) we see the independent variables that were significant predictors of those who had ever been suicidal, but had not had social worker contact. Immediately we can see that two factors appear in both tables 5 and 6 – namely a history of non-suicidal self-harm and a history of suicidal thoughts. Those who have 'deliberately self-harmed but with no intention of killing self' are almost four times (*b* 1.318, *OR* 3.734, p<0.001) more likely to be in this category. This is very similar to table 5, suggesting that self-harming without intention of killing self (often referred to as non-suicidal self-injury) is an important predictor of suicidality.

Table 5 – Significant predictor variables for value (2) lifetime suicide attempt and social worker contact in last year.

Variable/values	Direction of relationship (*b*)	Odds ratio (*OR)*	Significance (*p)*
Never had any thoughts of suicide.	-1.887	0.151	<0.001
Has deliberately self-harmed, but with no intention of killing self.	1.454	4.279	0.008
Have a drug dependency	1.373	3.948	0.022

The effects of DSH fit with previous studies that indicate that risk-taking behaviours in the guise of self-harming greatly increased the risk of subsequent suicide (Zahl and Hawton, 2004; Cooper *et al.,* 2005). However, Adler and Adler (2011), have highlighted that some forms of self-injury, such as self-cutting, are maladjusted coping strategies and are not undertaken as a threat to life. This recognition has led to the inclusion of non-suicidal self-injury (NSSI) in the latest revision of the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition* (DSM V). These findings are a reminder that even DSH which is not ostensibly linked to current suicidal intent could indicate increased risk of a suicidal act at some point in the future. As Skegg (2005) has noted, people who DSH are a heterogeneous group; there is a great deal of variation in patterns and meanings of behaviour.

Not having 'thoughts of suicide ever' decreases the odds of being suicidal (compared to the reference category), irrespective of social worker contact. When we reverse the odds ratios we can see that having thoughts of suicide, both with (OR=6.62) and without (OR=38.46) social worker contact, is an important predictor of making an attempt on one's life. From the odd ratios we can see that the thoughts of suicide are particularly important in instances without social worker contact. While it is perhaps unsurprising to find such a strong relationship between attempts on one's life and thoughts of suicide (it is after all unlikely that someone would attempt to end their life if they did not have thoughts of doing so). Establishing this relationship suggests that social workers should be alert to the need to ask about these thoughts when assessing suicide.

Table 6 – Significant predictor variables for value (4) lifetime suicide attempt, but no social work contact in last year.

Variable/values	Direction of relationship (*b*)	Odds ratio (*OR*)	Significance (*p*)
Never had any thoughts of suicide.	-3.645	0.026	<0.001
Has deliberately self-harmed, but with no intention of killing self.	1.318	3.734	<0.001
Age by quintiles:			
Aged 34-46	0.660	1.934	0.043
Aged 58-69	0.869	2.384	0.002
Religion of participant:			
No religion (agnostic or atheist)	-1.126	0.342	0.018
Roman Catholic	-1.538	0.215	0.003
Protestant	-1.452	0.234	0.003
Other Christian	-1.200	0.301	0.021
Islam	-1.596	0.203	0.038
Not being in local authority care prior to the age of 16	-1.102	0.332	<0.001
Gross income of participant by quintiles:			
£0-5,199	0.672	1.959	0.015
£5,200-10,399	0.585	1.794	0.027
£15,600-25,999	0.646	1.909	0.014
Self-reported excellent to fair health	-0.481	0.618	0.023
Has no money problems at all	-0.618	0.539	0.008

None of the other independent variables were found to be significant in both values. However five other variables were found to be significant to predicting suicide in the absence of social worker contact. Holding certain religious beliefs, such as Roman Catholic (*b* -1.538, *OR* 0.215, *p*=0.003) or Muslim (*b* -1.596, *OR* 0.203, *p*=0.038), greatly reduced the odds of being suicidal and not having a social worker in comparison to the reference category. This is consistent with research (Stack and Kposowa, 2011) that emphasises the protective nature of religion in reducing suicide rates. Interestingly, having no religion was also found to reduce the odds of being suicidal and not having a social worker. This might be explained by concepts of psychological self-assurance: essentially those who have no religion either feel no need for it or have resolved that it is not of interest to them. In both instances it

might be argued that the individual has a strong sense of self that might be acting as a protective factor against suicidality.

Having explored the independent variables that are of use in understanding suicidality, I will now examine the independent variables that affect social worker contact.

Question 2 – Findings: Social worker contact (part 3).

In the previous section, we discussed values related to suicidality and explored how they are similar and how they differ. In this part, I will do the same but focus on social worker contact. Table 7 shows that four variables were useful predictors for the dependent variable value 'never suicidal, but have social worker contact'. It is important to note that the model struggled to predict those who were not suicidal, but did have social worker contact. As such some caution is urged when considering the implications of these finding.

From table 7 (see next page) we can see that those who have never been suicidal, but do have a social worker are three times more likely (*b* 1.124, *OR* 3.076, *p*=0.032) to have a drug dependency than those in the reference category. We have also seen in table 5 that those who were suicidal and had a social worker were also far more likely to have a drug dependency compared to the reference category (*b* 1.373, *OR* 3.948, *p*=0.022). It appears therefore that having a drug dependency increases the likelihood of having a social worker in this data set, irrespective of suicidality.

This suggests that social workers are already working with one of the groups that have a high vulnerability to suicide (Appleby *et al.,* 1999; Pridemore and Spivak, 2003). This potentially also reaffirms Joe and Niedermeier's (2008) suggestion that social workers are more likely to come into contact with suicide related problems than other issues. It also seems likely that social workers working in substance misuse are as integral to suicide prevention as their colleagues working in mental health. This is a topic that was also found to be of importance in my qualitative findings (see chapter 7.2).

There were no other independent variables common to social worker contact across these two values, but it is possible to make one final observation about social worker contact by noting some of the characteristics of those who are suicidal, but do not have social worker contact. In table 6 we can observe that some age groups are less likely to have social worker contact than others. For example those aged 34-46

and 58-69 were more likely to be suicidal and not have a social worker compared to the reference category (*b* 0.660, *OR* 1.934, *p*=0.043, and *b* 0.869, *OR* 1.360, *p*=0.002 respectively). We can therefore state that those aged 34-46 are almost twice as likely to have been suicidal and not had social worker contact compared to those in the reference category.

Table 7 – Significant predictor variables for value (3) never having attempted suicide, but have had social worker contact in last year.

Variable/values	Direction of relationship (*b*)	Odds ratio (*OR)*	Significance (*p)*
Have a drug dependency	1.124	3.076	0.032
Not being in local authority care prior to the age of 16	-1.572	0.208	<0.001
Working or have worked in last 12 months	-1.644	0.193	<0.001
Self-reported excellent to fair health	-1.025	0.359	<0.001

The lack of social worker involvement with these age groups might be partly the result of the structure of social services with a focus on the young (i.e. children) and the elderly. Social constructs of vulnerability may be leading to social workers having only limited contact with individuals outside of these groups (Parton, 1996). Conversely it might be a lack of engagement by those in these age groups, who do not want or are unable to seek help from social workers. This relative lack of social worker contact with people in mid-life who have attempted suicide might also reflect the popular preoccupation, as reflected in media reporting and Government policy, with suicide in young men (Shiner *et al.,* 2009).

Question 2 – Findings: Social worker contact but not suicidal, and suicidal, but no social worker contact (part 4)

So far we have been able to establish that having thoughts of suicide and self-harming with no intention of killing oneself are both significant predictors for suicidality in this data set. Similarly, we have also found that those with social worker contact are between three and a half to four times more likely to have a drug dependency. What we have yet to do is contrast those who have social worker contact but are not suicidal (table 7) with those who are suicidal, but do not have

social worker contact (table 6). In this final section of results there are some puzzling and apparently contradictory findings.

The first theme to emerge is around being in local authority care prior to the age of 16. Being in local authority care before the age of 16 increases the odds of not being suicidal, but having a social worker (expressed in negative terms *b* -1.572, *OR* 0.208, *p*=<0.001). It is possible that those who have been in the care system as children may have social work input throughout their adult lives. Indeed the statutory duty of local authorities to looked after children can extend into adulthood. For example under the Children (Leaving Care) Act 2000, young people still in care aged 16 and 17 who have been looked after for (a total of) at least 13 weeks from the age of 14 are entitled to support until the age 21 (and in some cases 24).

However, we also find that being in local authority care prior to the age of 16 increases the odds of ever making an attempt on own life but having no social work contact (expressed in negative terms *b* -1.102, *OR* 0.332, *p*=<0.001). Essentially those who have been in local authority care prior to the age of 16 are more likely to be suicidal and not have social worker contact than the reference category. This is supported by Vinnerljung *et al.,* (2006:723) who found that;

> 'former child welfare clients.... [were] four to five times more likely than peers in the general population to have been hospitalised for suicide attempts'.

It appears that being in local authority care prior to 16 is important in both social worker contact and suicidality. The previously discussed issues of under-dispersion are likely to have hindered the ability of the model to effectively explore the effect of being in local authority care. What we might conclude from this slightly confused picture is that further research into suicidality, social worker contact and being in the care system would be of great benefit.

A second theme that initially appeared to be contradictory was that of employment and economic well-being. People who have not been employed in the last twelve months were five times more likely to have had social worker contact in the last year and never been suicidal compared to the reference group (i.e. those who were not suicidal and not in contact with a social worker) (results for those who <u>had</u> been employed in last 12 months: *b* -1.644, *OR* 0.193, *p*=<0.001). In contrast to this we can see in table 6 that those on relatively lower incomes (£1-10,399 and £15,600-25,999) were between 1.7 and two times as likely to be suicidal and not having a

social worker. Similarly those who reported having no money problems at all were less likely to be suicidal and not have a social worker (*b* -0.618, *OR* 0.539, *p*=0.008 – table 6).

The important distinction of whether a person has a social worker or not appears to hinge on employment rather than income, people with a low income were disproportionately found to have made an attempt on their life but with no social worker contact. It is not surprising that some of these unemployed should have social worker contact, given that the remit of social workers is, as Sheldon and MacDonald (2009:3) suggest, 'the poor, abused or discriminated against, neglected, frail and elderly, mentally ill, learning disabled, addicted, delinquent, or otherwise socially marginalised up-against-it citizen in his or her social circumstances'. As those out of employment are at risk of economic hardship, they might be viewed as in need of social support. Unemployment has been found to be strongly associated with suicide (Platt and Hawton, 2000) and while this was not identified as the primary issue for suicidality in my analysis, it is interesting to note that it was associated with having social worker contact and not being suicidal. This divide between unemployment and economic wellbeing might be explained by the division of roles between social security and social welfare.

In contemporary UK, statutory social workers are not empowered to provide financial assistance. Subsequently it is possible that only those individuals who are suffering from the other social ills that can stem from unemployment (e.g., loss of self-esteem) come into contact with social workers. Economic disadvantage is not sufficient in its own right to warrant social worker contact. It also seems likely that a large number of individuals who are suicidal partly, or primarily, because of economic constraints are not in contact with social workers.

In contrast to issues of economic wellbeing and employment, being in self-reported excellent to fair health reduced the odds of not being suicidal and having social worker contact (*b* -1.025, *OR* 0.359, *p*=<0.001), and of being suicidal and not having social worker contact (*b* -0.481, *OR* 0.618, *p*=0.023). It seems that being in self-reported good health is a protective factor against suicide and social worker contact.

Question 2 – Summary of findings.

We have established that those who are suicidal are approximately four times more likely to DSH without the intention of killing themselves (i.e. non-suicidal DSH) compared to the reference category. Similarly having thoughts of suicide greatly

increases the odds of someone making an attempt on their own life. In the case of social worker contact, we find that irrespective of suicidality those with a drug dependency are roughly four times more likely (when compared to the reference category) to have contact with a social worker.

We have also seen how some age groups are less likely to have social worker contact than others, and how religion serves as a protective factor against suicidality. Being in self-reported good health reduces the odds of having a social worker and/or being suicidal. It also appears that a gap exists between income and being in employment. Those who are on low incomes are at increased odds of being suicidal, whilst having been employed in the last twelve months decreased the likelihood of being having ever made an attempt on own life. These findings, although limited, do provide us with some important understandings of the circumstances under which social workers come into contact with suicidal individuals.

Chapter 5.6 - Conclusion

In concluding this chapter it is helpful to return to the two original research questions set at beginning of the chapter:

1. Can a significant relationship be identified between suicide and social worker contact?
2. Under what circumstances do social workers come into contact with suicidal individuals?

We have seen that, in answer to the first question, a significant relationship can be identified between social worker contact and suicidality (x^2=51.553, 1 *d.f.*, p=< 0.001). This relationship indicated that more people than expected were suicidal and having contact with social workers (n=25, E=6.9).

When this relationship was explored through the use of a multinomial logistic regression I was able to gain a greater understanding of the context under which social workers come into contact with suicidal individuals. The main findings indicate that non-suicidal self-injury increased the odds of suicidality regardless of social worker contact, and those with social worker contact were four times more likely to have drug dependency irrespective of suicidality. It was also possible to identify how other factors such as age, religion, income, and employment affect the relationship between suicidality and social worker contact.

There are several possible implications from this chapter for social work services, some of which will be further explored in the chapters which focus on the qualitative interview findings. First, it is encouraging that people with drug dependency have social worker contact. The importance of substance misuse, or more specifically issues of dual diagnosis and service delivery, is also raised as an important topic by the social workers in the qualitative component of my research (see chapter 7.2).

Second, there are factors associated specifically with suicide attempt in the absence of social worker contact which might suggest a deficit in social work service provision for people in need. These were the age groups 34-46 and 58-69, people with low incomes and people with a background in local authority care (although this last group was also associated with having a social worker in the absence of suicide attempt).

Finally, self-harming behaviour without intention of death was found to be strongly associated with suicide irrespective of social workers contact. Previously in chapter two I highlighted the complex relationship between self-harming and suicide. This topic also proves to be important to the social workers and service users interviewed in the following chapters (see chapters 6.1, 8.6 and 8.8).

Before looking at my qualitative findings it is important that the limitations of the data analysis in this chapter be made clear. Four issues were identified that seriously limit how much the findings can be generalised and limit the conclusions we can draw from this work. First, the data set was not designed to explore the issue at hand (i.e. the context under which social workers come into contact with suicidal individuals). This means that the questions asked and the prominence given to them would not be the same as if I were conducting the study myself. In addition to this the sampling technique used for this survey was not designed to focus on the population of specific interest in this study, that is to say those in receipt of social work support.

Second, there is a disparity in the relative time frames of social worker contact and attempted suicide. As the information about suicide relates to a lifetime and the social worker contact is limited to a twelve month period, it is possible that a respondent may have been suicidal many years prior to any social worker contact. The social work contact could be related to entirely separate issues.

Third, due to uneven distribution of data (i.e. 93.3% of cases being located in one value of the dependent variable) issues of under-dispersion limit the effectiveness of

the model to correctly predict outcomes of minority variables. Specifically the model failed to explain the value ‘never been suicidal, but has had social work contact’ with 0% of cases correctly predicted. Subsequently, the effectiveness of the model is necessarily limited.

Finally the frequency of some values in the dependent variable is extremely low raising concerns about the models reliability. For example, in table 2 the frequency of those who have been suicidal and had social worker contact was just 25. As a result of this the model struggled to correctly predict the three minority values. This is concerning given that the minority values were primarily concerned with the topic under examination (i.e. suicidality and social worker contact). Subsequently we must conclude that this model is only able to provide limited insight into the context under which social workers come into contact with suicidal individuals.

Despite these limitations, I have systematically explored the available data sets and the data available within the topic areas. I am confident that, while the dependent variable is not ideal, it does lend an important insight into this under-researched topic. What is apparent is the need for a study to be conducted exclusively addressing the issues of social worker contact with suicidal individuals; variables addressing issues such as frequency of contact, place and nature of contact (i.e. home, social services office, etc.), length of time known to social services, and training received by social workers. All of these would greatly enhance our understanding of the contexts in which social workers come into contact with suicidal individuals.

Yet even a more detailed survey may struggle to provide any understanding about how social workers understand suicidality; what they think about those who are suicidal; the types of assessments and interventions they utilise and their perceived effectiveness, or even the support they get when a service user takes their life. These are all points that might be explored through qualitative research methods, as illustrated in the following chapters.

Chapter 6 - How social workers understand suicide and the social worker role in multi-agency and interdisciplinary working

6.0 - Introduction

In the previous chapter I used a secondary analysis of the Adult Psychiatric Morbidity Survey (2007) to explore the context under which social workers come into contact with suicidal individuals. At the conclusion of that chapter it was highlighted that we still have little understanding of how social workers work with suicidal service users or how they *understand* suicide.

To gain an insight into the understandings held by social workers, I undertook a series of interviews with three stakeholder groups: (i) statutory social workers, from various areas of practice, who have experience of working with suicidal service users (*n*=17); (ii) Community Psychiatric Nurses (CPNs) who have worked alongside social workers in instances where service users have been suicidal (*n*=3); (iii) service users who have been suicidal whilst in receipt of support from a social worker in a statutory role (*n*=3). Table 8 (on the next page) provides a breakdown of the participants. The findings from the social worker interviews are explored in this chapter, and chapter seven. The CPN and service user interviews are discussed in chapter eight.

The current chapter is divided into three sections. Section 6.1 explores the second of my research questions; how do social workers understand suicide and suicidal behaviour? Here, I examine how social workers understand suicide, with particular attention being paid to training and peer learning.

Finally, in section 6.2 I explore the third of my research questions: what approaches to assessment are currently used by social workers? To what extent does research evidence impact on the practice of social workers in this context? The variability in assessment techniques used by social workers to assess suicidality is uncovered. The relative dearth of research evidence used to inform their practice is also examined.

Table 8 – Breakdown of participants

Name	Stakeholder group	
	Status	Team
Abigail	Social worker	CMHT
Adele	Social worker	CMHT
Alan	Social worker	CMHT
Alesha	Social worker	CMHT
Alex	Social worker	CMHT
Alison	Social worker	CMHT
Amy	Social worker	CMHT
Andrew	Social worker	CMHT
Anna	Social worker	CMHT
Becky	Social worker	Children's Services
Bethan	Social worker	Children's Services
Bridget	Social worker	Children's Services
Carol	Social worker	Substance Misuse
Claire	Social worker	Substance Misuse
Chloe	Social worker	Substance Misuse
Dee	Social worker	Older persons
Donna	Social worker	Disability (Adults)
Alison	CPN	CMHT
Erin	CPN	CMHT
Eric	CPN	CMHT
Francine	Service user	N/A
Frank	Service user	N/A
Frazer	Service user	N/A

6.1 – How do social workers understand suicide and suicidal behaviour?

Gaining an insight into how social workers understand suicide and suicidal behaviour will help us to explore what factors they consider when assessing and intervening with suicidal service users. Here I explore how and where social workers gained their understanding of suicide.

Seventeen social workers were interviewed about their understanding of the role of social workers in suicide prevention. The social workers were from all areas of practice, and yet there was generally a high level of continuity in how they understood suicide. Social workers spoke about four clearly distinguishable factors that were important to their understanding of suicide: first, they demonstrated an awareness of the multi-faceted nature of suicide and the need to take a holistic approach to assessment; second, social workers spoke about the inevitability of service user suicides in the course of their careers as social workers; third, the opportunity, experience and effect of formal teaching on suicide were discussed; finally, peer learning was highlighted as being of particular importance. I have explored these four factors in turn.

Suicide as a multi-faceted issue

All of the social workers interviewed spoke about the importance of working on a 'case-by-case basis' (Claire, a social worker with a substance misuse team). By this they meant that they were aware of the large spectrum of issues faced by their service users, issues that contributed to suicidality. This perspective is consistent with Golightly's (2008) suggestion that a holistic approach to assessment is a tenet of social work practice. Bethan (a social worker with children's services) summed this up when she suggested that a suicidal person might be affected by:

> A traumatic incident in their childhood, long term depression, bi-polar. It could be something as simple as using alcohol or drugs, and that then causes a dip in their emotional wellbeing.

Here, Bethan is highlighting issues that she believes are important in understanding suicide. These range from psychological issues, such as childhood trauma, and potential biological explanations, such as bi-polar, through to social issues, such as substance misuse. An understanding of the bio-psycho-social models of mental health, as advocated by Pritchard (2006), is shown by social workers; a point I will

illustrate in the next two sections. First, I will discuss the social factors social workers identified as being associated with suicide. In the second section I explore biological and psychological understanding of suicide.

Social factors

Perhaps unsurprisingly, social workers were highly adept at identifying social factors that they felt contributed towards suicidal behaviour. Issues ranging from relationship breakdown, financial issues, abuse, housing, substance misuse, social isolation and exclusion were all identified. These issues rarely occurred in isolation and it was often the combination of issues that were thought to result, in what my participants described as, a 'crisis'. For example, Bridget, a social worker in children's services, talked about her experience working with a family where the mother was suicidal:

> They haven't seen a health visitor for a long time, they haven't got any kind of services in place and we've got a lot of behavioural issues with the three year old... You know, they're absolutely skint, even more so because they're in privately rented accommodation as well and they're covering that with his wages. They can't go for a bigger house at the moment, because of the rent. They're just really in a crappy situation which is all impacting on her [*the suicidal service user*] at the moment. But she's feeling like she doesn't want to have a relationship with the father, and where's she going to go, and she's just not in a good place.

Here we can see how Bridget explains the suicidality of the service user with reference to the current social situation. The implications are that the service user is both socially isolated and excluded, issues that are known to be linked to suicidality (Stark and Riordan, 2011). The importance of social isolation and exclusion was also highlighted by Carol, a social worker in a substance misuse team:

> A lot of people we work with, their family and friends have disengaged for one reason or another. [*Service users often have a*] circle of friends who don't really necessarily look after their best interests. So, yeah, there's little kind of indicators really.

Again, we can see how social workers actively noted the importance of social connections in their understanding of suicide risk. The breakdown of relationships, both with partners and families, is often cited as being strongly associated with suicide, especially amongst males (Evans *et al.,* 2012): social

workers are acutely aware of the need to check on the wider social networks of their service users. However, even when social workers became involved, they recognised that their actions could, inadvertently, lead to service users feeling isolated. Dee, a social worker with an older people's team, discussed how:

> [a] lady who is in a nursing home wanted to take an overdose of all her tablets, but she does not have access to her medication (…) I can really put myself in that place and think, yeah I really might feel the same. I can understand why you would be feeling like that. Because I suppose in a way, the idea of killing yourself would be a way of taking back control that you have lost, like things are kind of going away out of your control.

The service user described by Dee was isolated and had limited mobility; this was affecting her mental wellbeing. The social situation of the service user was felt to be an important issue in understanding suicidality. Dee felt that suicide might be deemed rational given the service user's current situation. This echoes Yashiro *et al.,* (2001) research into suicide amongst terminally ill patients, who noted that isolation can be determinant of suicidality.

The idea that suicide might be a rational decision was also discussed by Alex, a social worker with a forensic mental health team, who suggested he supported euthanasia, but felt the debate was difficult, particularly when it came to mental health:

> It's difficult because I think most people agree that if someone is suffering from a degenerative disease, then they should be allowed to end their life. But it's more complicated with mental health... I have service users who have serious mental disorders and find everyday life difficult. They are genuinely suffering. Is their suffering any less? (...) You could say it's about capacity, but can a depressed person have capacity to make an informed decision about ending their life?

From Alex's comments, we can see that suicide can be understood by workers as a rational act for those suffering, but suffering is (as he notes) a very broad category. The comments of both Dee and Alex represent the general complexity that social workers face in their understanding of suicide. On the one side, there is a genuine desire to promote the rights of service users, but this is tempered with an account of

wanting to assist service users. It seems that a discussion about euthanasia, mental capacity and suicide would be greatly advantageous to the social work profession.

Biological and psychological factors

In addition to social factors associated with suicide, social workers also demonstrated an awareness of biological and psychological factors. Dee, for example, said that she was aware that biology was important, but was not exactly sure how or why:

> I know that there's been research on the way the brain works, but I'm not sure that I really think about this most of the time [*when making an assessment*]... Well, unless they've had a brain injury or something (…) A colleague told me about how chemicals in the brain affect our mood, but I'm not really that sure about them.

Dee's uncertainty about the biological factors associated with suicide was a common theme amongst social workers, with eleven social workers making comments about the biological associations of suicide. Social workers were, also, often uncertain about details of issues such as familial suicide. This point was articulated by Alan, a social worker with a CMHT:

> I think that there are some genetic links sometimes (...) You get families where, when you talk to them, have quite a few suicides in... I'm not sure what or why, but there's definitely a link. I'm also not sure how true this is, but I think this is the same for mental illness as well.

The importance of understanding family histories, both in relation to mental health and suicide, was raised by five of the social workers. Although Alan appears to have associated genetics with familial suicides (Statham *et al.,* 1998), others have suggested that grief and shame could also be used to explain the familial link (Seguin *et al.,* 1995).

From the quote above we can also see how Alan draws a link between mental illness and suicide. Fourteen of the social workers interviewed spoke about the importance of depression as an indicator of suicide. For example, Bridget, a social worker in children's services, identifies bipolar as being linked to suicidality:

> Often people are depressed. I had a mother recently who had bipolar... I can't remember which type though [*i.e. type 1 or type 2 bipolar*]. She

> was in a pretty bad way and I think without help from the mental health team she would probably have killed herself at some point soon.

This fits with the literature in chapter 2, where various mental illnesses were associated with suicide (Cavanagh *et al.,* 2003). Although it should be noted that depression is not always a good predictor of suicide (Rihmer, 2011).

Social workers generally acknowledged the importance of understanding mental illness in relation to suicide, but one topic that seemed to be problematic was that of self-injurious behaviours with or without intention of death. This fits with the research highlighted in chapter 2.2 where the relationship between Deliberate Self-Harm (DSH) and suicide was found to be highly complex (Brausch and Muehlenkamp, 2013; Cooper *et al.,* 2005). Claire suggested that to differentiate between DSH and suicide was to understand intentionality:

> Somebody's drinking and they medicate, or cut, that would maybe not be a suicide, that would be an accidental death really, an accidental overdose.

For it to be a suicide there needed to be some sort of intent, yet this was confused by discussions around 'attention-seeking' behaviour. Bethan, a social worker with a children's team, talked about her experiences of service users who would tell her that they were going to take their own life:

> I don't think they really mean it. And I think, you know, whether they're going to actually end their life or not, if they're saying that, then they need support somewhere even if it's, you know, right at that point or whether it's in the long term.

Her impression was that even when someone professed to be suicidal and she felt this to be untrue, they were invariably still in need of some assistance. Bethan's suggestion that support might be of use even when the intention for death was in doubt seems to again highlight the complex relationship between DSH and suicide (Brausch and Muehlenkamp, 2013).

Bethan was not alone in her belief that not all service users who said they were suicidal were 'genuine'. For example, Claire recounted an instance of a service user who wanted to stay in hospital. Every time he was not detained under the Mental Health Act(s) (1983/2007) he would 'up the ante, you know… Because that was what he wanted, it wasn't so much to kill himself'. The distinction between those who

are ‘genuinely’ suicidal and those ‘attention-seeking’ is often borne out of social workers’ frustration about accessing services for those they are trying to support, a point I will explore in the next chapter.

Ruch *et al.,* (2010) have noted that social workers are often obligated to work with uncertainty in the course of their work. Whether working in child protection or mental health social workers are often working with limited or incomplete information (Munro, 1996; Stalker, 2003). Further to this risk, assessment is, as Lipshitz and Strauss (1996), remind us an inexact science. Yet as Burke and Cooper discuss, social workers often have to ‘defend and sustain’ (2007: 193) complexity to both internal managerial and external public pressures. It seems that in suicide prevention, as in many areas, social workers are wrestling with uncertainty in the course of their everyday work.

Further to this perspective about ‘attention-seeking’ are not unique to social workers. For example, Bolton (2012) and McGrath and Dowling (2012), observe how negative attitudes are pervasive amongst health care professionals. For social workers working in multi-agency or interdisciplinary contexts it is likely that they will be aware of such attitudes. In addition to this public attitudes to suicide as a ‘cry for help’ (Nock and Kessler, 2006) or a selfish act (Joiner, 2010) might also be affecting how social workers perceive those who harm themselves.

In summary, social workers appreciate that suicide is a multi-faceted issue and, as such, it is important that a holistic approach to understanding the individual is utilised (Golightly, 2008). Further to this, the social workers interviewed seemed to have a good appreciation of the bio-psycho-social model (Pritchard, 2006). This is encouraging given that suicide is, as was discussed in chapter 2, a multifaceted issue. Social workers specifically highlighted the importance of social relations (i.e. social exclusion and social isolation) and substance misuse; family psychiatric histories were also seen as important factors to consider when exploring suicidality with service users. More problematic issues for social workers included debates around euthanasia, mental capacity and self-injurious behaviour; this is perhaps not surprising given the complexities and debates that surround these topics (Hawton, *et al.,* 2003).

Suicide as an inevitable act

Despite an appreciation of the bio-psycho-social model and the empathy that social workers had for their service users, there was another less sympathetic theme; that

of the inevitability of suicide. This theme appears to be both a rational reaction to working with a population that are at an elevated risk of suicide, and a coping mechanism that allows the social worker to create a professional distance or boundary between themselves and the service user (O'Leary *et al.,* 2013).

What emerged from the interviews was a belief amongst the social worker sample that suicides could not always be prevented. For example, Dee (a social worker with older persons) suggested that 'if someone is really determined and has the means to go about doing it, they will'. Similarly Alison (a social worker with a CMHT) suggested 'when you're dealing with people, they'll kill themselves'.

This theme might appear to be a reflection of the reality of working with a group at elevated risk of suicide; the screening process employed by CMHTs means that only those most in need get assistance. For example, Anna, a social worker with a CMHT, described returning to her notes after a service user death to see if she had missed anything. When she returned to her notes she felt:

> Reassured by what I'd written.(...) I always kind of thought it is a matter of time before it [the loss of a service user to suicide] happens... It could've been when I'd only been in the job six months. It happened to be nine years, it sounds weird to say.

Anna's comments clearly indicate that a service user suicide was seen as inevitable over the course of her career. This belief in the inevitability of suicide seemed to offer her some form of reassurance, indicating that the theme of inevitability could be a way of coping with the day to day stresses of the social work role. For example, Ting *et al*., (2011) in their study of social workers in the US who work with suicidal service users observed that the practitioners suffered from both short and long term stress and secondary trauma. This suggests that there is a very real impact on the emotional wellbeing and mental health of social workers resulting from working with suicidal service users. The impact of work-related factors on the subjective wellbeing of social workers has also been examined by Shier and Graham (2011). They found workload, and type of work both impacted on the subjective wellbeing of social workers.

Rajan-Rankin (2013) notes that to cope with the stresses and pressures social workers have developed a variety of coping strategies to improve their resilience. It seems probable that in instances of completed suicides social workers will want to be able to draw on notions of suicide as inevitable in order to help reduce the impact

on their own mental wellbeing. Further to this, Anna's reading of the case notes might indicate a desire to be absolved of any blame that might result from the service user's death (Smith *et al.,* 2003). This is a topic that is developed further in the next section (chapter 6.2) when looking at the approaches social workers take to preventing suicide.

Anna's comments also resonate with comments made by Andrew, an experienced social worker in a CMHT: 'I suppose, you're desensitised to kind of asking kind of questions about suicide'. Andrew's comments seemed to connect with Bride and Figley (2007) and Kinman and Grant (2012) who have discussed the importance of self-care in social work practice for those regularly coming into contact with service users in acute situations. Specifically they note that the result of regular exposure to such acute cases can lead to compassion fatigue. Essentially this means a reduction, or inability, to empathise with service users due to over exposure (Wilson, 2013). Given the highly stressful nature of working with suicidal individuals it seems probable that issues of compassion fatigue might be impacting on the ability of social workers to assist suicidal service users.

To help manage the stress of working with suicidal service users it seems that social workers need to develop coping mechanisms. The suggestion by Andrew that he has become desensitised to addressing the topic of suicide seems to echo coping mechanisms that have been observed amongst medical professionals working in pressurised environments. For example, Glaser and Strauss (1968), in their study of an Emergency Room (ER), noted how medical processes were disrupted when the ER staff treated a former colleague who had been shot by an ex-lover. The familiarity of the patient meant that they were overly familiar with her, and it took several minutes before 'normal' medical processes returned. Glaser and Strauss (1964) suggest that the medical professionals were aware of the 'necessity of routine in maintaining sentimental order' (1964:101).

The professional boundaries identified by Glaser and Strauss, continue to be seen in contemporary health care. For example, Hayward and Tuckey (2011) discuss how nurses create emotional boundaries in the course of their work. The professional-patient boundary in the medical professions has, according to O'Leary *et al.,* (2013) been emulated by contemporary social workers. In essence social workers seem to be creating a professional distance between themselves and their service users, a distance that is partially derived from their position as 'expert' (Evetts, 2003; Abbott and Wallace, 1990).

The concept of professional distancing in social work is, however, not without its critics. For example, Green *et al.,* (2006) discuss how professional distance has been critiqued for its implicit endorsement of expertise which is portrayed as a barrier to the building of relationships between service users and social workers (Evetts, 2003). Further to this, Pugh (2007) discusses how such distancing can be blurred for social workers in rural contexts where they will often have contact and knowledge of service users outside of working hours (Turbett, 2004).

It seems that the conceptualisation of suicide as inevitable enabled social workers to create a professional distance, and maintain the sentimental order:

> No matter how much intervention, crisis intervention may be offered, it [service user suicide] will happen. (Alison, a social worker in CMHT)

One interpretation is that portraying suicides as inevitable enabled participants to maintain their 'ontological security' (Giddens, 1984:23); that is to say a belief and understanding of the world which makes them able to act (in this case as social workers). The need for 'ontological security' seems to be paramount in occupations characterised by high levels of stress and uncertainty. As previously indicated, Ting *et al*., (2011) noted that social workers who had worked with suicidal service users were more likely to suffer from stress and secondary trauma. Coffey *et al.,* (2009) have also found that 36% of social workers in children's services were suffering from a mental disorder, and that 47% of social workers in mental health had a potential psychological disorder. The complexities of working with 'imperfect knowledge' (Munro, 1996:799) to make complex decisions places social workers under high levels of stress. For example, Abigail, a social worker with a CMHT, summed up the difficulty in knowing if someone is suicidal:

> I think we don't know what's going on for somebody, do we? I mean we only know what the person is telling us. We can go into somebody's home and it can look chaotic or it can look pristine. What does that tell us?

Abigail was not alone in this opinion, but perhaps put it the most succinctly. There was a sense that it was hard to know if someone was suicidal or not, and that this added to the pressure on the social worker. Similarly, Alesha highlighted how for some service users, suicide was a constant issue:

> I think, we all, probably in the team, have got people on our caseload who will say that they're suicidal pretty much every time you see them.

The theme of inevitability seems to help social workers with the strain and stress of working with suicidal individuals and dealing with the associated uncertainty.

The importance of such narratives is not to be underestimated. Munro (1996) noted in her review of child death inquiries that people are resistant to altering their beliefs, even when evidence to the contrary exists. It is possible that when a suicide occurs, the conceptualisation of suicide as inevitability comes to the fore, even if some form of intervention might have been possible. As Munro states 'once formulated or adopted, theories and beliefs tend to persist' (1996:800). So how and where do social workers get their knowledge on suicide?

Formal training in suicide prevention

Feldman and Freedenthal (2004) found that social workers in the USA receive little training on suicide or its prevention. When speaking to social workers about their understanding of suicide and how best to prevent it, I explored issues of training.

As discussed in chapter 3.1, claims to professionalization typically cite the formalising of knowledge and the regulating of training (Freidson, 2001; Housley, 2003). For social workers in Wales the introduction of the Care Standards Act (2000) meant that for the first time 'social worker' became a protected title with a regulating body registering those who qualify through graduate training (the Care Council for Wales). Social work courses must now be accredited and deliver an approved curricula set by the Care Council for Wales. Examining the formal training of social work allows me to explore the formal knowledge base that social workers possess on the topic of suicide.

The social workers in my sample identified three different types of training: initial social work training (Certificates/Diplomas in Social Work and degree courses); continuing professional development (CPD); and Approved Mental Health Professional (AMHP) training. Social workers identified little to no relevant training in either their initial training or as part of their ongoing professional development. The AMHP course did, however, provide some training, albeit highly legalistic in nature. I will explore each of these points in turn, before looking at how social workers and health care professionals view each others' training.

Initial social work training

The social workers had received their initial training at various institutions and over a wide period of time. Some had been in practice for up to fifteen years, while others

had only recently completed their training (e.g. within eighteen months of being interviewed). Despite this, the social workers consistently reported having received no training in suicide prevention during their initial training. For example, when Chloe was asked if she had received any training in suicide prevention during her initial training, her response was concisely expressed as: 'No. Nothing.'

Amy, a social worker with a CMHT, took this further, stating that not only had she not received any training in suicide prevention, her qualifying programme had generally failed to 'prepare you for work on the ground'. For her, the focus of the initial training was too heavily orientated towards theory, and not enough towards practice.

Anna, like Amy, took exception to her original social work training:

> Certainly not something [suicide prevention training] you learn on a social work course; they're far too busy telling you about child protection. Let's worry about, like, people wanting to kill themselves! I think there is a bit of an issue with social work deployment… I feel that there was a lot of emphasis on social work with children and a lot less on mental health and adults. Generally, I didn't feel the balance was really there between adult and child, I think it was quite heavily child services…

The generic nature of social work training in England and Wales (with practitioners being required to have a knowledge of both children's services and adult services – see the College of Social Work, 2012; Care Council for Wales, 2012), had in Anna's opinion eclipsed other issues such as mental health. This was not a view expressed by other practitioners, but the relationship between social workers in children's services and other fields of practice was an area of tension (this is discussed in greater detail in chapter 7).

Continuing Professional Development (CPD)

A minority of social workers were either aware of, or had been on, training after initial training; for example, Bethan (a social worker with children's services) stated:

> Well I know there is a policy for England and Wales, erm… but no. It's not something [*suicide*] that I'm like, I think has got a step by step plan, because I got concerns for this family about suicide.

Bethan's general awareness of a national policy was one of the few references made by participants to indicate that they knew of the existence of national suicide prevention strategies/plans. Even then, we can see that she is unaware that specific and separate policies exist for England (Department for Health, 2012) and Wales (Welsh Government, 2008).

This lack of knowledge on suicide prevention strategies amongst front line professionals may not be surprising as such policies are rarely designed solely for practitioners. This does not mean that policies cannot have an impact: for example, the few social workers who had been on post-qualifying training (referred from here on as continuing professional development) all identified the Applied Suicide Intervention Skills Training (ASIST) programme advocated by the Welsh suicide prevention strategy (Talk to Me – Welsh Government, 2008).

The lack of awareness of the suicide prevention strategy in Wales might not be as concerning at it first appears. Evans (2010) suggests that the interpretation and implementation of policies can take place at multiple levels and emphasises that not all policies are of relevance to frontline practitioners. Building on the work of Lipsky (1980) and Howe (1991), Evans and Harris (2004) suggest that professional discretion remains very much part of everyday practice. They proliferation of policies, rules and regulations have not necessarily curtailed professional judgement and social workers continue to exercise professional discretion in the course of their work (Scourfield, 2013).

Policies are also reinterpreted and implemented differently at national, regional and local levels. Evans and Harris (2004) suggest this is due in part to the often vague and ambiguous language used in policies requiring social workers and managers to interpret how they should be implemented. It is even possible that some policies and procedures are not brought to the attention of frontline practitioners, as managers may have deemed them unnecessary or erroneous for their roles (Evans, 2010).

Additionally policies can overlap, presenting competing agendas requiring social workers to negotiate conflicting demands during the course of their work. This means that the enactment of policies on the ground can look considerably different to what was originally envisaged. As Lash (2002) notes, there is often a process of negotiation between individual agency, in this case social workers, and formal structures, such as social services departments.

The implication of this is that frontline practitioners draw on more than just formal policy in their work. Tacit knowledge, policy, regulations, procedures, moral dilemmas/judgements, practical considerations and relationships all impact on their decision making (Broadhurst *et al*., 2010). Taylor and White (2001) argue that social work is comprised of both practical-moral and technical-rational practices. It is only through a recognition of both these concepts that we are able to understand social work practice. Essentially social workers are able to exercise professional judgement and discretion in much of their work to negotiate formal and informal knowledge and methods of working. As Ellis (2014) notes, however, professional discretion can be both positive and negative.

Out of seventeen social workers five had been on the ASIST training, and had varying attitudes about its effectiveness. Chloe, a social worker with a substance misuse team, felt that the training was designed with a different audience in mind:

> I kind of, I don't know why, they were all a bit 'American'… It's all a bit religious and people are a bit, I don't know whether he's Christian in his beliefs; I'm not sure, but that was a bit…but I think there's some really good, sound points in there and it gives people confidence to check stuff out and…you know?

Other social workers also expressed some dissatisfaction with the ASIST programme for reasons best articulated by Claire (a social worker with Substance Misuse Team):

> I supposed when I went on the ASIST I thought they were going to give me all these wonderful answers to people who were contemplating suicide, but you know maybe it just boils down to how a worker deals with it, and within the team that you've got. But I suppose, yeah. I don't particularly want training, but training is good, too.

Claire's desire to have 'wonderful answers' seemed to indicate that she desired clear practical tips on how to manage suicide risk more effectively, and was disappointed when these were not forthcoming. White (2009) has discussed that while uncertainty is part of the terrain of social work, practitioners often fail to embrace it. Claire's comments suggest that while she recognises the complexity and uncertainty of cases she is struggling to embrace this uncertainty in her work.

Like Claire, Alison also found the ASIST training useful:

> It takes training to highlight, really, what you would do as a matter of course, you know.(...) I think that would be a natural thing that a lot of us would do, and say, you know, go out and have a chat and find out, what's made you do this today? And why did you feel like that today? So, yeah, I found it quite good. It highlighted things. You think, oh, yeah, I'll do that.

For Alison the training was more a confirmation of her own practice, and this was what she found helpful. The mixed attitudes of professionals to the ASIST program have also been observed by Evans and Price (2013). The desire to have 'wonderful answers' and the positive reinforcement of their own practice was important not only to those who had undertaken training, but also to those who spoke about wanting further training. For example Bethan (who had not been on the ASIST training) mused about what she felt she would want from suicide prevention training:

> If we could think of a strategy, we could have strategies for emergency training. Because, like, last year risk assessment became this massive strategy, that everyone would have to risk assess on every file and every case, we had training in a couple of weeks. A day's training. If that's the case with suicide, then it would make sense really, wouldn't it? I know now from that training that I risk assess on every case. If I had that I'd be using it all the time. But you can't do tick box stuff with suicide; it's just too broad. The risk assessment's a bit more... It is more straight-forward for risk assessment because you apply the same things to each case.

What Bethan expresses here is what seems to be the paradoxical issue for social workers in suicide prevention training; social workers are caught between a desire to have simple assessments with 'miracle questions' on the one hand, and an appreciation that the complex issues that underline suicide cannot be effectively understood through 'tick boxes' on the other. As previously noted, Stalker (2003) has highlighted that social workers have to work with complexity which can be stressful. Additionally social workers are often caught between the competing demands of needing to grasp and emphasise complexity whilst also presenting information in a concise and clear way (Burke and Cooper, 2007). This paradox seems to be made all the more challenging in suicide prevention because of the fear of not knowing what to do, as Dee stated:

> Yeah I would appreciate having more training in it, just in knowing how to deal with that situation [suicide prevention] if I… because I think you

> can just come up and then just get kind of ambushed by it, “What do I do?”.

Approved Mental Health Professional (AMHP) Training

The role of Approved Mental Health Care Professionals (AMHPs) was created under the Mental Health Act 2007, replacing the Approved Social Worker (ASW) role. AMHPs are given specific roles under the Mental Health Act, such as the duty to arrange and participate in assessments that might result in a service user being 'detained in the interests of his [or her] own health or safety, or with a view to the protection of other persons' (MHA83 S2(b)). Social workers (and other professionals) are obligated to undertake a further formal qualification (often at a Higher Educational Institution), before being warranted by a Local Authority (to whom they are ultimately answerable[20]). Given that one of the main reasons for being detained under the Mental Health Act(s) (1983/2007) is in the interests of a person’s own safety, it is not surprising to find that those who had undergone AMHP training had received some additional training on suicide prevention.

For Adele, being an AMHP meant that she:

> Had extensive, and would continue to have, extensive training.(...) [*This training focused on a*] risk assessment questionnaire that we fill in with people. It has a lot of the questions that are based on research evidence, you know. Age, sex, for a starter, here…factors you know. Previous self-harm, previous… how strong is their suicidal ideation? So all these things are thought about and they’re based on evidence; so we go through risk assessment questionnaires with patients we have. We have the research that backs up the severity of the risk outcome really.

Here we can see that Adele felt that the training provided for AMHPs drew heavily on research to inform practice. The impression given is that she felt the AMHP training equipped her with the knowledge and skills to assess suicide effectively. Alan agreed with Adele, in that he felt that the AMHP training allowed him to deal with the ‘elephant in the room’ and address issues directly with service users. For example:

---

[20] This applies irrespective of who is their normal employer (e.g. health services).

> If somebody's hearing voices it's ok to ask, "Am I in any danger?" "Does anybody want to harm you?" It is as simple as that really.

Despite this, Alan did not feel that he had received any specific training on suicidality in either the AMHP training or at any other time:

> On your question about particular training [on suicide assessment and prevention], I can honestly say, no.

Nevertheless, Alan felt that the skills he had acquired from the AMHP training enabled him to assess suicide more effectively. The experiences of Alan and Adele seem to be juxtapositions, with Adele clearly identifying specific training on suicide assessment and Alan indicating that this was not something he received. The reasons for this are unclear, but might include factors such as different training courses, training undertaken at different points in time or even missed sessions through illness or other reasons.

The apparently scant attention paid to suicide in the AMHP training was also highlighted by Amy, who said that:

> They talked so much about legislation. So, it [*suicide*] was touched on but it might have been a lesson or maybe two.

Amy felt that the focus on legalities detracted from wider discussions about how suicide might be assessed, or what forms of support might best aid a suicidal service user. It seems that AMHP training is generally well regarded by social workers, who appreciate the additional knowledge and skills that it provides. However, specific training on suicide as part of the AMHP course seems variable. Training on suicide is likely to vary on different courses, as individual courses are designed by individual institutions and approved by Health and Care Professions Council (HCPC, 2013).

To summarise, attitudes to AMHP training appear to be divided, with some social workers reporting that it greatly enhanced their knowledge, and others feeling that it failed to provide enough training on the topic of suicide. The legalistic emphasis of the AMHP training was also highlighted as a potential issue, detracting from more specific training on subjects such as suicide.

Informal learning

If formal training on suicide is quite limited for social workers, then where and how do social workers learn about suicide? The answer seems to be from their peers and through practice experience. The importance of informal learning in the work place has been discussed by Eraut (2000). Healy (2014) notes that experiential and tacit knowledge form the basis of much learning for frontline social workers. As will be demonstrated in this section, peer learning and tacit knowledge form the basis for much of the knowledge social workers have on suicide and how it is best prevented. The importance of informal learning was also highlighted by the CPNs in my sample, see chapter 8.2.

When asked about how she had learnt about suicide prevention, Anna said; 'Oh, I don't know. I just picked it up from everyone else.' Anna's rather succinct point was expanded upon by Amy, who seemed almost mildly surprised when asked about how she gained her knowledge about suicide:

> Colleagues of course! It's a pretty experienced team here. There's a couple who are new but mostly we're pretty experienced with all 5, 6, 7, 8, 10 years in mental health. I'd call on anybody that I thought could help. I took a colleague out with me on a Monday, no problem. Somebody asks you to go on joint visit just to double check something, there's never a problem.

Amy seems to be making two points here. First, she is affirming her belief that experience breeds expertise. Her notion of an experienced team indicates that this makes them more proficient at their role. This might have some truth in it, but there remains the potential for bad practice as well as good to be created and reinforced. Second is the point that a social worker can validate their own practice through 'double checking' with a colleague. Again we might interpret this as the process of gaining tacit knowledge through practice (Healy, 2014). Further to this we might interpret this as social workers using peer validation to justify their decisions and help them manage working with uncertainty (Gibson, 2014; White, 2009; Harris, 1987). Discussions on defensive social work are developed further in section 6.2.

The importance of peer learning and support might also be demonstrated through the inclusion of practice placements in social worker training. Bates *et al.,* (2010) looking at newly qualified social workers in England noted the importance of practice placements in the social work degree programme. These placements it seems act as an opportunity for students to gain experience, and possibly build up emotional resilience to cope with uncertainty and the stress that can result from social work

practice (Rajan-Rankin 2013; Grant and Kinman, 2012; Acker, 1998). However, we might also be able to see these as the process of becoming a social worker, gaining tacit knowledge and understanding about how professional discretion operates (Evans and Harris, 2004; Healy and Meagher, 2004; Eraut, 2000).

The role of peer learning might serve to create and maintain a belief about the inevitability of suicide already described. The importance and strength of peer learning is also indicated by Claire's (substance misuse) comments:

> I think [I gained my knowledge on suicide] from the other team members, this is what you need to do. I've gone on a suicide training [*ASIST*]… The only thing I got from that was, if somebody says they're going to kill themselves, how are they going to do it? Have they got a plan and can they speak to somebody? Have they got somebody close?(...) But I think it was mainly colleagues, and now it would be more, I think, as a team and within our county how we look upon somebody who says they're going to kill themselves. We've got more of a structure and how you're going to…. Contingency plans. You know, you need to ring this person and so forth…they say they're all sort of working together. So it's more, now, about risk assessment. Now if somebody rings up then, I feel… if you get to know that person well, if a stranger or somebody maybe who you worked with, or actually met once or twice rings you, then that can be hard, but if you know somebody quite well, then you can, I think, you can make them…talk them through it, but just feel a bit more confident in the things you can say.

Here Claire emphasises three things. First, colleagues are unequivocally identified as the main source of support, and subsequently the main knowledge base for her understanding of suicide. Second, the formal ASIST training provided some limited understanding of suicide, but this was clearly made subordinante to the role played by peer learning. Finally, contingency plans and structures within the team provided Anna with support that she feels enables her to better manage instances of suicidal behaviour.

Building on the points raised by Anna, Carol also highlighted how discussing issues as a team allowed for those with greater knowledge/ expertise on suicide (or at least those perceived as having expertise) to be consulted (Healy, 2014):

> Knowledge and experience, and your colleagues. I think with this team, actually we've got that. That we talk to each other, ask each other, "What do we do? I don't know." And they often go, "I don't know. I would have to get back to you. I am going to speak to…" …some of the girls that have been on that suicide training… [this was later identified as the ASIST training] And [they] come back and we will share that, because sometimes it's not practical for everyone to go on that. And they will share in peer groups or in a team give an overview and share the information that they have brought back. So it's a range of things.

Carol draws our attention to how knowledge is disseminated amongst social workers. It would be impractical for a whole team of social workers to undertake training at the same time, and it might be some time before training becomes available again in the future. To help manage this, it seems the social workers in the sample who have been on specialist training help to educate their peers. This point was also touched upon by Amy, who noted that:

> No. It [training] doesn't come routinely. Psychology will often put something out, you know, like they would put something after working with personality disorder. And so, that's what it has been, a couple of sessions when it's run by our own psychologist.

Amy here seems to problematize the boundaries between formal and informal training. The psychologists are seen to be more expert on these matters, but yet it is not clear if the sessions being offered are anything more than informal training within the team. Peer learning can take many forms, with some blurring with formal training sessions.

The importance of peer learning seems to resonate with the professional artistry approach to social work (Fish and Coles, 1998, see chapter 3.1). For example, Samson discusses the importance of 'practice wisdom', that is to say the knowledge that social workers draw on both the 'art and science' of social work practice (2014:1). This is similar to Taylor and White's (2001) concepts of practical-moral and a technical-rational activity in social work. Essentially it seems that social work is not just the practice of what is formally learnt. Instead social workers draw on knowledge from practice, their peers and formal knowledge in the course of their work (Healy, 2014). Informal mechanisms of learning seem to be of particular importance in social workers' understanding of suicide and how it is best prevented. This is not to say that official professionalised training cannot help to inform social

workers' understanding and practice, but it does not seem to be the dominant form of knowledge acquisition for suicide.

Summary

In summary, it seems that peer learning is the primary way that social workers gain their insight into suicide prevention (Healy, 2014; Eraut, 2000). While the boundaries between formal and informal training are, at times, problematic, it seems that the advice and support of colleagues were given a particularly strong weighting by the practitioners in my sample. Practical issues around the timing and availability of training can serve as barriers to more formal training. In short, peer learning seems to be accepted by social workers as a key method of knowledge transfer, and whilst it offers opportunities to disseminate information, there is also the potential for poor practice to be reinforced. The importance of tacit and peer learnt knowledge in everyday practice is discussed further in the next section when issues of professional discretion are developed further (Evans and Harris, 2004; Lipsky, 1980).

In addition to the importance of tacit knowledge and peer learning we have also seen how discussion of the inevitability of suicide were commonplace amongst the social workers interviewed. This it was argued exists to help place a professional distance between them and those they are trying to work with (O'Leary *et al.,* 2013). The purpose of this distance appears to be a reaction to the fear being blamed for a service user's suicide, or as a coping mechanism to working with high risk and vulnerable service users (Rajan-Rankin, 2013; Shier and Graham, 2011; Smith *et al.* 2003). These concepts are built upon further in the next section.

6.2 - What approaches to assessment are currently used by social workers? To what extent does research evidence impact on the practice of social workers in this context?

In the last section I established that social workers in the sample claimed relatively little formal training about suicide or its prevention. Peer learning was identified as the main source of knowledge about suicide. What was not explored, however, was how social workers use this knowledge in practice, and specifically how they assess suicidality.

The findings from my social worker interviews have been divided into three parts. In the first part I examine the types of assessments used by social workers. The second part examines assessments under the Mental Health Act(s) (1983/2007), a form of assessment that was felt to be of particular relevance. The final part, entitled 'asking the question', discusses the experiences of social workers addressing the issue of suicide with service users.

Types of assessments

Assessments are part and parcel of the social worker role (Crisp *et al.,* 2007) and have become a cornerstone of modern practice. The move towards a community care approach to welfare has led to standardised assessments becoming a common feature of social work practice. For social workers in statutory services, four statutory assessments were identified; initial assessment (children's services), core assessments (children's services), unified assessment (adult services) and Mental Health Act assessments (AMHP). All of these tools are the result of statutory instruments. One further assessment was identified by those working in CMHTs, the care programme approach (CPA). This came to be the primary assessment adopted by mental health services, with the rise of multi-agency working in the form of CMHTs (Simpson *et al.*, 2003; Burns, 2004).

A common feature of all these assessment tools is a strong emphasis on the need for a holistic approach, with all areas of the service user's life being considered, a point made by Amy (social worker, CMHT):

> I think if you look at the assessment form now, from compared to ten years ago, it has shifted. Now it includes spirituality for instance, so it's definitely holistic. A lot of the "speak" is social work speak now, where we've moved away from problems and we look at need.

Amy's observation that the contemporary assessments used by different professionals contained a lot of 'social work speak' ties in with wider discussions that a social work orientation is often adopted by other professionals (see chapter 3.2). Carpenter *et al.,* (2003) have discussed how holistic approaches to

assessment have been adopted by health care professionals working alongside social workers in multidisciplinary teams. The increased recognition of the social model in health has also been highlighted by Yuill *et al.,* (2012) who note that it is particularly important in instances of multi-agency and interdisciplinary working.

The focus on identifying need was a theme that consistently emerged during the interviews. For example, when Alex spoke about the unified assessment he also identified:

> We'll [his team] actually have a detailed look at the situation and we'll see what the outcome of the needs assessment is.

Identifying need was, however, only possible when the assessments were 'holistic', as identified by Amy, but also provided sufficient information to evidence the needs identified. Chloe (a social worker with a substance misuse team) felt that:

> A really good social work assessment should be really robust and give you lots of information on a person.

There was a strong consensus that an assessment should be holistic, with as much relevant information as possible being incorporated (Coulshed and Orme, 2012; Carpenter *et al.,* 2003; Lloyd and Taylor, 1995). Only by doing this was it possible to identify needs clearly. The ability to do this was not, as we shall see later, always seen as a skill that other professions had; it was often felt to be a social worker skill. Despite this, when social workers were pressed about whether they had any specific assessment technology for suicide, the responses highlighted a large diversity in the tools used. For example, Andrew (team manager, CMHT) commented on how the use of suicide assessment techniques had come about in his Local Authority:

> It wasn't as a regular on-going review, I think. We were kind of stuck with it for ages, even though you'd have to be hard pushed to find anybody who used it at all. Nobody thought it was the gold standard in risk assessment documentation. I think one of the triggers that had been revised, was the merger again actually. Because I think that suddenly it raised the issue… health board B had brought into [a new risk assessment] and suddenly the two health boards had merged... This was a prompt for it to be reviewed.

Here Andrew highlights how in his local authority there was no systematic approach to reviewing the assessments used. It was only with the merger of two health boards

that the assessments were considered. Even then, Andrew said that the tool adopted was only selected because one of the health boards had recently bought into a new assessment scheme.

For others, the main purpose of an assessment was to simply rank the perceived risks during team meetings. Chloe spoke about how when it was felt a service user was suicidal:

> We [the team] score them to low, medium, and high and then every time we review, we have professional meetings and just a rescore, so that's what it gives you, a baseline really.

There was no systematic approach to this scoring system. Instead it was the result of collective peer-informed notions of risk. The approach to risk management did not appear to be empirically driven. Instead it seemed that social workers and CPNs were drawing on their own knowledge and experience to determine the severity of risk. O'Melia and Miley (2002) suggest that much risk assessment and management is heuristic in nature rather than being empirically driven. Further to this, issues of hesitancy and indecisiveness are often present in risk assessment (Lipshitz and Strauss, 1996). In essence risk assessment is an inexact art which cannot be understood simply by reference to empirical evidence or formalised processes (Webb, 2001).

The lack of formal approaches to the assessment of suicide identified by Andrew seems consistent with these wider discussions on the conceptualisation of risk in social work. This is a concept further discussed by Amy and Carol (social workers with a substance misuse team) in their interviews:

> We [our team] don't use anything in particular. (Amy)

> We don't do the…we don't do the assessments. Because we don't use [assessments], we just, we go along to the CPA as the worker. (Carol)

The social workers found it hard to identify specific suicide assessments, and when asked would often specify assessments such as the CPA. When social workers did mention specialist assessments they were unable to name the tools, and spoke about them in vague terms. There was no mention of well-known models such as the Beck Scale for Suicide Ideation (BSSI) (Beck *et al.,* 1979) or the Columbia Suicide Severity Rating Scale (Posner *et al.,* 2008). It seems that the assessments used were done so with little awareness of the evidence base underpinning them.

What we are left with is a picture of a confused and haphazard approach to the formal assessment of suicide. All of the social workers in my sample were either able to identify generic social work assessments (such as the CPA), or did not know the details of the more specific assessments that they were using. Potentially this might be explained by the limited formal training social workers receive on suicide prevention (Feldman and Freedenthal, 2004). The social workers in my sample seemed to rely on peer learning and tacit knowledge to inform their understanding and assessment of suicide (Horlick-Jones, 2005).

Further to this we are able to draw parallels with the work of Broadhurst *et al.*, (2010) in their discussions of the formalisation of risk assessment and management in children's statutory services. They note that tacit knowledge continues to play a significant role in the work of frontline social work professionals. Again we seem to be seeing the importance of Fish and Cole's (2000) professional artistry.

Yet despite the lack of specialised assessments and the low levels of training offered to social workers in suicide prevention, there was a sizable continuity amongst my participants, in the types of issues that they considered when assessing suicide. For example, Alex spoke of particular issues he took into account when assessing suicidality:

> I might assess a number of times [*they have previous attempted to take their own life*]... [*If*] they've suffered a kind of deterioration in their mental health. And, they've reached the kind of crisis point where something more needs to come from services.

Similarly, Chloe also commented on what she felt was important when considering the risk a service user posed to themselves:

> If somebody is sort of quite high risk or, you know, has made attempts quite a lot, we'll do a risk assessment.

Social workers considered the importance of prior attempts in their assessment. This is encouraging as Maris *et al.,* (2000) has highlighted that it is common for people to make multiple attempts on their lives before completing the act of suicide.

Assessments under the Mental Health Act

Only one assessment was mentioned on a regular basis: the assessment mandated by the Mental Health Act(s) (1983/2007). This assessment is conducted by an AMHP when a person is felt to be a risk to themselves or others; if appropriate, a

person subject to a Mental Health Act assessment can be detained for further assessment or treatment. However prior to getting to this stage, Amy indicated that an informal, 'pre' assessment was sometimes conducted:

> So I went out to visit, as a sort of 'pre-Mental Health Act assessment', because a Mental Health Act assessment is a lot of work, a lot of time, a lot of people, a lot of cost.

Amy's suggestion that a pre-assessment might be informally employed to reduce costs implies that assessments are not just about risk and need but also act as a way of rationing services (Webb, 2006). Waterson (1999) has discussed how community care assessments are increasingly focused on risk management as a way of rationing resources. Conducting a full assessment would necessitate an AMHP arranging for a consultant psychiatrist, a 'section 12 doctor' (as defined under section 12 of the Mental Health Act 1983/2007). By having an AMHP social worker attend, Amy is highlighting that costly and time consuming assessments can be avoided. Amy was alone in expressing this view, but her point serves to highlight how the convening of formal assessments can be subject to the judgement of those empowered to undertake them. This seems to resonate with the earlier discussions of professional discretion in social work (see chapter 6.1). In this instance it seems that AMHP social workers are potentially using informal processes to help manage their roles in assessing service users under the Mental Health Act(s) (1983/2007). The existence of such informal processes might be a reflection of Lipsky's (1980) 'street-level bureaucracy' with practitioners exercising professional discretion through the use of informal systems and processes (Evans and Harris, 2004; Webb, 2001). As we will see in chapter 8 the CPNs interviewed also spoke about the importance of having informal support from AMHP status social workers.

The Mental Health Act assessments were also felt to be unlike other assessments in that there was a belief that through AMHP training and the assessment tools used, this would generate better evidence, a point articulated by Alan:

> The forms that you fill in afterwards from the Mental Health Act Office which makes…it's a document that is accountable then, in terms of why you come to that conclusion.

The importance of these assessments as a record of what had been found was a point that seems to be of particular importance. Alesha spoke of how as an AMHP and a social worker, she was worried about the amount of protection afforded to her

as a professional in her decision making (Ellis, 2014; Evans and Harris, 2004; Harris, 1987):

> I think, what concerns me about suicide, as a social worker, is the lack of protection for us as professionals. So, if we did go out and see someone and not assess that they're suicidal, and then they died a few hours later, and there's a lot of complaints about that. I don't know at what stage that could get to, whether it could end up, you know…presumably within the local authority if they felt you practised to a fairly low standard, they'll be, sort of, a disciplinary but I don't even understand as a worker whether there'd be a criminal case about the death…are you protected legally about this?

The fear of repercussion for failing to identify suicide is clearly evident in Alesha's comments, and it seems that the need to provide clear accountable assessments becomes of paramount importance. Gibson (2014), drawing on the work of Harris (1987), discusses how the fear of shame that might result of making a mistake can lead to defensive practice. Social workers they argue can become risk-averse, stringently adhering to policies or suppressing information. In terms of suicide prevention it seems likely that social workers might become more risk-averse. The complexity of issues and the fear of getting things wrong were apparent in my interview with Alan who spoke of the complexity of balancing human rights with the need for treatment:

> [There are] a lot of issues when you talk about people's human rights and the fact that, at the end of the day, you'd effectively incarcerated someone. If appropriate then the outcome is to make the application for a detainment. So, it is quite the responsibility [being an AMHP] at that point where you're thinking about it.

Alan's comments indicate that assessments can be used not only to record information, but also as a way of noting the debates that are present in the mind of workers; essentially, a way of recording his thoughts in the event that his decision making was challenged. The judicious use of case notes could represent Alan's wish to avoid the shame of failing to prevent a suicide. Through a meticulously record of incidents that justify his actions he might seek to avoid blame for service user deaths (Smith *et al.,* 2003).

For other social workers, this was not seen to be an issue in the same way. Alison simply stated that when conducting a Mental Health Act assessment; 'It's the law, and the law is the law. And I always go for the least restrictive'. For Alison the assessments were only part of the decision making process (Webb, 2001).

Social workers, and more specifically AMHPs, viewed assessments under the Mental Health Act(s) (1983/2007) not just as a means to identify need and risk (Webb, 2006), but also as a document for recording how and why they made their decisions (Gibson, 2014). The assessments protect them in instances where they are called to account, a point particularly important to AMHPs.

Asking the question…

One last issue that arose in assessing suicide was how social workers addressed direct questions about suicide to service users. Many of the social workers expressed some hesitancy when first faced with asking a service user directly if they were suicidal. This apprehension might be interpreted as part of the process of building resilience for new practitioners when discussing emotionally sensitive topics, or when managing issues of uncertainty (Grant and Kinman, 2012; White, 2009). For example, Carol spoke about how she felt when a service user first called her saying they were suicidal: 'I think its plain panic and then really, you know. And I think you learn from peers...'

Carol said that she learnt from her peers about how to address issues of suicidality with service users, again highlighting the importance of peer learning. Carol's comments were not isolated; Alex recalled how he had gone from being reluctant to speak about suicide, to it becoming a part of everyday practice;

> I remember thinking, "Gosh, I can't ask that [*whether someone is thinking of taking their own life*]. This is kind of as personal as questions go." So, it's funny I kind of feared asking; "Gosh, I'm going to ask someone now, 'Have you ever thought about killing yourself?'" And it was something I felt really uncomfortable with. Now, I'm kind of surprised at the ease at which I can ask someone that and then run through my checklist, when I think about initially the real anxiety I had about that.

Alex's suggestion that asking about suicide had become normalised indicates that doing so has become a routinized part of his work, but it might also illustrate a distancing between service users and social workers (O'Leary *et al.* 2013; Evetts,

2003). Further to this we can also draw parallels with Anna's comments in chapter 6.1 where she talked about becoming desensitised to asking questions about suicide (Bride and Figley, 2007).

While social workers understand the relevance of suicide ideation as a factor that can influence suicidality, they are initially struggling with directly addressing suicidality with service users. The Applied Suicide Intervention Skills Training (ASIST) (2002) advocated by both the English (Department of Health, 2012) and Welsh (Welsh Government, 2008) suicide prevention strategies emphasises the importance of directly addressing issues of suicidality. However, as has already been discussed, only a minority of professionals interviewed had undertaken this training. Incorporating the importance of these direct questions on suicide ideation during initial social worker training would likely improve social worker confidence.

Summary

Social workers often do not have specific assessments for assessing suicidality. Where specialist assessments exist, social workers are often unaware of where these assessments have come from, or the evidence base underpinning them. Instead, the holistic approaches of statutory assessments have come to serve as the basis for social assessments of suicidality.

Despite the lack of specific assessments, it seems that social workers are aware of some of the main issues affecting suicidality. They consider issues such as prior attempts, substance abuse, gender, and suicidal thoughts. Social workers expressed some hesitancy when first tasked with asking service users direct questions about suicide, but with experience and support they became confident in doing so.

6.3 - Conclusion

In this chapter I have discussed my findings from interviews with seventeen social workers. The social workers occupied different fields of practice and were situated in three social services departments, each in a different local authority. Specifically, this chapter focused on two research questions:

RQ 2 – How do social workers understand suicide and suicidal behaviour?

RQ 3 – What approaches to assessment are currently used by social workers? To what extent does research evidence impact on the practice of social workers in this context?

In relation to the first question, the social workers interviewed appreciated the multi-faceted nature of suicide prevention and considered the biological, psychological and social factors that are associated with suicide. In short, they adopted a holistic approach to assessment and understanding suicide (Golightly, 2008). Specifically, social workers identified the importance of family (Seguin *et al.,* 1995), substance misuse (Pridemore and Spivak, 2003) and mental illness (McGirr and Turecki, 2011; Paris and Zweig-Frank, 2001) as important factors affecting suicide.

There was also a belief that suicide could be a rational act. This seemed to be linked to wider debates about euthanasia (Schildmann and Schildmann, 2013; Seale, 2006). This was illustrated by the empathy displayed to the situation of some service users. Essentially the social workers reported feeling that if they were in similar situations to the service users they might also have been suicidal (Gerdes and Segal, 2009).

However, this empathy was tempered by the comparative lack of affect displayed to those who were not felt to be 'genuine' in their attempts to end their lives. Specifically, the social workers in my sample spoke of service users displaying attention-seeking behaviour. The discovery of discussions about attention-seeking behaviour in instances of DSH amongst social workers is perhaps unsurprising given that such attitudes are found to be present in health professionals (Bolton, 2012; McGrath and Dowling, 2012). Further to this, Joiner (2010) and Nock and Kessler (2006) have observed the prevalence such attitudes in the general population. It seems likely that these wider sentiments seep into social worker understanding, and potentially, their practice. Central to the social workers understanding of genuine attempts was the concept of intentionality. However, this was acknowledged to be highly complex.

The confusion surrounding this issue is not surprising, given that the relationship between DSH and suicide is heavily contested (Brausch and Muehlenkamp, 2013; Arensmand *et al.,* 2011; Zahl and Hawton, 2004; Kerkhof, 2000). However, we might also interpret these beliefs as social workers attempts to manage working with risk and uncertainty (Ruch *et al*., 2012; Ting *et al.,* 2011).

Similarly the theme of the inevitability of suicide might serve to help social workers manage working with risk and uncertainty, and the blame/shame that might result from a service users' death (Bride and Figley, 2007; Smith *et al.,* 2003). By conceptualising suicide as inevitable social workers were able to create a professional distance between them and their service users (Glaser and Strauss, 1964). This distance helped create an emotional boundary that helped them in the course of their day to day work with risk (O'Leary *et al.,* 2013; Hayward and Tuckety, 2011). By drawing on their position as 'experts' social workers are able to create and maintain distance with their service users (Green *et al*., 2006). By doing this social workers can create some sentimental order over the risk and uncertainty they face in maintaining their ontological security (Giddens, 1984).

None of the social workers interviewed had any training on suicide during their qualifying social work training, and only a few had taken any CPD training. The few social workers who had been on the Applied Suicide Intervention Skills Training (ASIST, Ramsay *et al.,* 1999) reported mixed experiences. Those social workers who had been on the AMHP training generally felt it to be useful but also reported feeling that it was too heavily focused on mental health law, rather than on assessment and intervention to prevent suicide. In addition to the lack of formal training the social workers seemed to have no awareness of the suicide prevention strategy in Wales (Welsh Government, 2008). Although as Evans (2010) and Evans and Harris (2004) note the role of policies in frontline social work is far from straightforward.

Experiences of the AMHP training were generally positive, although there was some suggestion that it was too heavily focused on mental health law, rather than being focused on assessment and intervention to prevent suicide.

While formal training on suicide was reportedly highly limited, peer learning and tacit knowledge were commonplace (Eraut, 2000). This according to Samson (2014) allows them to draw on both formal and informal information in the process of decision making. Healy (2014) notes that experiential and tacit knowledge form the basis of much learning for frontline social workers.

The importance of tacit knowledge and peer learning was also present in discussions around the forms of assessment used by social workers. O'Melia and Miley (2002) note risk assessment and management is often heuristic in nature. None of the social workers interviewed was able to name specific risk assessments used in suicide prevention. While the social workers described an understanding of

case evidence gathering in the form of a bio-psycho-social model they primarily relied on practice wisdom and peer learning in the course of their work (Samson, 2014; Horlick-Jones, 2005; Eraut, 2000).

Some generic assessments used in practice were identified, such as Core Assessment (children services) and the Unified Assessment (adult services). The Care Programme Approach (CPA), an assessment frequently used by CMHTs, was the most common form of assessment identified by social workers. To complete these assessments social workers described drawing on generic assessment skills. Primarily they spoke about adopting a holistic approach to these assessments (Coulshed and Orme, 2012; Lloyd and Taylor, 1995).

It also seems that the social workers interviewed relied on AMHP status workers to help them in the course of their work with high risk clients. Pre-mental health act assessments and expert knowledge held by AMHPs were felt to help inform their practice. However, both these AMHP-supported assessments and assessments more generally were used defensively by social workers to help justify and rationalise their decisions (Gibson, 2014; Smith *et al.,* 2003 Lipsky, 1980;). The concept of defensive social work is developed further in the next chapter.

In summary, this chapter has explored the second and third of my research questions, providing an insight into how social workers understand and assess suicide. In the next chapter I explore the social worker perspective in relation to the following research questions:

RQ 4 – What roles are currently played by social workers in suicide prevention? Do social workers have a distinct role in suicide prevention or has the increase in multi-agency working blurred the roles of different professionals?

RQ 5 – What sorts of social care provision are available to suicidal service users and what is the nature and frequency of their engagement with these services?

RQ 6 – How are social workers supported when working with suicidal service users?

Chapter 7 – Interviews with social workers: What role(s) do social workers have in suicide prevention?

7.0 – Introduction

In chapter 6 I explored how social workers understand and assess suicide. It was established that despite a lack of training on suicide, social workers adopt a holistic approach to their understanding and assessment of suicidality. Social workers have an appreciation of the multi-faceted nature of suicide, and some awareness of the bio-psycho-social factors associated with suicide. Suicide was, however, often discussed as being an inevitability, an occupational assumption that seemed to be employed to help cope with the stress of working with suicidal service users.

In this chapter I continue to explore the data from social worker interviews and focus on the following three research questions:

RQ 4 – What roles are currently played by social workers in suicide prevention? Do social workers have a distinct role in suicide prevention, or has the increase in multi-agency working blurred the roles of different professionals?

RQ 5 – What sorts of social care provision are available to suicidal service users and what is the nature and frequency of their engagement with these services?

RQ 6 – How are social workers supported when working with suicidal service users?

I explore each research question, before bringing together my findings from the social worker interviews in my conclusion.

7.1 – What roles are currently played by social workers in suicide prevention? Do social workers have a distinct role in suicide prevention, or has the increase in multi-agency working blurred the roles of different professionals?

In chapter 6 I examined social workers' knowledge and understanding of suicide and how it is best prevented. However, we still have no clarity on what roles social workers have in preventing suicide. This is a particularly important question given the rise of multi-agency and interdisciplinary working.

To explore the role of social workers in suicide prevention, I have divided this section into two parts. In section 7.2 I will explore how the diverse remit of social work can lead to different areas of practice having different approaches to working with those who are suicidal. The interplay between the diverse areas of social services (primarily children's services and adult services) is examined and implications for practice discussed.

In section 7.3 I examine issues of multi-agency and interdisciplinary working. Here the complexities of working across agencies and with other professions are discussed.

7.2 - Social work diversity

My participants were purposely drawn from a wide range of practice settings: ranging from physical disabilities teams to community mental health teams (CMHTs); from older persons teams to child assessment teams. The diversity of the social work profession is reflected in the way these services are organised in terms of (i) area of social work practice (that is to say the diversity of social work), and (ii) differences between local authorities. I will now explore these points in turn.

Given the wide remit that is afforded to the social work profession (Sheldon and MacDonald, 2009) and that social work training in the UK is generic in nature, it is unsurprising that social workers can undertake roles in several different areas of practice over the course of their career. Of my participants, ten had worked in more than one area of practice, whilst seven had only worked in one since qualifying. This meant that many of my participants were able to reflect on how social workers in different areas of practice related to one another.

One fault-line that was identified was between adult and children services. Bethan (a social worker with an assessment team in children services) spoke of her mixed experiences working with adult mental health services. Bethan recounted how she had been working with a family where the mother had attempted suicide and had been admitted to hospital. Where she was assessed by a psychiatric nurse and discharged. At discharge she was told that a referral would be made to the CMHT, the home treatment team (which provides short term assistance with high risk service users), and children's services. Bethan and her team responded to the referral and went to visit the family on the day it was received. On visiting the family it became apparent that they had not yet heard from the CMHT and had been offered no support. Bethan said that she called the CMHT and home treatment teams who confirmed that the mother was not eligible for their services. The existence of such gaps in service delivery is unfortunately not uncommon. For example, Bruce and Evans (2008) have highlighted gaps in service between Child and Adolescent Mental Health Services (CAMHS) and CMHTs. Similarly Bailey and Liyanage (2012) have discussed gaps in delivery between mental health and substance misuse services (this is elaborated on further in the next section). Worryingly, Bethan discussed how the family were unaware of the decision by mental health services not to provide support:

> [I] spent quite a lot of time on the phone everyday with this family and I think part of that is because they haven't had a service from mental health at all (...) I found that I was with the family for hours. I was out for about four hours. Just purely because you're just someone for them to talk to, who's not family or a friend; not kind of stressed about how this is. You know I think people get really anxious for what the future holds really, rather than dealing with what's happening now and what services are doing.

Bethan felt that she was acting alone and managing a situation where other services should also have been assisting.

Bethan was not alone in her experience. Bridget (another social worker from Children's Services) spoke of her experiences trying to get a mother some help from a CMHT:

> They said that because the mother lived at the top of the valley, and this woman had only just returned to work, she'd been on sick leave, and she would get in from work at quarter past four. And they said that,

> because they only work until 5:00, they therefore couldn't do an assessment because it takes two hours. So, they couldn't begin to work with her.

The frustration experienced by Bridget was apparent later in the interview when she spoke about mental health services, commenting:

> Not everyone fits in the box for that service, and I think I mean I tried to support the family through the crisis. And I still am, but I'm a child social worker so it's very difficult to be supporting parents as well as kids (...).

Bethan and Bridget were primarily concerned with the perceived lack of CMHT services made available (i.e., they were slow to respond and unwilling to work outside certain hours). By contrast social workers in mental health services expressed frustration with children's services. Amy (a social worker with a CMHT) said:

> The difficulty is children services (...) I don't think they understand [suicide]. So, if there's harm around this child, they don't…I think they find it difficult to grasp, but it's probably improving (...) I was at a case conference about a month ago, and it was most unpleasant actually, and I was the only person with a service user, and her husband, and there was about fifteen of us around the table and it was all health, education and they clearly, none of them had any patience with them, you know. It just comes to the point of 'let's just get the kids from them' and it was quite unpleasant actually.

The case conference described by Amy is a meeting where professionals and family members meet to talk about risk posed to a child. At the end of the meeting, the professionals vote on whether they believe the child's name should be added to the Child Protection Register. In this particular conference the suicidality of the mother was felt to be an issue. Amy clearly felt that the risk of suicide was not sufficiently understood by the other professionals. In her opinion they were over estimating the risks posed.

Connolly (2006) has discussed how case conferences in child protection can serve as a place of discussion and conflict. This conflict can take place between professionals as well as between service users and professionals. In Amy's case it seems that the risk posed by the service user's mental illness led to conflict between professionals from children and adult services.

CMHTs also came into conflict with substance misuse services. Service users with substance misuse issues and mental health problems (i.e. dual-diagnosis) were an area of particular contention. The relationship between substance misuse and mental health problems has often given rise to various 'chicken and egg' debates (Appleby *et al.,* 2000) that seem to have filtered through into social work. Dual-diagnosis is felt to be a complex issue as it can be unclear whether the substance misuse is the cause or symptom of a presenting mental illness (Rosenthal, 2003). Essentially it can be unclear if the use of substance causes mental illness or if the service user is using substances to 'manage' their mental illness. Given that both substance misuse and mental illness are associated with suicide (Pridemore and Spivak, 2003; Cavanagh *et al.,* 2003) interventions for dual-diagnosis would likely reduce rates of suicide.

Despite the close association between substance misuse and mental illness it is perhaps surprising to hear that the relationship between substance misuse and mental health teams was described as being less than harmonious by the social workers in my sample. Claire (a social worker with a substance misuse team) succinctly described her experiences of working with mental health services:

> I don't think we have a lot of faith in the crisis team, the hospital or CMHTs because we work with people, obviously drugs users and alcoholics who present under the influence [of drugs or alcohol] feeling suicidal. They're saying they're feeling suicidal and they've been drinking, they're not going to assess them anyway.

Claire suggests that mental health services are reluctant to assess service users who present under the influences of alcohol or drugs. This reluctance is, in part, determined by the Mental Health Act(s) 1983/2007 (MHA83). Under the MHA83, a person cannot be assessed or provided with services when they are under the influence of substances (controlled or otherwise). Mental health services are therefore unwilling to provide services or support to those who present in this way. This is concerning given the strong relationship between substance misuse and suicide (Pridemore and Spivak, 2003).

Claire was not alone in voicing her concerns around the relationship between substance misuse and mental health. Chloe (a substance misuse social worker) spoke about how she is:

> Often trying to work with dual diagnosis. People with mental health and, you know, people see the substance use first and foremost, and often that's what's the most frustrating. People not seeing beyond, when that's even a part of a person's life that we're working with, you know. Often there are many issues; whether that is trauma or, you know, psychological things going on or psychiatric illness as well.

Her frustration was directed towards both the public at large and other professionals. She felt frustrated that crisis intervention services and mental health services were reluctant to assist those with substance misuse problems. The problematic divide between substance misuse and mental health services has been commented on by Lawrence-Jones (2010), Schulte *et al.,* (2008) and Lowe and Abou-Saleh (2004). The division between these services has, according to Lowe and Abou-Saleh led to service users falling between the cracks. Worryingly, Lawrence-Jones notes that while progress has been made, it is slow and variable. This divide is perhaps ironic given that Weaver *et al.,* (2003) found 44% of CMHT service users reported having substance misuse issues in the last year. The reluctance of mental health teams was something that Chloe lamented:

> It can be really hard to get mental health services involved (…) Sometimes it would be really helpful to have their input, but then you call them and it's like "well they [the service user] is using drugs so that's the main issue… (…) If they're already with us [substance misuse team] then they [the CMHT] won't take it on.

This frustration with mental health services was also shared by Carol, who talked about how the team she managed (substance misuse) had tried to overcome the issues by forging personal links with CMHTs:

> We tried going up to the teams, going in to their team meetings, giving talks and workshops and things like that. But still it seems to be that it's experience and different personalities [that affect the relationship between mental health and substance misuse services].

Carol felt that despite attempts to engage with mental health services, it ultimately came down to the individual working relationship with a particular practitioner. Mental health and substance misuse services appeared to be divided by structural, legal, and cultural differences (Lowe and Abou-Saleh, 2004). More fundamentally, the divide between mental health and substance misuse services comes down to

debates (both medical and legal) about the relationship between substance misuse and mental illness (Buckley, 2005). As Claire suggests:

> It can be difficult because somebody may say that they've got this psychotic because they've been taking amphetamines, but somebody is still psychotic, but they just say drug-induced psychosis and they won't be seen by mental health services.

Thus far we have seen how the remit of an organisation (whether in the guise of a divide between adult and children services, or divides on issues such as dual diagnosis) can have an impact on the way social workers respond to issues of suicidality. CMHTs are often perceived to be difficult to engage with, despite the desire by social workers in others areas of practice to draw on their expertise and skills. But how do wider multi-agency and interdisciplinary issues affect the social worker role(s)?

7.3 - Multi-agency and interdisciplinary working

So far we have looked at the relationship between social workers in different areas of practice. Yet social workers do not work in isolation and many other professionals were mentioned by social workers during interviews: CPNs, the police, GPs, accident and emergency staff, psychiatric nurses (working on wards), ambulance personnel, psychiatrists, psychologists, the third sectors, private companies, social services support workers, teachers, carers and families. The rhetoric of multi-agency interdisciplinary working has become a common feature of government policy, particularly in the area of mental health (Evans *et al.,* 2012; Onyett, 2003; Barr and Huxley, 2002). Multi-agency and interdisciplinary working are often linked, but they are also distinct concepts: multi-agency working refers to different organisations (agencies) working together; interdisciplinary working refers to working across professional boundaries (e.g. nursing and social work) within or across different organisations.

Working with other professions and across agencies poses both opportunities and challenges to social workers. These opportunities and challenges can, as I will now demonstrate, impact on how social workers respond to and assist those with issues of suicidality.

Anna (a social worker in a CMHT) suggested that the lack of knowledge and training for support workers in other agencies meant that she was not always given the information necessary to effectively assess and manage a situation:

> You get a phone call [from a support worker in a voluntary agency] saying "oh, this is so and so today and I'm worried about them. They seem quite low and they said they were suicidal, blah, blah, blah". So you do try and glean as much information from that person as you can. But they haven't necessarily asked the questions that you would ask if you'd been with the service user. So, they can't possibly give you all the information, and it's not as full of information as you would like.

Anna's frustration is evident. From her perspective, support workers lacked sufficient training and knowledge about suicide. However, Alesha (a social worker with a CMHT) expressed some sympathy with support workers:

> When I was a support worker, if I had a person telling me they were suicidal, I would want to pass that information on and for me not to have to worry about it anymore (...) I think we can get quite blasé as social workers and mental health team workers to sort of say, "oh they're always saying that, don't worry about it".

Given that support workers are often unqualified and with a junior status to social workers, it is perhaps not surprising that they would (and should) pass such information on (Huxley *et al.,* 2009b; Evetts, 2003).I was interested that Alesha suggested that social workers might be 'blasé'. Interestingly, Alesha also suggested that support workers might sometimes have insights that social workers do not:

> It's difficult, because you'll have different services on it…different ideas of the service user, and you've got to get everybody's view into account, I think. For example, your home care was concerned about someone…I would take that seriously because home care are probably seeing them much more regularly than I am (...) So, they are able to check or map people's moods, probably better than we are. So I think you can't dismiss anybody who mentions that they're worried about someone.

Alesha acknowledged the importance of support workers and carers in alerting social workers to suicide risk. Specifically, their regular contact with service users means they are able to observe any change in the mental health of those they are working with. Huxley *et al.,* (2009b) noted that support workers are less likely to

change roles than social workers and so are able to build and relationships with service users and thereby more aware of their needs on a day to day basis. The benefit of multiple perspectives is however tempered by the large number of different viewpoints that social workers, as case managers, need to consider.

The multiple and different perspectives also had the potential for conflict between professionals (Bailey and Liyanage, 2012; Rees *et al.* 2004; Norman and Peck*.,* 1999). Alison (an AMHP status social worker with a CMHT) provides an insight into how different professions work together when assisting suicidal service users:

> The GP said that these concerns have been raised by the family. She'd gone in that afternoon but this lady wouldn't let her in. And she wouldn't let her in because she knew family members there and they want to get in and she didn't want the family in there. This went on back and forth with the GP, and whatever have you. Back to the psychiatrist and he said, "oh, it's going to take one hour actually". He said "to go out and get a 135[21]". "I can't go out and get a 135, I haven't got enough information". But anyway, this goes on right up until six o'clock we eventually got a hold of her brother-in-law. Now I'd spoken to the GP twice who hadn't told me the service user was diabetic. She was drinking soda, three weeks ago, she had a pace maker fitted. And they found that she had a severe heart condition. It was a good thing that we didn't have a warrant, if the police had turned up with us to execute the warrant then she might have had a heart attack.

What is of particular interest in this extract is the nature of the relationships between different professionals. We can see from Alison's comments that her role as an AMHP led to her being the key coordinator of an intervention: she had contact with both primary (i.e. the GP) and secondary (i.e. the psychiatrist) health care services, family members, and potentially the magistrates and police. The complexity of working in multi-agency and interdisciplinary contexts seems to be further complicated by high levels of uncertainty and professionals working with incomplete information (Stalker, 2003).

---

[21] 135 refers to Section 135 of the Mental Health Act 1983. Under S135 an AMHP may make an application to a magistrate's court for a warrant to access a private residence and have a person assessed under this act.

Multi-agency working (even at the point of crisis) is a fundamental prerequisite of the AMHP status (College of Social Work, 2014; Brown, 2013). Alan points out that the AMHP status is distinct from the wider social work role:

> I think that it is a distinct role [AMHP], because I think from the point of view of working with consultants and the clinicians, and even the GPs. We hold a lot of power and have clearly defined roles in law.

What about how social workers negotiate their role in interdisciplinary/multi-agency settings when not acting in their capacity as AMHPs?

The social workers interviewed described being caught between (i) the rise of generic work in areas such as mental health (as discussed in chapter 3.1); and (ii) a belief that the social work profession is uniquely placed to understand the social situation of service users. The rise of interdisciplinary working (e.g. with the formation of CMHTs) had created concern amongst participants that the specialist roles of social worker and CPN are becoming redundant. Anna (CMHT social worker) said:

> I think it's becoming more generic and I think that's probably the social worker's fault. For quite a long time, we've been so protective of our caseloads and stuff, and batting things away (...) We've kind of pushed those roles a bit on to the other professions and taken away our own kind of value. We're making ourselves redundant a bit, I think. So, I think it is becoming more generic across CMHTs, of how people work.

For Anna, social workers are themselves partially to blame for the increased genericism within CMHTs. The blurring of roles within CMHTs was, in Anna's opinion, a largely one way process, with other professions (e.g. CPNs) taking on an increasing number of roles that were traditionally associated with social work.

Anna's comments have resonance with discussion in chapter 6.2 about the assessments used by social workers and colleagues in the health service to assess suicide. There, it was suggested that increased focus on holistic assessments drew from the social work tradition (Yuill *et al.,* 2012; Carpenter *et al*., 2003). The implication of this, and Anna's comments, is the blurring of professional identities between social workers and CPNs (Bailey and Liyanage, 2012; Robinson and Cottrell, 2005).

In contrast, Andrew (CMHT social worker) suggested that although there does seem to be a great deal in common between the roles of social worker and CPN at a superficial level, in practice the roles were different:

> [Referrals get] looked at generally by the nurse and the social work managers on a daily basis. And the work was being allocated out on the basis of who had capacity rather than this being. This is for social work, this is for the CPN. That hasn't happened to quite the same extent here [draws comparison between his current CMHT and the previous CMHT he worked for] (...) On the one hand you've kind of got this theory like it's going back to the Venn diagram, that it's all being very overlapped. And so, you know, in principle, we could be doing very similar work. But I think if you actually looked at the work of a social worker against the work of a CPN, you'll actually find we work quite differently.

From Andrew's comments above, we can see that there does seem to be a great deal in common to both professions, so that at a superficial level we might consider the roles of social worker and CPN to be synonymous. Despite the large degree of cross-over between social worker and CPN roles, Andrew believed that when examined in more detail the roles of social worker and CPN were quite distinct, although he found it hard to effectively articulate the difference. This view was shared by Alesha (CMHT social worker):

> We're much more concerned with how somebody fits in socially in the community, how they live in the community, how they adapt to community. We're not solely concerned in how well they are. It's not only about that, somebody can be quite well mentally but still not functioning well in the community and I think, our role perhaps is not as black and white as a medical role. This is really important when looking at suicide, because it's never really black and white.

The skill and ability of social workers to understand the individual and their situation in the wider community was felt by Alesha to be of particular significance. As previously indicated, Carpenter *et al.,* (2003) found an increased adoption of a holistic approach by health professionals in CMHTs. They noted that CPNs strove to adopt this particular approach from their social work colleagues. However, Amy, (a CMHT social worker) was sceptical of how far CPNs had actually adopted a more holistic approach to their work than CPNs:

> CPNs will argue, they probably don't see the point of us sometimes, you know, because they do it all (...) With the assessment tool, the CPA [Care Programme Approach] assessment, very often CPNs may not do it now but probably they go straight to the medical part and they start with the problem and work out. Whereas, social workers will tend to, you know, ask you why you're here today, we are going to know what's going on. We'll be more holistic and we're more interested in you, your environment and probably medical [background].

For Amy the uniqueness of the social work profession is its holistic approach (Golightly, 2008), thus while CPNs, and other professionals, may use the same assessments and forms as social workers, this does not mean that they automatically possess the same skills and understanding (see chapter 3.2). Adele (a CMHT social worker) also touched on this point, emphasising what she felt were distinguishing features between social workers and CPNs:

> There are traditional medical hierarchies, that a nurse will always be more bound by them. Social workers, I think, we have as part of our training, our values and our skills, a more holistic approach rather than just a medical approach. And we were supposed to be enablers and helping people sort their own problems as much as possible, and assisting and enabling and empowering.

Adele clearly felt that the training of social workers enabled them to adopt a holistic approach rather than a medical approach (Beresford, 2002; Engel, 1977). For her, a medical approach meant a focus on treating the individual symptoms of the service user rather than taking a holistic approach to working with the service user. Adele felt that social workers sought to empower those they worked with, rather than just treating the symptoms they presented with, something that again she felt came from social worker training.

The differences between social workers and other professionals were also felt to be problematic because of comprehension amongst other professions about the role and powers of contemporary social workers. Claire (a substance misuse social worker) captures the frustration that many social workers felt in multi-agency and interdisciplinary working:

> Professionals don't actually know what we do, and even though you may explain to them, nurses in particular. I was at a meeting yesterday with

> someone who's in a mental health unit. As soon as this person was a risk I suggested they might be better in hospital, and when they do finally get into hospital it turns out that they've been being financially abused by their son, and this has been going on for two years. The money stolen was in the thousands of pounds. Other professionals then started asking "Well, what have you done about it?" It's time to self-explain my role [as a social worker] and what our powers are.

The frustration in Claire's voice during this part of the interview was very evident and served to emphasise that this was a regular issue. The challenges made to Clare by the mental health nurse perhaps indicate the complexity of interdisciplinary working and the challenges to the professional status in these situations (Evetts, 2003; Abbott and Wallace, 1990).

However, given the contested nature of social work (chapter 3.1), it is perhaps unsurprising that other professionals are confused about the role of social workers. In addition, the shift away from a community to a case management approach (see chapter 3.1) means that the CPN beliefs about the role of social workers are increasingly out of date with actual practice.

Much of the discussion so far has focused on interdisciplinary relationships between social workers and CPNs, but multi-agency issues could also impact on how social workers seek to reduce suicides. Anna (a CMHT social worker) highlighted how different CMHTs within her local authority operated differently, something she attributed to the different cultures that existed within two neighbouring different health trusts:

> But it differs a lot from team to team. I would say that in this team, there is a more defined social work role here than there was in West Town CMHT. And I don't know whether that's because the CPNs starting here are less willing to do those kinds of tasks [viewed as social work tasks]. They will still come and request a social worker to do it, and that's what happens. Whereas in West Town, the CPN is just sort of, "oh, fine. I'll do it then." Maybe it's because the current health board was originally two boards of trust.

The interaction between social workers and their CPN colleagues is shaped not only at the personal level, but also by wider agency practices. This means that even within one local authority, different approaches to working can exist. Abigail, for

example, said that 'nurses have never done duty [the duty rota for new or emergency cases] in this team'. She suggested that this was unique to her team, with different teams in the same local authority having a joint duty rota between social workers and CPNs.

In summary, the diversity of the social work profession necessitates that social workers negotiate their roles in relation to each other, as well as with interdisciplinary and multi-agency teams. While there are considerable concerns about the emergence of a generic role in CMHTs, participants said that they were unique in adopting a holistic approach and understanding the wider circumstances of service users. The relationship between substance misuse and mental health services seems to be particularly problematic, as does the relationship between mental health services and children's services. In the next section I explore how these various tensions impact on the social care provision for suicidal service users.

7.4 – What sorts of social care provision are available to suicidal service users and what is the nature and frequency of their engagement with these services?

One theme that emerged consistently throughout the interviews was that participants in this study rarely provided services and support directly to service users, a point discussed in chapter 3.1. Anna (who previously trained as an occupational therapist) explained how her transition to social work led to a clash in professional approaches:

> When I came from my OT I was kind of like, "I'm not going to do that [case manage]. I am going to try and carry on doing things myself as much as possible," but I'm only here three days a week and it's not possible and it's frustrating. And I've tried to do it, I just ran myself into the ground where I've got a backlog of people; so it was like "Oh no!" (...) I had thirty-five service users altogether on my caseload and so obviously I wasn't being able to provide direct support myself to all these people. Really I was only providing care for about, say five.

Anna's caseload made it impossible for her to continue to provide direct interventions with her service users. Instead she needed to move towards a case management approach, as discussed in chapter 3.1. As a social worker, Anna would organise packages of care to help assist service users. These packages of

care would draw on a whole host of different services that were tailored to meet the needs of individuals. As Andrew (a CMHT social worker) put it:

> We try to look at the individual and work out what their needs are during our assessments. Then it's just a case of trying, or in some cases hoping, that we can match services to them... It can be really difficult sometimes.

Andrew indicated how the assessments and services provided to service users were needs led. However, trying to match services was not always an easy task. The difficulties of getting services to engage with service users were problematic for two reasons: first, there was variation within and across local authorities; second, the eligibility criteria for services was felt to be variable and not transparent.

The variability within and across local authorities was discussed by Abigail (a social worker with a CMHT):

> It can be difficult knowing exactly what services we have, they change all the time. Sometimes we have services in one part of the county, but not in another (...) This can be because they're provided by different health boards or voluntary organisations (...) Different local authorities also have different services. It's all quite confusing.

From Abigail's comments we can see that social workers struggle to know what services they can draw on. The variability in services also indicates that service users are likely to get support based as much on availability of such services in their area as on need. This correlates with the findings of Goddard and Smith (2001) who noted that mental health services are often not available based on local demand.

Even when social workers were able to locate services, this did not guarantee that such services would be available to their service users. This was felt to be particularly problematic for the crisis intervention teams (the composition of these team varied between local authorities and health boards). These teams provide support to service users who are experiencing acute crises, with service users having regular contact (daily, or multiple times a day). Amy (a CMHT social worker) had faith in the service provided by the crisis/home intervention teams, but struggled to know whether her service users would be accepted onto their caseload:

> The crisis team can be really useful. They can visit every day, sometimes a couple of times a day. They can also visit at weekends and

> bank holidays (...) There was a lady last week that came to a [section] 117[22] review, she was feeling very, very low. She was having thoughts [of suicide] but she had no plans, even though she looked at the knife in the kitchen. However historically she has [been suicidal] (...) So we put the crisis treatment in over the weekend. They [the crisis team] were great, but they don't always accept cases even when someone really needs it. It doesn't help that they are constantly changing their criteria, not once or twice, but all the time!

The crisis team was identified by many of the social workers as being pivotal for service users at the point of crisis. Pritchard (2006) notes that services users will often have fluctuating needs and that social workers will often have to assess and reassess in the light of new information and changing circumstances (Martin, 2010). However, this can be complicated by changing eligibility, a point discussed by Alesha (a CMHT social worker):

> I'm never sure whether they will actually take a case on. It seems like they take a case one week, but then won't the next.

The crisis team seems ideally placed to support service users, but accessing the service was deemed problematic. A series of other services were identified by social workers as being essential to preventing suicide. Claire (a substance misuse social worker) suggested that interventions based on substance misuse can be of particular help to service users:

> We've got drug and alcohol counsellors which can really help, especially with those service users that are a bit more, how can I put this... impulsive (...) They [substance misuse counsellors] have really helped with some cases.

As we have already seen, however, substance misuse could act as a barrier to accessing services. Andrew (a CMHT social worker) described how one of his service users presented at a local psychiatric ward whilst under the influence of alcohol. He was not admitted to the ward, even for assessment, because he was intoxicated. The service user went on to take his life:

---

[22] Section 117 of the MHA83 entitles those detained under section 3 to services that are free at the point of delivery. The section 117 status is reviewed periodically.

> Our [the health board] policy is we don't allow people into the wards when they're intoxicated. And I don't know…it kind of…I think I was just kind of left feeling, yeah, it was…yes, this is what happened and those are policies and procedures (...) the nurse who'd been on the door, who'd refused to let him in (...) There's high risk and there's policy that you know we can't cope with somebody because they've had a drink. And we [mental health services] won't assess him and that person has not been assessed, and they've been turned away and they've wound up dead. And if I'd been the family faced with that, I don't know…it wouldn't have been much consolation to me.

Andrew wrestled with the ethics of these policies and felt that such services often failed service users. The empathy felt by Andrew is, as Gerdes and Segal (2009) suggest, a component of social work practice and seems to encapsulate the dilemma faced by social workers in managing the practical-moral and technical-rational activity aspects of practice (Taylor and White, 2001).

Another service identified by Alison (a CMHT social worker) focused on stress management:

> I did refer her [a service user with an anxiety disorder] to these stress management trials. This is where they sort of teach people to sort of handle stresses differently. It's been really helpful... [The service user has] not been trying [to take her life] as much recently.

Such specialist services are rare, but we can see from Alison's comments that in this instance it was well received and in their view seemed to be effective.

Thus far I have focused on how social workers draw on wider services, but they also have specific methods and processes which they employ themselves. Social workers in mental health often find themselves working with complex, difficult and dangerous service users and need to employ methods that help them manage these relationships safely and effectively (Littlechild, 2013; Littlechild and Hawley, 2010). The need to manage these cases seems like a way to manage the stress of working with service users. For example, Acker (1998) highlights that social workers working with service users who have severe mental illnesses suffer from higher levels of burnout and lower job satisfaction.

An example of a strategy employed by the social workers in my sample was discussed by Abigail (a CMHT social worker) who described how a protocol was

designed which allowed the team to manage a service user with a history of suicidality more effectively. The service user had made multiple attempts on her life, and many attempts to assist her seemed to have failed:

> We've set the protocol. It seems harsh but it's…especially with personality disorder, that protocol, it's been really good (...) Whereas, everyone used to run scared when someone like that woman phoned up. Oh, but we know once you give five minutes and have a chat, that's all…and it worked rather…it's still a lot of time, yeah, to do. I know that's what worked… So, we'd set that protocol and it worked real well, especially with personality disorder.

The protocol described by Abigail was designed by social workers in conjunction with psychologists. Essentially, the protocol restricted the amount of telephone contact between the service user and the CMHT. This approach was felt to be of particular importance for personality disorders, a disorder marked by unpredictable and self-destructive behaviours (American Psychiatric Association, 2013). It seems that specific interventions are sometimes tailored to meet the needs of service users in collaboration with other professionals.

Abigail also described what seemed to be one of the main forms of interventions: monitoring service users' mental wellbeing and visiting on a regular basis:

> Social workers do the monitoring in mental health. They sort out all the outpatients (...) I'm always here at the end of the line (...) I would prefer to be coordinating and being here is where I'm really needed.

Abigail's comments encapsulate a view that was articulated by several participants; monitoring mental health through regular visits and taking phone calls is seen as an important method of suicide prevention. The continued monitoring of service users has been one of the main principles of the care in the community programme (Gray, 2012; Hoult, 1986). As discussed in chapter 3.3, case monitoring of service users has been found to be associated with improved engagement with mental health services, and potentially, reduced incidents of hospitalisation (Burns *et al.,* 2007; Catty *et al.,* 2002; Tyrer *et al.,* 1995).

This monitoring becomes a form of social support, bringing together existing informal support, such as families (Topor *et al.,* 2006), and more formal support, such as crisis teams (Huxley *et al*., 2009b). Alesha (a CMHT social worker)

described this when she summed up what she felt social workers did best to support suicidal service users:

> I think, from a social work point of view, what we try and do is show a sort of social support. So, I will often get family involved in sort of increased monitoring of the person. Say they've been attending some sort of day service, then I'll ask if they can go there more regularly. So it's two things, more of the monitoring of the person and also a distraction for the person…finding things for them to do. But we can't watch people 24 hours unless we admit them. So, you know, you're never going to have a perfect plan but what I find most successful is to involve families in the discussion and keep everybody aware.

Alesha's comments clearly illustrate the importance of the relationship between support workers and social workers in supporting those felt to be at risk of suicide. They also demonstrate that contemporary social work practice is not about social workers providing direct interventions, but managing packages of care to support service users. For social workers it can be difficult to validate when they have achieved a positive outcome. As Lymbery (2001) notes, relationship are often not associated with case management. Instead the focus is on performance management targets. Further to this, MacDonald and MacDonald (2010) have highlighted that risk in social work is often conceptualised in negative ways. The positive impact that social work can deliver is often not acknowledged or considered. The combination of negatively framed risk and the lack of appreciation of the positive effect that good relationships with service user means that social workers might struggle to identify when they have been 'successful' in their practice.

7.5 – How are social workers supported when working with suicidal service users?

In chapter 6.2, I explored the limited training that social workers received in suicide prevention. However, other forms of support were not explored. How social workers are supported when working with service users, or after the death of a service user, remains unknown. In this section, I examine what support exists for social workers in addition to their training.

Suicide is a sensitive topic. Andrew (a CMHT social worker) said:

> Nobody wants to feel that somebody's taken their life and there's something that they might have been able to do to prevent it. And I think it's one of the worst.

In chapter 6.2 (and 6.3) I highlighted the plight of Anna, a social worker with a CMHT, who had two service users complete the act of suicide in the week prior to being interviewed. What emerged from her interview was that she had received limited support since their deaths:

> The manager and things, and offers; "Yeah, come and talk to me any time". But yeah, I don't know. Nothing more formal than, you know? And so… I haven't been in to be debriefed by anyone about anything.

Anna joked that she was 'using [the research interview] as my debriefing' and after the interview she seemed unsure what would happen next:

> I'm not sure what will happen next… If there's going to be a review or enquiry then no one's mentioned anything. God I hope there's not going to be a review!

Would there be a review of the deaths? If so, who would be leading it (health or social services)? Would the coroner want to speak to her? Anna's anxieties about such questions and the prospect of a review were well founded. The increased use of external audits and reviews in social work has been much discussed (Fish *et al.,* 2008; Munro, 2004; Parton, 1996) and stems in part from an greater focus on wanting to be safe from risk and a belief that risks are quantifiable and 'manageable' (Giddens, 1990; Beck, 1992). Additionally, Walker (2002) has linked the increased demand for individual accountability with the rise of neo-liberalism. The use of reviews, particularly in the case of children's services, has been critiqued for creating a culture of 'heads will roll' (Broadhurst *et al.,* 2010:366). Inevitably the impact of such reviews can add to the fear of shame practitioners might expect if reviews were unfavourable to their actions or conduct (Smith *et al.,* 2003).

Interestingly, Andrew (a team manager with a CMHT), saw such reviews as a form of support:

> *Researcher:* What sort of support was offered to that worker?
>
> *Andrew:* There was a clinical review process.
>
> *Researcher:* Being a health led process?

> *Andrew:* That was a health led process. And also I tried to offer what support I could on an informal basis and supervision to the worker. But you know I was very aware the support I tried to offer, it didn't take away from the fact that, you know, that happened and the person was left with, you know, was left with that.

Andrew felt that reviews offered a good opportunity for learning, although he admitted that he was 'not aware of what the outcome was with that one in terms of, I haven't had any feedback'; he was not sure whether this was due to a breakdown in communication or if the review had not yet been formally completed.

The importance Andrew afforded to such reviews might be explained by his experiences after the loss of a service user in his early career. The service user had been found to have taken an overdose after attempting to get admitted to a psychiatric unit. The unit had refused to admit the service user because he was intoxicated at the time and could not be assessed. Officially the death was not designated a suicide and Andrew was unsure whether it was accidental or not. A meeting had been held between health and social services to review what had happened. This meeting was described by Andrew:

> It was absolutely a helpful process. I remember it because, in a way, it kind of felt that there was a particular thing about what happened with the ward. It was especially useful from the family's point of view. I knew he'd gone to the ward and tried to get himself admitted and he'd been turned away.

For Andrew, this review had provided an opportunity for systemic issues of practice to be scrutinised. Andrew's experiences seem to indicate that while he feels the reviews can be useful for helping to scrutinise practice, professionals are rarely given any official support when they are subject to these reviews. Again we might draw parallels with the opportunities for learning that Serious Case Reviews (now Child Practice Reviews in Wales) afford us in children services (Brandon *et al.,* 2012; Brandon *et al.,* 2010). Reviews and audits of practice can provide opportunities for learning and development that can aid practitioners both individually and collectively.

Andrew was not alone in suggesting that reviews could be useful for supporting professionals and informing practice. Alan (an AMHP social worker with a CMHT), also spoke of his experiences:

> The inquiry highlighted what was done by the CPN, by ourselves, by the hospital, was in sort of good practice. There were no issues around resources… So, the outcome in that was quite positive in terms of, you know, no blame then.

Alan seemed to equate a positive outcome with the absence of blame. This perhaps indicates a more sinister understanding of the 'support' that a review might provide. We might surmise that if a review were to render an ambiguous verdict or actively attributed fault to a social worker, then such reviews would provide less support to social workers. Alan was the only participant who explicitly stated the possibility of a professional being blamed for a service user's death, but there were other references to the fear of being held accountable (Broadhurst *et al.,* 2010). Reviews into the shortcomings of mental health services serve as testament to very real pressures faced by social workers (Reed, 2014). The anxiety caused by such reviews, or the potential for them, was evident in my interview with Anna. She discussed scrutinising her case recordings after the death of her service users, a process that reassured her:

> And it sounds awful but I just felt reassured by what I'd written and what I was able to read.

Anna's use of case notes as a validation of her actions has resonance with Alesha's discussion in chapter 6.2 about the use of notes as confirmation of her assessments. Again the fear of what might result from these deaths and the stigma, or shame, that might result from them seems to have been at the forefront of Anna's mind (Gibson, 2014; Harris, 1987). Anna's relief at reviewing the case files suggests that she was comforted in her belief that she had done everything she could to help, but might also indicate some concern with how others (such as a review) might interpret her actions.

These reviews are important in scrutinising and improving practice. Nevertheless, they are retrospective in nature and would only be held after a service user completes the act of suicide. As such, many social workers would only rarely experience them in their career, if at all. Consequently, a review would offer limited support for most social workers, and then probably only in circumstances where the social worker was exonerated of any wrong doing.

Thus, whilst Andrew identified reviews as a support mechanism for learning, they also have the potential to cause distress. Alan, for example, talked of how he was supported through the reviews by a colleague:

> And there was an inquiry then, health inquiry that I had to attend which was in the hospital and my colleague attended with me. So, from my point of view it was support. It was peer support.

Clearly reviews, whilst useful, are not without their own stresses, stresses that Alan managed through peer support. The experiences that Anna, Andrew and Alan related are far from isolated examples. Sophie (an AMHP with a CMHT) makes this point:

> I had support here in the team informally, but there was no offer of formal support.

In fact, peers were generally seen as preferable to any formal methods of support. Abigail (a CMHT social worker) said:

> If one of my clients committed suicide, I think speaking to my colleagues, peer support, and speaking to my manager would be what I wanted. I don't know if there'd be anything I still would need.

Whilst it is perhaps not surprising that social workers (like other professionals) draw support from their colleagues, the apparent lack of formal support is perhaps worrying (Feldman and Freedenthal, 2006). The death of a service user by suicide raises the possibility that some practitioners may need counselling or other support. The failure of social work employers to provide such support suggests that the caring profession can be less than caring towards its own (Evans *et al*., 2006).

Peer support is not, however, without its limitations and issues. Anna spoke of how she was notified about the death of her service users. Her manager was away at the time, and Anna was not in the office when news arrived. This meant that Anna's colleagues made decisions about contacting her. With the first service user, a colleague called Anna, notifying her of the death but with the second service user:

> They didn't phone me to tell me about that on Friday because I think they thought, "Well, there's nothing Anna can do about it and it's pretty much just going to upset her more." In a way I wish they had let me know because then on Monday when I came in I was like, "What?" I

> was on my way to go and visit her when I called the office and found out. I didn't know.

It was therefore only by chance that Anna spoke to a colleague before heading to the service user's home: the best intentions of Anna's colleagues almost resulted in her being placed in a difficult and distressing situation. Whether Anna's manager would have handled the situation differently is unknown, but we can see how the perceived benefits of peer support can have unexpected consequences.

Peer support is also limited in that it does not necessarily provide assistance with specific issues. For example, Alesha (a CMHT social worker) spoke about her concerns:

> I think, what concerns me about suicide, as a worker, is the lack of protection for us as professionals. So, if we did go out and see someone, or assessed that someone was not suicidal and then they died a few hours later, and there's a lot of complaints about that. I don't know at what stage that could get to…Presumably within the local authority if they felt you practised to a low standard there would be a disciplinary. But I don't even understand as a worker whether there'd be criminal case about the death(...) These are the sort of things that, as social worker, would wake you at three o'clock in the morning…Are you protected legally about this? It's very difficult.

We can see from Alesha's comments that social workers are concerned about the potential implications of having a service user suicide on their caseload. The uncertainty about the process(es) of review, combined with fears of criminal and professional misconduct, seem to be a significant concern for social workers: nine of the social workers interviewed commenting that this was something that concerned them. The presence of concerns about actions resulting from service users' suicides might in part explain the high levels of anxiety and stress experienced by social workers (Coyle *et al.,* 2005; Huxley *et al.,* 2005; Lloyd *et al.*, 2002).

A formal support service that included legal advice would likely be invaluable to social workers in these situations. However, we know from chapter 6.2 that the social workers interviewed seem to be using defensive social work practice to help them manage the fear of working in such a high pressured environment (Gibson, 2014). An example of this is the extensive use of case notes as a way to record and justify their actions (Smith *et al.,* 2003).

In summary, my participants identified two main forms of support (i) socio-emotional and (ii) task orientated support. For the former, the social workers were primarily reliant on peer support. Peer support was often identified as the main form of both knowledge acquisition and emotional support. Despite this, peer support is by its very nature often uncoordinated and haphazard. Peer support has the ability to reinforce both positive and negative forms of working.

For task orientated support, social workers identified that formal reviews held after a service user death (from suicide) could be helpful in some instances. The social workers were often unaware of details of the procedures for reviewing the death of a service user, as these were often health led. Although these reviews can be useful in terms of learning, they can also be stressful. Again peer support provided emotional help to those social workers subject to a review.

Finally, it seems that concerns about legal liability and litigation serve to trouble social workers. Pritchard's (2006) assertion that suicide is a cause for anxiety in the field appears to have been validated by the social workers interviewed. Social workers need to be supported with both their practice and with their emotional wellbeing. For the interviewees most support was informal and the few formal mechanisms that did exist were seen as much a source of anxiety as a form of support.

7.6 – Conclusion

This chapter is the second empirical chapter focusing exclusively on the interviews with social workers. In which three of my research questions have been explored:

RQ 4 – What roles are currently played by social workers in suicide prevention? Do social workers have a distinct role in suicide prevention or has the increase in multi-agency working blurred the roles of different professionals?

RQ 5 – What sorts of social care provision are available to suicidal service users and what is the nature and frequency of their engagement with these services?

RQ 6 – How are social workers supported when working with suicidal service users?

I will briefly summarise the findings from each of these.

Social workers engage with a diverse set of people ranging from children to the elderly (Sheldon and MacDonald, 2009). The broad scope of social work means that social work can take many organisational and disciplinary forms, which have the

potential to come into conflict. Two divides, both focussed on the relationship with mental health services, were identified as being particularly problematic.

The first of these divides was observed between those working in mental health and those in children services. Social workers in children services felt that mental health services could be slow to engage. This meant that social workers in children services often found themselves supporting parents and carers with mental health issues. Similarly, social workers in mental health services felt that children services often lacked an understanding of suicide. The lack of understanding held by social workers in children's services, combined with the child protection processes (such as case conference – Connolly, 2006) were felt to be highly alienating for service users.

The second divide was between social workers in mental health and substance misuse services. The relationship between substance misuse and mental health is complex (Rosenthal, 2003; Appleby *et al.,* 2000). Unfortunately the complex debates of causality that surround dual diagnosis seem to have translated into policy and practice (Lowe and Abou-Saleh, 2004). This has resulted in a well-documented gap in between substance misuse and mental health services (Lawrence-Jones 2010; Schulte *et al.,* 2008; Lowe and Abou-Saleh, 2004). My participants suggested that this meant services, support and expertise, that might have greatly assisted service users, were not always being made available.

As well as the divisions within the social work profession the social workers interviewed also identified complex multi-agency and interdisciplinary working arrangements that needed to be carefully negotiated. Social workers expressed frustration with those support workers, who failed to provide relevant information. This passing on of responsibility might be conceptualised as part of the professionalisation of social work (Evetts, 2003). For example, Huxley *et al.,* (2009b) note that support workers often fulfil many roles that were previously associated as the preserve of social workers.

This, however, was tempered by an appreciation that support workers, carers, families and other groups were important sources of support to service users. Such individuals could also be helpful in monitoring the well-being of service users (Huxley *et al.,* 2009b).

The rise of multi-agency and interdisciplinary working also raised challenges to the identity of social workers (see also chapter 3.2) (Huxley *et al*., 2009b; Abbott and

Wallace, 1990). Social workers felt that at a superficial level a generic approach to mental health care could be observed (Bailey and Liyanage, 2012; Robinson and Cottrell, 2005). For example, common assessments being used by both CPNs and social workers. However, the social workers felt that the approaches to assessment were varied, as were the understanding of issues, by different professions. Social workers firmly believed that they were more holistic in their approach to understanding suicide than their colleagues in health.

The complexity of the social worker role was also present during conversations about what interventions social workers employed in suicide prevention. The most common form of intervention identified was the monitoring of service users (Gray, 2012; Hoult, 1986). Effectively, monitoring was characterised by close ties with service users, existing family and informal support networks (Topor *et al.,* 2006; Lymbery, 2001).

Arranging support for service users was often complex. Variability in the availability of services combined with unclear and changing eligibility criteria served to hinder this role. This was felt to be particularly problematic with crisis/home intervention teams. Again, the contentious nature of dual diagnosis led to difficulties in accessing services. For example, access to services at moments of crisis could be refused on the basis that a service user was under the influence of drugs or alcohol.

In some instances social workers, working in conjunction with colleagues in health, had tailored specific protocols for managing the behaviour of some service users. These could be used to help change behaviours such as frequent high risk attention-seeking behaviours. Examples of such interventions were rare, however. This is developed further in the next chapter.

While social workers possessed a strong desire to support their service users, social workers themselves did not feel well supported. Social workers who had lost a service user to suicide stated they received little or no support, and were anxious about the potential repercussions (e.g. legal liability, professional conduct investigations, and reviews of the death) (Gibson, 2014; Broadhurst *et al.,* 2010; Harris 1987). Peer support was once again highlighted as a major source of support, but the limitations of this support were acknowledged by respondents.

In summary, social workers negotiate complex multi-agency and interdisciplinary working relations to assist service users in difficult situations. Their attempts to assist service users can be hampered by a lack of services and issues of service

eligibility. They claim to do so with limited support beyond that offered by their peers. The next chapter will explore the CPN and service user perspectives of the role of statutory social workers in suicide prevention.

Chapter 8 – The role of statutory social workers in suicide prevention: Community Psychiatric Nurses (CPN) and service user perspectives.

8.0 – Introduction

In this chapter I explore the perspective of Community Psychiatric Nurses (CPNs) situated in Community Mental Health Teams (CMHTs) and service users. While there is much that is common to the perspectives of social workers and these two groups, such as their limited access to formal training, there are also very different viewpoints that need to be examined in order that we might better understand the role of statutory social workers in suicide prevention.

Previously, in chapter 4.5, I highlighted the small sample size of the CPNs and service users (*n*=3 for each group) and I will briefly recap here. The degree to which a sample size is 'sufficient' particularly in instances where you are seeking to gain 'rich data' remains highly contested (Sandelowski, 1995). Any arbitrary recommended number fails to take into account the importance of issues such as data saturation (Strauss and Corbin 1990). Saturation, the notion that no new information would be uncovered by further research, does however carry its own problems. Specifically validating how, and when, saturation has been achieved is a heavily debated topic (Ritchie *et al.,* 2003; Bowen, 2008). Marshall (1996) notes qualitative sampling is often determined by convenience and practicalities. When researching hard to reach populations, such as suicidal service users, issues of access and time can often be primary factors for determining the size and reach of a sample.

Further to this, I was reliant on social workers to identify service users who would be willing to participate in the study. It would have been impractical and unethical to have accessed service user data without the support of professionals and consent of service users. Despite the limitations of notably small samples, we should not dismiss the insights gleaned from these interviews. Denzin and Lincoln (2013) remind us that interviews provide an opportunity to gain an insight into the subjective

worlds those we are studying. Essentially the CPN and service user perspectives provide a series of alternative insights into a previously under-researched topic area.

It is also hoped that by separating out the narratives of both CPNs and service users we are able to better understand the complex environment in which social workers operate. As Pritchard (2006) notes, social workers do not work in isolation and the focus of their work is people. As such gaining an insight, even a small one, into the perspectives of other stakeholders on social work can allow us to explore the continuity of themes from alternative positions. Through the course of this chapter I hope to illustrate where themes have continuity with those identified in the previous chapters focusing on social workers, albeit from a different perspective, whilst also identifying new themes and concepts that appear unique to the two identified groups.

The first half of the chapter explores the CPN perspective, examining issues that were often similar in nature to those raised by social workers. This section is divided into three sub-sections. The first provides an overview of general multi-agency and interdisciplinary[23] working from a CPN standpoint. The next subsection focuses on the second of my research questions, namely what roles are currently played by social workers in suicide prevention. The last subsection builds further on our understanding of what approaches are employed by social workers when working with suicidal service users (research question three).

In the second half of the chapter the last of my research questions is addressed: how do service users perceive the role of statutory social workers in suicide prevention, particularly where those workers are located in multi-agency and/or interdisciplinary teams? A brief narrative of each service user is provided to help contextualise the subsequent discussions and provide the reader with an understanding of the service users' experiences. The suicidal experiences of those interviewed are then briefly discussed, followed by a detailed examination of the relationship between suicidal service users and social workers. The roles and interventions of social workers in suicide prevention are then explored from the experiences of service users. Finally, the service users' views of multi-agency and interdisciplinary working are discussed.

---

[23] As was noted in the previous chapter the terms multi-agency and interdisciplinary care are often used interchangeably. In this thesis multi-agency refers to instances when two or more agencies work together. The term interdisciplinary is used when two different professions work together.

Before exploring the perspectives of CPNs and service users, it is important that I consider how my status as a former social worker may have impacted on the interviews and findings. All the CPNs and service users were aware of my status as a former social worker prior to being interviewed. Equally, they were aware that the focus of this study was on the role of statutory social workers. It was emphasised to all participants that I was not there to defend or advocate for the social work profession but was interested in their ideas and experiences (positive or negative). Despite this, it is possible that they may not have been as forthcoming with me about their experiences due to an awareness of my background. In addition to this the limited sample size means that we cannot draw wider conclusions.

8.1 - The Community Psychiatric Nurse (CPN) perspective on the role of statutory social workers in suicide prevention

Three Community Psychiatric Nurses (CPNs), all based in interdisciplinary and multi-agency CMHTs were interviewed about their experiences of working with social workers in instances where service users had been suicidal. Their perspective as colleagues working alongside social workers (but coming from a different profession) is of particular interest, especially given the highly discussed, if increasingly refuted, divide between the medical and social models (Bury and Monaghan, 2013; Bywaters, 1986). To explore their perspective, I have divided the findings into three parts. In the first part, I examine the relationship between social workers and CPNs irrespective of suicidality. Here, wider structural factors and professional divides are examined. In the second part, I expand further on the second of my research questions, what roles are currently played by social workers in suicide prevention? In the final section, I examine CPN perspective on the approaches currently used by social workers in their work with suicidal people (research question 3).

8.2 - The CPN perspectives on social workers in interdisciplinary and multi-agency settings

This section does not specifically focus on the role of social workers in suicide prevention, but rather provides a context to understanding wider interdisciplinary and multi-agency working. As noted chapter 3.3, CMHTs have become a central part of multi-agency and interdisciplinary working in mental health (Morris, 2008;

Onyett, 2003). This has led to social workers and health care professionals working in increasingly close proximity to one another. As such, gaining an insight into wider issues of interdisciplinary and multi-agency working helps us to understand how different professions and agencies work together to prevent suicide.

The interdisciplinary nature of CMHTs has posed challenges to the professional identities of both social workers (Bailey and Liyanage, 2012), and CPNs (Robinson and Cottrell, 2005). These debates are complicated by the sheer diversity of forms that multi-agency and interdisciplinary working can take (Atkinson *et al.,* 2002). There is, as we shall see, great variation in how agencies and professions work (or in some cases do not work) together. In order that we understand the CPN perspective on the role of social workers in suicide prevention, it is first necessary to examine the relationship between social workers and CPNs in general. As will be demonstrated, some of these general issues have implications for social workers in suicide prevention.

At the start of each interview, the CPNs described their current role and talked briefly about their careers. Two of the CPNs interviewed had worked in England in the past ten years and commented on the different approach to interdisciplinary working between the two home nations:

> In England there was far more generic work, whereas in Wales there are still clear divisions (...) People might say that they need a CPN allocated, and I used to say you mean you want a care coordinator allocated, and who is the most appropriate? But it’s like it’s incomprehensible for them to think in these terms. (Emma)

Emma, a CPN manager, explains how in England there was more generic working; something she considers to be a positive. When explaining the nature of a generic role in England, Emma identified four professional groups in CMHTs: social workers, CPNs, occupational therapists (OTs) and doctors. Doctors were highlighted by Emma as being particularly problematic as in her view they would 'just do their own thing'. Apart from the doctors, other professional groups were largely percieved to work together in relative harmony, with personal working relationships being the key to effective team dynamics.

Eric, another CPN who had worked in England, also described his experiences of working in both nations:

> The team was less divided in City A [in England]. We'd just sort of do things, but here it seems like things are more divided [between social workers and CPNs].

The national divergence in approaches to the provisions of mental health services has, as Mackay (2011) notes, been the result of devolution. This Mackay suggests is leading to increased differences in legal frameworks in which social workers operate across the nations. However, Scourfield *et al.,* (2008) have noted that this variance is slow and much still remains common to social work practice across the nations, particularly between England and Wales.

Explanations about the different experiences of working across the two nations were however linked to wider discussions about team dynamics. Ultimately there was a view that each team worked differently based on the personalities of its members (irrespective of nation):

> Really I think it comes down to individual personalities, and each team is also different. Doctors tend to be outside of the teams a bit, I guess. (Emma)

The relationship between professionals was also felt to be affected by wider structural issues. Emma described the adoption of an integrated management structure for community mental health services in her area. The Health Board and the Local Authority were in the process of implementing this new structure at the time of the interview. This essentially means that rather than social workers and CPNs/other health professionals reporting to two separate managers, a single manager would oversee the team. The move towards single management structures has been an increasingly common feature of CMHTs (Onyett, 2003; Obang, 1997). The move to an integrated management structure also provided additional challenges to professional identities (Bailey and Liyanage, 2012).

The adoption of an integrated management structure with separate clinical supervisions was welcomed by the three CPNs, but had been marred by perceived managerial incompetence and multi-agency issues. For example, the Local Authority could not force contractual changes on its employees as quickly as the Health Board. The result of this was integration taking place at two different speeds, and a discrepancy in salaries between CPNs and social workers had become apparent: social workers on average earned less than the CPNs. Hannigan (1999) discusses the complexity of integration within CMHTs and notes that issues ranging

from eligibility criteria and the allocation of roles, through to the use of information technology and personnel issues, all impact on the effectiveness and success of CMHTs. Failure to consider a whole host of factors can, according to Hannigan, present challenges to the effectiveness of CMHTs.

The discrepancy in pay grades had resulted in more social workers applying for, and being appointed to, the new integrated manager role (five out of eight were from a social work background). Essentially, the lower social work salaries made the integrated manager roles more financially appealing for the social workers than for their CPN colleagues. Here multi-agency issues appear to have affected interdisciplinary working arrangements, although the implications of this were unclear. Other multi-agency issues that had reportedly caused some low level friction between social workers and CPNs included issues around who owned and maintained buildings (e.g., responsibility for locking the premises, or sorting out cleaning).

The importance of wider factors, such as a lack of integration in other areas that support integrated teams like CMHTS, has been noted by Rees *et al.,* (2004) to have a negative impact on the ability of multi-agency teams to operate smoothly. Additionally, Rees and colleagues note that these can lead to intra-team conflicts.

These multi-agency issues help to provide an insight into how working relations can be affected by larger organisational factors. The impact of these issues appeared to be comparatively marginal: interdisciplinary factors were presented as far more problematic. The CPNs all commented that their social work colleagues seemed to have smaller caseloads:

> Social workers are better at protecting their caseload (…) Social workers seem to take on a case and work with them to complete more clearly established goals (…) We [CPNs] are not very good at saying when we're not needed. We don't say 'right this is what we do and this is where I can draw my line'. As a nurse we're not really sure where we draw the line; social workers can articulate why they can't or won't take on a case. I think that it's from being on the wards; if you're on the wards you just do things and don't really think about your role. (Eric)

Eric's comments illustrate how CPNs perceive social workers as being more able to protect their caseload. This was a skill that he seemed to admire and felt was due, in part, to social workers having a better understanding of their role. As discussed in

chapter 3.1, professional identifies are characterised by issues of legitimacy and power (Abbott and Wallace, 1990). The protection of caseloads described by Eric suggest that social workers are establishing their professional identity through specific actions or tasks (Evetts, 2003).

The negotiation of roles within CMHTs, and in interdisciplinary or multi-agency contexts more generally, has led to considerable discussion (Carpenter *et al.,* 2003; Bailey, 2012). Norman and Peck (1999) suggest that differences in culture between professional groups and their respective value bases often serve the point of conflict.

Interestingly Brown (2000) in a study of CMHTs found that while there was some evidence of role blurring, professional identities were more likely to be embraced and promoted where there was a lack of managerial direction and promotion of generic working. They noted that interdisciplinary working could actually serve to promote distinct professional identities.

Eric's comments about a lack of awareness of the social worker role amongst CPNs seems to have resonance with Claire's (a social worker in a substance misuse team) suggestions in chapter 7.3 that other professionals don't know what social workers do.

CPNs, Eric suggests, are trained to work in hospital wards, the hectic nature of which he felt gives less time for reflection on their role. Building on this point, Eric spoke about how he felt social workers were also better at making sure they had regular 'allocated or protected time for supervisions'. Again, he felt that this was due to a lack of space and time on wards, resulting in CPNs not placing the same importance on this protected time. Whatever the reason for the perceived difference in caseloads, it is clear that there were some concerns amongst the CPNs about the 'fairness' of how cases were allocated. The division along professional boundaries identified by the CPNs suggested that professional divides continue to be prevalent in contemporary CMHTs (Bailey, 2012). A potential impact of role conflict, or professional rivalry, is stress and burnout (Edwards *et al*., 2000). The importance of good working relations has also been highlighted by Oynett (2011) who noted that CMHTS suffer from high levels of burnout and low job satisfaction.

The general disquiet that seemed to stem from the allocation of cases was in part fuelled by the protection afforded to social workers with Approved Mental Health Professional (AMHP) status who were entitled to a reduced caseload as they had to

be free for periods on the AMHP rota; 'the AMHP rota trumps everything else' (Emma).

None of the CPNs interviewed knew of any CPNs who had AMHP status and only one knew of a CPN colleague undertaking the AMHP training. Despite this resentment at the protected status of AMHPs, the CPNs felt that their social worker colleagues had a greater understanding of mental health legislation (Brown, 2008). Emma (a CPN manager), for example, suggested that:

> Social workers are taught legislation much better (...) partly, I guess, this is because of the AMHP role, but even those that aren't AMHPs seem to know more about the law than we do.

This was a skill that was admired by the CPNs and it has important implications for the role of social workers in suicide prevention (as I will demonstrate shortly). However, this proficiency in legislation was tempered by what the CPNs perceived as a loss of traditional social work roles, such as housing advice. For example, when Eric spoke about how social workers questioned why their input was needed, he would be left bemused about what their role was:

> Why do you want me [a social worker] involved, why am I [a social worker] needed? I'll go through what I think I need their help with and then they'll say that they don't do that!

The CPNs found it hard to quantify what social workers did and did not do, but recognised that they have specific skills (such as a good understanding of the law). The CPNs seemed to equate the social worker role with tasks that do not form part of contemporary social work. This transition discussed in chapter 3.1 does not seem to have been fully comprehended by the CPNs interviewed.

A final point on the complexities of interdisciplinary working was that of training. The CPNs were vaguely aware of social workers' training and felt that, generally, social workers were not as knowledgeable about mental health issues when they qualified as CPNs were. This may in part be due to the generic nature of social worker training. However, as with the social workers in the previous chapters, peer learning was identified as being the main mechanism for enhancing knowledge, a point made by Eric:

> No one trains you how to do anything half the time, you pick it up and you might be lucky to have a good mentor.

This process of peer learning seemed to be multi-professional with whoever was felt to have the appropriate skills, and more importantly time, training others. Peer learning across professions was felt to be a positive thing by the CPNs. Here we are able to see some continuity with the findings from the social workers interviews in chapter 6.1. Like the social workers, the CPNs felt that much knowledge acquisition takes place in an informal manner (Eraut, 2000). CPNs and social workers both constantly reflect on their practice gaining tacit knowledge from their reflections and through discussions with colleagues (Healy, 2014). For suicide and its prevention it appears that informal learning and tacit knowledge form the basis of practice for both CPNs and social workers alike.

In summary, we can see that the relationships between CPNs and social workers are affected by a combination of multi-agency and interdisciplinary issues; for example, the allocation of cases and the structure of services both seem to have impacted on how CPNs and social workers relate to one another. The AMHP status of some social workers was admired by CPNs, who had not yet taken up the opportunity of AMHP training. Understanding these wider issues helps to contextualise how these two professional groups work together to help prevent suicide.

8.3 – The CPN perspective on the role(s) social workers play in suicide prevention

It is apparent that both multi-agency and multi-professional issues can affect the relationship between social workers and CPNs, but what impact does this have on the roles played by social workers in suicide prevention? Do social workers from different fields, or those social workers with AMHP status, have different roles?

Perhaps the most interesting thing to emerge from the CPN interviews was how new referrals to the team for suicidal service users were allocated. CMHTs are secondary mental health services and as such receive requests for services from primary mental health care, such as GPs. Referrals are scrutinised by CMHTs to determine if they meet their criteria or not. This process allows the CMHT to maintain its boundaries but it also leads to internal discussions about the nature of a referral and who is best placed to manage a new case (Chew-Graham, 2007; King, 2001). In my interview with Emma she described how suicidal service users were more likely to be allocated to CPNs:

> My experience is that someone who is acutely suicidal would be assigned to a CPN, that is felt to be part of their role. Even if the social worker has carried out the initial assessment it may hold some sway, if I'm lucky, but often not (...) If there's even a whiff of complexity then there's a request for a CPN. (Emma)

> It just seems that we [CPNs] get the suicidal cases more often. Perhaps it's because we've got some clinical experience, but I'm not really sure why. (Erin)

Both Emma and Erin felt that CPNs were more likely to be allocated cases where service users are suicidal (compared to social workers). Emma's suggestion, that even where a social worker had already assessed a service user the case would likely still be given to a CPN, indicated some resentment towards the social workers. When asked more about why they felt this happened, none of the CPNs interviewed were able to identify a clear rationale. One possible explanation suggested by Bailey and Liyanage (2012) is that social workers are perceived to lack the skills of their health care colleagues in acute health cases. This is supported in part by suggestions that social workers (apart from those with AMHP status) did not receive the same level of training in mental health as their health colleagues (see chapter 8.2).

Equally, however, this perception may be borne out of multi-agency issues. Social workers are employed by local authorities, who are often the 'junior partner' (Emma) in comparison to health boards in mental health services. An example of this imbalance was captured in the National Survey for Mental Health in England (2006) when it was noted that social workers are not present in 27% of CMHTs (NIMHE 2006). Interestingly Carpenter *et al.,* (2003) found that social workers were more likely to have poorer perceptions of team functioning and experience high levels of role conflict. While Carpenter *et al.,* did not specifically identify the inequality between health and social services as a factor their sample had over 50% more health professionals than social workers. This potentially means that social workers often sit outside the organisational structures in health, and in consequence not influential in decision-making processes. Again this has been noted as a potential barrier to multi-agency and interdisciplinary working in CMHTs (Onyett, 2003). As such, knowledge of their skills and abilities was maybe. Cases might, therefore, be allocated to those professionals who are known to have the relevant skills (i.e., CPNs).

While the CPNs interviewed felt that they were often the default support for suicidal service users, social workers with AMHP status were noted to have special functions and knowledge. Specifically when a service users was potentially in need of an assessment under the Mental Health Act(s) (1983/2007), the expertise of AMHPs was particularly appreciated. Erin and Emma both commented on this point:

> Sometimes it can be very helpful to have the input of an AMHP, it can give you a bit more confidence in your assessment as they're able to give more weight to decisions. (Erin)

> Even if you weren't sure [about whether a service user might need to be detained] you might take out a social worker with AMHP status with a CPN (…) They [AMHPs] have more training in mental health and are more skilled to deal with those sorts of [suicidal] clients in more acute situations. (Emma)

These statements indicate that the role of AMHP may afford some social workers a unique and powerful status, both within CMHTs and in the role of suicide prevention. Clearly a divide was felt to exist between those social workers without the AMHP status. The specialist knowledge of legislation, combined with their ability to convene a Mental Health Act assessment, makes the AMPH uniquely important in dealing with high risk service users (Rapaport, 2006). The importance afforded to AMHP status social workers and their skills in working with suicidal service users was reinforced by Eric's admission; 'You learn from them [AMHP social workers]. It makes you think about the types of questions you need to ask and what to think about'. Bressington *et al.,* (2011) in their study of new starters on the AMHP training programme noted that mental health nurses often have less understanding of the role than their social work colleagues. This might in part be due to the AMHP function previously being a social work exclusive role (i.e. the Approved Social Workers role). However, we could potentially infer that the lack of knowledge of the AMHP status is possibly contributing towards the perception of AMHs as experts (Freidson, 2001).

One possible implication of the importance afforded to AMHPs is the development of a fault line between those social workers with the AMHP status and those without it, creating a two-tier system for mental health social workers. The implication is that only those social workers with AMHP training are sufficiently skilled to work with high risk groups, such as suicidal service users. Yet this division is not as alarming

as it may at first appear, as most of the social workers in CMHTs are, according to the CPNs interviewed, AMHPs.

Given the importance attached to the AMHP status by CPNs in this small sample, and their apparent appreciation of the skills possessed by AMHP status social workers, it remains surprising that social workers are (in the eyes of CPNs) less likely to be allocated suicidal service users. One possible explanation for this is that the AMHP role is primarily there for crisis intervention (i.e. they undertake assessments to determine whether someone should be detained under the mental health act). As such they are unlikely to be provided with cases that are not acute.

Despite this apparent divide between AMHP and non-AMHP social workers, the CPNs interviewed did not feel that social workers assessed suicidality or mental health any differently to themselves. For example, Eric said:

> Is there a difference in our assessment? I doubt it, we all learn from each other.

In fact, Emma noted a move towards a more 'social work style of assessment', specifically stating that:

> The Unified Assessments (UA) and the Care Programme Approach (CPA) both have lots of focus on social issues. In fact I think the UA was originally a social worker assessment (...) We [CPNs] get taught about the importance of social issues in our training so, to be honest, I think that this is something most professionals think about.

As these assessments were used by both social workers and CPNs, it is unsurprising that they should draw on both traditional medical and social models. Like their social work colleagues in the previous chapter, none of the CPNs identified any specific assessments to be deployed for suicidality.

One barrier that was identified by Emma to the assessment process was the different computer systems used by health and social services, impeding the sharing of information and effective case recording.

> I suppose it doesn’t really help that we have two different systems, one for us [CPNs and health professionals] and another for the local authority. There’s no link up (…) Generally if you put information on one system then it doesn’t show on the other system.

Assessment and other documents would show on one system, but not on the other, or they would only be accessible on one system. The implication of this is that important information could be missed by professionals. In instances where service users are suicidal, not having easy access to information could be problematic.

Emma's experience of fragmented information systems (IS) has resonance with Gillingham's (2013) and Parton's (2008) discussion of the use of IS in children's services, and social care more generally. Both Gillingham and Parton highlight the considerable amount of researcher and political interest over the use of IS in both health and social care services. These concerns focus on a wide range of topics. For example, Gillingham (2011) discusses how the IS databases have shaped the practice of social workers. Time is taken away from practice to focus on data input (Samuel, 2005). Similarly aspects of decision making and prioritisation have been altered through the use of IS systems (White *et al.,* 2009). The poor implementation of IS in the UK has led to Munro (2011) raising concerns that such systems can serve as barriers to good practice. It seems that issues of multi-agency working are impacting on the interdisciplinary practice and are potentially affecting the ability of both health professionals and social workers to assist service users.

We are able to deduce three themes from the CPN perspective on the role of social workers in suicide prevention. First, CPNs felt that social workers are less likely to be allocated suicidal service users on their caseload than themselves. Second, for the CPNs, AMHP status social workers are perceived to have expert knowledge, skills, and powers under the Mental Health Act(s) (1983/2007) which enhances their ability to work with suicidal service users. Finally, social workers are seen as equally skilled as their CPN colleagues at assessing suicidality.

8.4 – The CPN perspective on the approaches used by social workers in their work with suicidal people

CPNs felt that relationships between CPNs and social workers were generally fairly positive, but some multi-agency and interdisciplinary issues do appear to be problematic. Wells (1997) noted that political and managerial pressures can influence many aspects of the CPN and social worker roles, especially when drawing up packages of care. An example of this was highlighted by Emma, who described 'a trend towards positive risk-taking; as the Health Board, and everywhere else has bed problems'.

Her comments suggest that interventions are often affected by the availability of a particular service. The need to be aware of such restraints means that all professions (not just CPNs and social workers) have to tailor their interventions based on resources at any given time. CPNs discussed service users who might benefit from a short period on a psychiatric ward but was no longer have this option, a point made by Erin:

> Trying to get a bed for a patient is getting harder and harder. The focus is about supporting people in the community with crisis teams, but sometimes patients could really do with a few nights on a ward. It's a shame really (...) For us [CPNs and social workers] it can also be frustrating when you're constantly being told about bed shortages.

It is not surprising that rationalisation can impact on interventions, but as resources can vary between areas, the support received by suicidal service users seems likely to be highly variable. Coid *et al.,* (2001) studied seven English health regions and found that in areas of high demand there was an under-provision of services, the implication being that the threshold for services rises in areas with fewer resources. Further to this While *et al.,* (2012) have found that the provision, or lack thereof, can affect suicide rates.

The crisis team was identified by my participants as one of the mains sources of support that both social workers and CPNs would refer users to. These teams provide intense packages of care to service users who are in acute need of support (Hannigan, 2014). The effectiveness of these teams is, however, contested (Carpenter *et al.,* 2013; Glover *et al.,* 2006). Interestingly, Eric noted that the local crisis team did not contain any social workers but was unsure why this was the case.

As with the social workers interviewed, all the CPNs lamented the stringent criteria that were used by the crisis team, and said that their relationship with the team could be fractious. The CPNs shared the view that regular visits and phone calls were important tools to support service users. For example, Erin observed:

> More regular visits and phone calls can be really effective on monitoring and supporting those with acute mental health needs.

This, it was felt, enabled them to monitor the progress of service users and also helped them to discuss issues as they arose, avoiding things getting to a crisis point. The CPNs felt that both they and social workers used regular visits when working

with suicidal service users. Continued monitoring of service users has been one of the cornerstones underpinning the care in the community programme (Gray, 2012; Hoult, 1986). Ongoing monitoring of service users mental health/illness, their circumstances and response to any medication were identified by CPNs and social workers (see chapter 7.4) as being a major tool for preventing suicide (Burns *et al.,* 2007; Catty *et al.,* 2002; Tyrer *et al.,* 1995).

A more direct intervention included social workers and CPNs referring service users to, or possibly providing, psychological interventions such as cognitive-behavioural therapy (CBT). The provision of therapies did, however, entail a delay of up to twelve months due to issues of capacity in the system. This, they admitted, meant that many professionals no longer referred service users to these services unless they felt it was absolutely necessary. Psychotherapies, including CBT, which can be delivered in a brief structured manner have been found to be effective in reducing instances of suicide (Mehlum and Mork, 2011).

The CPNs did not identify any specific interventions for suicide, used by either themselves or social workers. Instead, they focused much more on the assessment processes and spoke in general terms about the importance of regular visits and phone calls. Even medication, a topic that both social workers and (as we shall see) service users saw as a staple of the CPN role, was mentioned only a few times in passing during the interviews. It is probable that the difficulty both CPNs and social workers appear to have in identifying how they assist suicidal service users is because they may be doing it unreflectively. As Thompson points out 'social work is what social workers do' (2000:13). Like CPNs they act and when stopped and questioned about their actions they may find it hard to quantify and express their actions.

Another potential explanation could be that the methods employed in this research did not allow me to adequately explore this issue. Specifically, interviews meant that I was to a large degree dependent on the ability of my participants to effectively reflect on their practice and experiences (Riach, 2009). Observations of CMHTs and other multi-agency (and interdisciplinary) teams might have allowed me to explore assessment, intervention and everyday practice more thoroughly. Although as discussed in chapter 4 observations would have been complex for ethical and practical reasons.

8.5 – How do suicidal people perceive the role of social workers in suicide prevention, particularly where the workers are located in multi-agency and/or interdisciplinary teams?

To understand more fully the role of statutory social workers in suicide prevention it is necessary to obtain viewpoints from those they work with, that is to say service users with a history of suicidality. It is possible that there is a gap between what practitioners believe they are doing and how service users interpret what they do (Warren, 2007). By interviewing service users (albeit a very small sample; *n*=3) I gained valuable insights into their perspectives, allowing me to address the last of my research questions.

To explore the service user perspective, I have divided the findings into four sections. The first section discusses the individual experiences of suicidality amongst the service users, comparing their accounts with relevant research. Second, I discuss how the relationship between service users and social workers can be understood. Third, I examine how service users perceive the role of social workers in suicide prevention: I touch on issues such as the qualities they look for in a social worker, as well as examining the different interventions noted by the service users. In the final section, I discuss the role of social workers in interdisciplinary teams from the perspective of service users.

Before we explore the service user perspectives it is important to understand the approach that has been taken to explore the data gleaned from the interviews. It is not my intention to present the service user narratives differently from those of the social workers or CPNs. The information provided during my conversations with participants should not be framed as 'fact' that has been, or would stand up to, external validation. Rather I am representing their experience and perception of events (Denzin, 2009). Neither am I attempting to empower those I spoke to by advocating on their behalf. As discussed in chapter 4.2, we should be cautious to assume that we have the right, or the ability, to advocate for those participating in our work. It is my intention to represent these three service users' perspectives as transparently as possible and convince the reader of the merit of my interpretation of them (Denzin and Lincoln, 2011).

8.6 - Service user experiences of suicidality

In order to help the reader and contextualise the service user perspectives, I have provided brief narratives of their individual experiences. These narratives are intended to help provide the reader with an insight into the circumstance of those who participated in my study. The narratives have been carefully edited to help protect the identity of participants. Specifically, any readily identifiable characteristics of the service users' histories have been omitted or altered to protect their anonymity.

Before I provide these narratives, it is important to note that they are based on the accounts provided by my participants. This is to say that these narratives, and the subsequent findings, are based on how the service users *experienced* and related to me during the semi-structured interviews. The individuals and situations described by my participants have not been validated by external sources or the testimony of others, a point I will return to later.

Francine – Francine has been living in her home for over twenty years. Francine recalled making at least six attempts to end her life, the majority of these by overdoses. Her last overdose led to her kidneys becoming seriously damaged and this is something that worries her.

Presently she has a very positive relationship with her social worker. Previously, she had varied experiences and relationships with her social workers. This has been partly borne out of regular changes of social workers, she also had interventions from social workers in Children Services which led to her children coming into care.

Family is particularly important for Francine and her grandson is a big part of her life. She has not worked for some time due to her mental health and has had support from a CMHT for most of the last fifteen years.

Frank – Frank has had contact with CMHTs for over twenty years. He has suffered mental ill-health since an accident which left him with neurological damage. Frank has made numerous attempts on his life and has been detained under the Mental Health Act(s) (1983/2007) on several occasions. He struggled to recall and separate some events due to the high levels of psychosis he has experienced.

Previously Frank suffered issues of social exclusion in his community and this led to him having to be rehomed on at least one occasion. Currently Frank lives by himself in a property that was found for him by his current social worker. This recent move has proved difficult for Frank. He enjoys travelling round the local area on public transport and on foot.

During his contact with CMHTs Frank has had numerous social workers, he was unable to recall how many. Frank gets on well with his current social worker but he had a particularly close relationship with his support worker, with whom he had regular contact.

Family was very important to Frank and after the death of his mother a few years ago he has come to receive considerable support from his extended family. Specifically his niece is a big source of support, a point that was explored in our discussions.

Frazer – Frazer has a history of substance misuse and mental illness. He suffered with depression after losing his job approximately fifteen years ago. Subsequently his marriage broke down and he left the family home. He has moved several times over the years and has been residing at his current flat for approximately two years. Recently he entered into a new relationship. Currently he is receiving support from a substance misuse team.

Frazer was unable to recall how many times he had attempted to end his life. However, Frazer had a history of DSH in the form of cutting his abdomen and arms. He had made several attempts on his life by inserting blades into his abdomen and chest, and has also attempted hanging and overdoses.

Over the past fifteen years Frazer has primarily been supported by substance misuse services with some support from mental health services (although notably no direct support from CMHTs). He gets on well with his current social worker and was also receiving support from a counsellor from a voluntary sector agency who he felt was a big source of support. The support he received from statutory and voluntary services was of particular importance as Frazer had limited support from his family. Frazer did report having several close friends who help to support him.

Access to this hard to reach group was only possible (as has already been discussed) through the cooperation of social workers. Social workers from CMHTs

and a substance misuse team identified three service users: two male and one female, aged between their mid-thirties and their mid-fifties. All three had, as indicated in narratives above, made multiple attempts on their lives. Not all of these attempts had occurred whilst in contact with mental health services.

My participants' multiple attempts to take their own lives is consistent with the findings of Mann *et al.,* (2005) who noted that it is rare for someone to complete the act of suicide on their first attempt. Further, as CMHTs are a secondary service only available by referral (e.g., from an accident and emergency unit), it is likely that those service users known to CMHTs will have already made at least one attempt.

All three service users had been in contact with mental health services for prolonged periods of time (between ten and twenty years). Contact with services had, however, been intermittent for all three with periods when they were not in receipt of support. Such periods could last from a few months to a couple of years, and seemed to reflect either improvement or decline in their mental state.

Frank, for example, described how at one point he had been out of contact with mental health services for about eighteen months to two years:

> I'd met this girl and she said she loved me. We got engaged and we went on holiday, but when we got back she just left. I spent all my money on her (…) I started to get low and was thinking about what I could do to myself. My mum started to become worried and she called them [the CMHT].

Had his mother not been able to contact the appropriate services it seems likely that he would have made another attempt on his life.

It is known that only a minority of those who complete the act of suicide have contact with mental health services in the twelve months prior to their death (Appleby *et al.,* 1999). This does not mean that they have not been in contact with services at some point; it might indicate a failure of services to re-engage with those at risk in times of crisis. For example, an Australian study (Burgess *et al.,* 2000) estimated that twenty percent of suicides in the state of Victoria over a five year period could have been prevented if a series of actions, including continuity of care were improved.

In the UK, Hunt *et al.* (2006) examined suicides of those who had been in contact with mental health services twelve months prior to death and noted that certain

populations appeared to be at heightened risk. Their work suggests that those who no longer have contact or cease to engage with services might still benefit from targeted prevention measures.

O'Brien *et al.,* (1998) have also noted that validating engagement with mental health services is complicated by the varying definitions and criteria used (O'Brien *et al.,* 2008). This adds complexity to validating the level of engagement and frequency of engagement. Furthermore, Kendrick *et al.,* (2000) suggest that it is often those service users who are not engaged with services that are most in need of support.

The importance of being able to re-access services after discharge has been recognised in Wales with the introduction of the Mental Health (Wales) Measure 2010. Part three of this Measure requires health boards and local authorities to allow service users to refer themselves directly back into services after discharge. This will hopefully reduce the time taken for service users to receive support, although it may be some time before we are able to see what, if any, effect this policy has.

Participants' multiple attempts did not however indicate diversity in their chosen method. When I asked Francine about how she had attempted to end her life she said;

> Mostly overdoses, I tried hanging myself once, but I couldn't get the rope over the fence (…) I'd overdose with anything, mostly paracetamol.

Francine's preference for overdosing stands in contrast to that of Frazer, who had a history of DSH in the form of cutting his abdomen and arms. He had made several attempts on his life by inserting blades into his abdomen and chest, but had also attempted hanging and overdoses.

During the course of the interview Frazer was keen to show me scars from his attempts and showed me a scar on his chest. Pointing at one scar he commented; 'This is the only one I really regret, because it was such a feeble attempt'. The scar was significantly smaller than the others and the tone of his voice suggested that he was ashamed or despondent about this attempt. Frazer's feelings on this particular point might indicate a desire on his part to attain 'authenticity' for his state of mind and his actions. The need for him to achieve 'authenticity' through 'serious' violent acts not only validates the seriousness of his distress (Crouch and Wright, 2004), but also affirms his masculinity (Canetto, 1995). Canetto suggests that men in part adopt more violent techniques when attempting to take their lives as it is seen as

'unmasculine' to survive an attempt (and hence the term 'failed' suicide) (see chapter 2.2).

Frazer's continuing history of self-harming behaviour, combined with his numerous bids to end his life, ties in to wider debates on the relationship between non-suicidal self injury (NSSI) and suicidal intent (Kapur *et al.,* 2013; Butler and Malone 2007; Cooper *et al.,* 2005). When displaying me his scars Frazer readily identified those he attributed to DSH and those associated with attempts to take his own life. DSH for Frazer is a self-advised way of coping during times of stress. For a clinician, being able to distinguish between an episode of serious DSH and an attempt to end his life would likely be difficult (Klonsky *et al.,* 2013).

The relationship between self-injurious behaviour and suicide can also manifest itself in other ways. Francine, who stated that she used to over-dose 'whenever things got too much' reflected on the effect this might have on any future self-injurious or suicidal behaviour:

> My kidneys might fail now, after the last overdose they said I'd done some real damage to them. I have to get them checked at the hospital regularly and I've been told that if I overdose again it will probably kill me. Whereas before I'd just turn around and do it, I know the next one I take will kill me (...)

In the second part of Francine's statement we can see that she now believes that her chances of surviving another overdose are slim. Previously overdosing raised the prospect of death, but now there is a greater likelihood the intention of the act has shifted from risk-taking ambivalence about life to a near certainty of death.

The boundary between self-injurious behaviour and attempts to end life are problematic for multiple reasons, chief amongst them being the complexity of multiple interpretations of the intentionality of any given act. For example, the service users' and professionals' views of suicidal intent might differ (Brausch and Muehlenkamp, 2013). However, even where the service users were clear that they wished to end their lives, wider factors affected their actions, as discussed by Frazer:

> I tried hanging myself with a phone charger, but I wanted to be found. This guy in the town had died and no one had known for ages and you can imagine the state he was in! I didn't want that to happen to me.

Frazer is clear that his decision about how and when to try and take his life was influenced by the fear of his body not being found afterwards.

Frazer's actions were also influenced by other issues, such as his misuse of alcohol, a factor heavily associated with suicide (Sher, 2005). Brady (2006) has previously commented that effective interventions for problem drinkers would likely help reduce suicide rates. Although Frazer professed that alcohol was only an issue in a minority of his attempts to end his life, he asserted that the first time attempted to stab himself was when drunk:

> It was after about sixteen pints of Magners [cider]. I took a knife and tried to stab myself. Skin is pretty resilient really, you see it in the films and it look easy, it isn't! (...) I got a hammer and knocked it in to me, about five inches.

Frazer mentioned at least another four occasions where he had consumed alcohol prior to, or at the point of, making an attempt on his life (his social worker was from a substance misuse team). The role of substances, particularly alcohol, in suicidality is well established (Murphy, 2000; Pridemore and Spivak, 2003), but while alcohol may be present in suicides, Frazer did not consider it to be the causal factor:

> I lost my job and didn't shave for three years, didn't have a haircut for two. I was drinking more and more (…) Then my wife and I split up, I wasn't seeing my kids much (…) I've got two counsellors, one with the substance misuse and the other for bereavement, they've been good.

Over the course of the interview, Frazer related his life story to me and made reference to significant life events, or crisis points (the loss of his job, the breakdown of his marriage and the loss of a parent). During such periods of heightened stress, the service users were more likely to make an attempt to end their lives. For example, Frank said:

> It got bad especially when my mother died (...) I just couldn't cope with it any more. I cracked right up, took an overdose and was in hospital for quite a few months (…) Things plays on my mind you know, things build up and I do worry then. Then I think of ending my life.

Frank's comment about 'things playing on his mind' demonstrates how during periods of stress he is unable to manage his feelings and it is at this point he thinks of ending his life. Roy, Sarchiapone and Carli's (2007) work on resilience and

suicide highlights how feelings of being overwhelmed can increase the probability of suicide. During these periods of crisis, coping mechanisms such as drinking, self-harming, overdosing, or even suicide attempts increase in frequency.

What is apparent is that for all three service users, suicidality (both in thoughts and in actions) increased during times of stress. It was at these points that interventions were needed. To understand these crisis points, it is necessary to know both the service users' histories and what was going on in their lives at the time of crisis, something that, as we shall see in the next section, could only be achieved when there was a good relationship between the social worker and service user.

8.7 - Understanding the relationship between statutory social workers and service users with a history of suicidality

Identifying when service users are in crisis and knowing how best to assist them can be a complex task. The service users interviewed felt that this could best be achieved by having a good relationship with their social worker, based on three themes, each of which is discussed in turn: (i) continuity of social worker contact, (ii) contact with social workers, and (iii) personality of individual social workers.

All of the service users voiced frustration with a constant change of social workers. The frequent change in social workers might in part be attributed to the high turnover experienced in some areas of the profession (Carpenter, 2012; Huxley *et al.,* 2005). Those social workers practising in statutory services have been found to experience high levels of stress and lower levels of job satisfaction (Balloch *et al.,* 1998). The implication of this is that they are more likely to move posts than those who are less stressed and have higher levels of job satisfaction. Further to this social workers also have more foreshortened career trajectories than other similar professions (Curtis *et al.,* 2010) Given that the service users in my sample had all received support from statutory services it is perhaps unsurprising to hear that they had all experienced multiple social workers.

Francine recalled having six social workers over twelve years; this period included episodes when she was not in contact with services, meaning that the actual contact time with specific social workers was even lower. Frazer could not recall the number of social workers and simply stated; 'I can't remember most of their names'.

Francine summarised why she felt social worker contact was important:

> Every time you have a new social worker you have to start from the beginning again. Sometimes it can be difficult to talk about things that have happened in the past, and just as you've told them and they've started to get to know you they change (…) They [social workers] get to know you and you get to know them.

For Francine, going over the past with new social workers meant that she was forced to partially relive her experiences. This was emotionally challenging for her, and compounded the need to build trust in the new worker. This process was made more difficult by the near absence of effective handovers. On only one occasion was Francine able to recall the outgoing social worker introducing her to the incoming social worker.

In addition to the discomfort caused by exploring her past with each new social worker, Francine also highlighted how having knowledge about her suicidal and emotional world could be helpful in times of crisis (Gilburt *et al.,* 2008; Granvold, 2000). For example, Francine explained how her social worker knew about her grandson and how much he meant to her. The social worker brought up this topic at times when Francine was in a low mood or had thoughts of ending her life:

> If I'm having a bad day then she'll talk to me about my grandson and try to remind me of things that are good in my life (...) She knows all about my family and I like to tell her about what's been going on when I see her.

As previously discussed, the importance of worker continuity has been noted by Beresford *et al.,* (2008) in their study of palliative care. Beresford's *et al.,* study is particularly interesting as it states those in palliative care are at increased risk of suicide (see also Grzybowska and Finlay, 1997). In fact, one of their respondents reported that their social worker was the person primary responsible for preventing their own suicide (Beresford, 2008:90).

Despite the importance afforded by continuity, the frequent change of social workers is not particularly surprising given the problems with retention of practitioners (Collins, 2008; Curtis, *et al.,* 2012). Whilst it is widely acknowledged that children's services have significant difficulties retaining social workers (Tham, 2007; Tham and Meagher, 2009), mental health services also struggle to retain social workers (Evans *et al.,* 2006), especially those with the AMHP status (Huxley *et al.,* 2005). Huxley and colleagues found that social workers often professed a great

commitment to the service users they were supporting and that this was often one of the factors that discouraged them leaving their post. The service user–social worker relationship discussed in chapter 3.1 is felt to be important for both parties.

It is apparent that regular changes in social workers can make it difficult for service users and social workers to build relationships. An equally important component of this process is the form and frequency of contact with social workers. As Francine's comments illustrate, relationships take time and effort:

> When I knew I was going to have Abigail [social worker] I thought 'Oh God, not her! She's far too strict and straight for me', but once I got to know her and trust her it was OK (…) She keeps my hope going.

Francine and Abigail's relationship was enhanced when Abigail came to visit Francine in heavy snow. Unable to drive to Francine's home, Abigail walked there, and this was something that Francine appreciated very much. Despite the apparent fondness and respect that Francine had for Abigail, their relationship was defined by a written protocol or 'contract' as Francine referred to it.

The use of contracts as a behaviour modifying tool is a well-established intervention in social work practice (Maluccio and Marlow, 1974). The use of what have been termed 'no-suicide' contracts has become increasingly common place in contemporary mental health care (Motto, 1999). These contracts are essentially an agreement between a service user and a professional that sets a series of parameters about what both parties can expect. Typically they include information about contingency strategies and agreements that service users will not harm themselves for a given period of time (Range, 2005). These contracts are not legally binding but are instead a therapeutic aid.

In Francine's case the contract was the result of discussions between Francine and Abigail. This was discussed from the social worker perspective in chapter 7.4. The contract set out certain expectations and agreements for both parties:

> I've got a contract, and if I overdose I've got to phone the ambulance myself. I'm also only meant to call Abigail once a week, unless something's happened. But this [the phone calls] is getting less and less now, it's more when I need to now. When I'm bad [feeling low in mood] I do find it hard to keep to.

This seemed to be empowering for Francine: she said with a degree of pride that she took herself to the hospital after the last overdose, and that she had made this decision. The use of a non-legally binding contract seems to be a way of managing Francine's diagnosis of borderline personality disorder, although it is uncertain how effective such an approach is with a category of mental disorder characterised by impulsivity and self-destructive behaviours such as DSH and suicide (DMS V-TR, 2005; ICD-10 F60.3, 2012). Potentially this approach establishes boundaries. Francine is aware of what she can and cannot expect from her social worker, avoiding potential points of conflict and helping to maintain the service user-social worker relationship (Ruch *et al*., 2010).

This process of creating boundaries is fraught with complexities. O'Leary *et al.,* (2013) assert that social workers have borrowed heavily from the medical professions approach to professional-patient boundaries. In doing so O'Leary *et al.,* feel that they are neglecting the 'ethos' of social work. This does not necessarily mean that Abigail has adopted a medical approach (as described by O'Leary *et al.,*). The contract between Abigail and Francine was negotiated between them and clearly gives Francine some ownership about what support would be provided in certain situations. Having clearly defined boundaries, in the form of a contract, seems to have been highly effective in the relationship between Francine and Abigail; but it was only possible due to Abigail's understanding of Francine's background, her mental health status, and her current situation. As Francine asserted:

> The other social workers did nothing (…) They just come round have a cup of tea and go, so they can say they've been.

Contact is not just about having time with social workers, but also about the social worker gaining an understanding of the service user's life. The social workers held in highest esteem by service users had contact not just with the service users, but the service users' support networks (Tew *et al.,* 2012). As Topor *et al.,* (2006) note, family, friends and professionals all support service users in their recovery. It is therefore essential that they be able to communicate with one another and be able to work together whenever possible. For example, Frank spoke about how his social worker and niece worked together to get him a new place to live after he was discharged from hospital:

> *Frank:* I didn't find out about the move until I was in hospital, I didn't go home I went straight in [to my new home] (...) I was angry about it at

> first, but now it's ok (…) She [Frank's niece] knew about the new place and got me furniture, I'm going to save up to pay her back. I don't remember anything; apparently I smashed the furniture up at my old place, but I can't remember.
>
> *Researcher:* Do you know if your social worker and niece talk a lot?
>
> *Frank:* I'm not sure. I guess so. She knew about the new place before I did. If the social worker can't get hold of me he'll call her.
>
> *Researcher*: How do you feel about him doing this?
>
> *Frank:* I don't mind. It's good that they talk, better for them to talk than not. I don't always remember things.

It is clear that Frank does not remember being consulted about the move, although he later admitted he struggled to remember things correctly when he was in hospital. His uncertainty about the frequency and nature of communication between his social worker and niece did not seem to concern Frank, and during the course of the interview he seemed to indicate that it was helpful to him. Frank had previously highlighted how it had been his mother who had contacted the CMHT after deterioration in his mental state. Communication between his family and the social worker(s) seems to provide Frank with an effective support network. After the death of his mother, Frank's niece had become his closest support.

By maintaining contact with the families, partners and friends of service users (i.e. their support networks) social workers made themselves accessible to such networks. Essentially this meant that during periods of crisis, social workers could be contacted by support networks, allowing them to respond at the right time. Social workers do not just work with the individual; they work with families and communities as well (Tew *et al.,* 2012). Fowler *et al.,* (2009) have also noted that supporting service users in the community within their existing familial and wider support networks helps to reduce hospital admissions and preserve relationships that might otherwise become damaged (Kondrat and Teater, 2009).

It is also possible that the legal obligation for AMHPs to make contact with the 'Nearest Relative' during the process of assessment under the Mental Health Act(s) (1983/2007) means that social workers in the mental health arena are more likely to know families and have contact information for them (O'Hare and Davidson, 2014; Rapaport and Manthorpe, 2008).

Despite the largely positive relationships described thus far, it is important to acknowledge that social workers and service users can have negative relationships. Francine, for example, claimed that one social worker told her to:

> Go ahead and do it [kill yourself] (...) he was really horrible.

The relationship between Francine and this social worker was recalled as particularly confrontational. She described how he refused to leave her property, as he was concerned that she was going to harm herself with a knife. Rather than being a protective factor, Francine felt that this made the situation worse: she felt that it was almost an attempt to goad her into cutting herself. Such recollections point to the pivotal nature of interventions and their interpretation by service users.

Relationships with social workers could, however, be hampered by factors outside of their control. Francine had some involvement from children's services for a period of about twelve to eighteen months whereby a social worker was assigned to her child; at the same time she continued to receive support from a mental health social worker. Having the two social workers was perceived as confusing, especially as they would have conversations about an ongoing child protection investigation, which would not, and probably could not, be shared with Francine. The sharing of information between Children's Services and Mental Health teams would not be uncommon. Where child protection concerns exist, information must be shared by statutory agencies (Children Act, 1989). However, Francine felt as though she was being undermined. That is to say that Francine felt disempowered in this interaction (Murphy *et al.,* 2012) which left her with a very negative impression of children services[24]. Had she not already had contact with social workers from mental health services, it seems likely that she may have been less inclined to work with a social worker from mental health:

> They [Children's Services] didn't listen to me or want to talk to me. They would do things without telling me and I didn't like it (...) I had a social worker from mental health while this was going on. They [Children's Services] would tell him things and not tell me! I didn't trust them [Children's Services].

[24] The divide between adult and children mental health services, although not discussed in this research, has been found to be highly problematic (Singh, 2009).

This potentially illustrates a dilemma with competing demands made upon the social work profession; as Webb and Wistow (1987) suggest social work can be a force for social change, a force for social control, or a force for social maintenance. Francine felt these different roles acutely affect how she negotiated Children's Services and CMHTs.

For Frank, neither social workers nor CPNs were his main source of support. The main people that assisted Frank were support workers and wardens at his sheltered accommodation:

> He's [the support worker] been a bigger support than all the others [social workers] put together(...) if I need anything I'll go and see him, and he'll call the social worker sometimes.

Frank's statement suggests not only that he felt his support worker was the biggest assistance to him, but also indicates some limited understanding of a relationship existing between his support worker and the social worker. Frank struggled to distinguish social workers from support workers, but was aware that they somehow worked together. The confusion faced by Frank is not particularly surprising given that much of what people might view as social work is in fact done by support workers. This seems to have resonance with Huxley *et al*., (2009b) who noted that many of the roles traditionally associated with social workers are increasingly being undertaken by support workers. These support workers often a consistent point of contact and are characterised by a focus on supporting service users.

The confusion between social workers and support workers did not seem to exist with other relevant professions. For example, Francine described feeling that CPNs were more remote than social workers:

> The only reason I had a CPN was to have a depo injection[25], they used to come to the house, but now I have to go to the clinic (…) Social workers give you more support.

This statement concisely sums up how the three service users demarcated social workers from CPNs: the CPNs did conventional medical tasks, such as administering medication, while social workers gave emotional support. Social workers would visit service users independently of CPNs and at different times,

---

[25] This is the administering of antipsychotic or antidepressant medication.

there was no mention by service users of any joint visits. None of the service users were aware of what contact social workers had with CPNs, or even if information was shared between them. Potentially this seems to be an endorsement of a disciplinary divide linked to notions of expertise (Abbott and Wallace, 1990; Beresford, 2002). Essentially service users seemed to have clear conceptualisation of what they believed CPN's did as medical practitioners and how that made them different from social workers.

What we can see from the service user perspective is that the individual roles of different professions are still very much identifiable by the tasks they carry out (for example, CPNs gave medication).

8.8 - Interventions by statutory social workers in suicide prevention, the service user perspective

Building a relationship with service users allows social workers to know better when and how to intervene. Suicidality is not a constant state of being. It ebbs and flows with service users experiencing periods of acute suicidal ideation and other, potentially extensive, periods of relative stability. This variability can make it difficult for social workers, and other professions, to help service users manage their well-being. So what interventions did the service users feel social workers used to help them?

For Francine, the most important thing her social worker could do was talk to her:

> I can talk to her [the social worker] about anything. It's great she knows about my family and my past.

Regular contact with social workers and engaging them in dialogue helped, but Francine's social worker had also put in a wider package of care, such as day centres and adult learning classes. All three service users commented on how this was highly effective in lifting their mood (Catty *et al.*, 2005; Catty and Burns, 2001). However, recent budget cuts meant that such services were becoming increasingly scarce; a point made by Frank:

> I used to go up the club [day centre], but they've started charging! Can you believe it? I don't know, it's all these bloody cuts so I'm told.

As well as referring service users to day centres, social workers were also felt to be instrumental in facilitating access to other services. Frank (who had problems with

his memory and mild learning difficulties) needed assistance travelling, so his social workers arranged for someone to take him on holiday. Frank had also had a move facilitated by his social worker with the cooperation of his family. This move was prompted after issues of harassment in the community.

Frazer mentioned how his social worker had helped to complete forms for him, normally those related to benefits and housing; 'social workers can get stuff done for you, like sort forms out'. It seems that some of the most valued practices identified by service users were those that focused on improving their material wellbeing or providing emotional support through visits. The case management aspect of social work was not highlighted as being as important for the services users, although it should be acknowledged that much of this work may be unseen by service users (Samuel, 2005).

Some social work interventions were more pragmatic harm reduction strategies. For example, Francine's social worker encouraged her to substitute taking pills with tic-tacs' (small mints). This strategy acknowledged that Francine could find it hard to manage the urges she sometimes felt, but focused on reducing the potential harm such activity might cause. This approach to risk minimisation through substituting behaviours in instances of DSH is commonly discussed in self-help and voluntary organisations (Harrison and Sharman, 2005). Although Pengelley *et al*., (2008) highlight that such minimisation techniques can also be used by professionals and that such approaches are permitted within NICE guidelines (NICE, 2004). However, they also note that professionals often lack the confidence to discuss harm minimisation with service users.

Another strategy employed by Francine's social worker was to try and encourage Francine to think about how long it had been since she last made an attempt on her life. Francine explained with a degree of pride that it was close to a year since her last attempt. This appears to be an attempt by the social worker to motivate Francine and build self-esteem (Fliege *et al.,* 2009).

Surprisingly, there was little mention of social workers providing assistance to service users in psychiatric wards at the point of discharge. This point is of further concern when we consider the high levels of suicides that occur amongst those recently discharged from psychiatric wards (Appleby *et al.,* 2006). The first two weeks after discharge present a period of particularly heightened risk (Bickley *et al.,* 2013). Further to this, previous researchers have noted the 'problematic nature of [hospital] discharges' (Glasby and Lester, 2005: 864) from psychiatric wards. It

seems that social workers are conspicuously absent in hospital settings, but perhaps this is not surprising given that they overwhelmingly work in the community. It might also relate to the division between the different levels of health care (secondary and tertiary health care), or even a professional barrier such that social workers do not see psychiatric wards as being part of their remit. In any case, given the emphasis on community care, where packages of care should be supporting service users at the point of discharge, it seems that there should be at least some minimal contact between the social worker and the service user prior to discharge. Whilst it is unclear what roles social workers play during this period of heightened suicidal risk, it seems this might be an area for further research.

8.9 – Conclusion

Both the CPNs and service users felt that social workers had an important role to play in suicide prevention. From the perspective of the CPNs, while multi-agency and interdisciplinary issues can serve as barriers at times, they generally had a positive working relationship with social workers. The AMHP status social workers were seen as being highly skilled and added greatly to the assessment process. This was primarily related to AMHP skills in legislation; 'it is their [social workers'] bread and butter' (Emma). Despite this, CPNs felt that they were more likely to be allocated to work with suicidal service users than social workers. The negotiation of roles within multi-agency and interdisciplinary environments can be complex and caught up with professional identities, boundaries and notions of expertise (Evetts, 2003; Abbot and Wallace, 1990; Carpenter *et al.,* 2003).

The skills that social workers were felt to possess with legislation were, however, off-set by the confusion amongst both CPNs and service users about what tasks social workers were able to do. For example, Eric's earlier quote highlighted a sense of frustration about speaking to social workers regarding issues such as housing or benefits, topics that are arguably never part of social work practice. The implication was that CPNs and service users both associated social work with tasks that are increasingly being undertaken by support workers and less by social workers themselves (Huxley *et al.,* 2009b).

All three service users identified the ability of social workers to build and maintain positive relationships with them, and their families, as the most important aspect of supporting them with their suicidality. Francine clearly valued the relationship that she had built with her social worker and found this to be of particular importance in

periods of crisis. Relationship-building is perhaps not a task often associated with contemporary case management approaches to social work (Lymbery, 2001).

The constant change in social workers was identified as being particularly problematic for the three service users, as it required them to re-explore their past with each new worker. This problem was exacerbated by the lack of effective hand-over meetings. Individual personalities could also be problematic. Poor relationships can greatly limit the effectiveness of social workers, as Francine herself stated;

> You can get some really good ones and some really bad ones (...) [when she didn't have a social worker] I was overdosing constantly, almost every week.

Francine's current social worker utilised harm reduction strategies, such as substituting tablets with tic-tacs and the use of written agreements. Both demonstrate that social workers are using established intervention techniques to prevent DSH and suicide (Shaw, 2012). Given that most social workers do not receive formal training on suicide, see chapter 6.1, it seems likely that such approaches are being learned from peers (Healy, 2014; Eraut, 2000).

Service users did feel that social workers were adopting a holistic approach by working with families, building relationships with professionals and service users, and by acting as facilitators with issues such as housing (Tew *et al.* 2012; Topor *et al.* 2006; Carptenter *et al.,* 2003). This focus on improving the general wellbeing of service users may potentially reduce the incidence of suicide attempts, and thus reduce the number of hospital admissions (Hatfield, 2008).

Chapter 9 – Conclusion

9.0 - Introduction

Over the course of this thesis I have explored the role(s) of social workers in suicide prevention. In chapters 2 and 3 I explored selectively relevant literature and found, like Joe and Niedermeier (2008), a dearth of information about the role of social workers in suicide prevention. It was also noted that the fields of suicidology and social work research (in the UK and Europe) are dominated by different ontological positions (the former being objectivist, the latter constructionist) (Hjelmeland and Knizek, 2010; Huxley *et al.,* 2009a; Stack, 2000a; 2000b).

Given the largely conflicting ontological orientations and epistemological perspectives of suicidology and UK social work research, careful consideration was given as to what methods should be employed in this study. I outlined in chapter 4 the ethical considerations and provided an overview of my methods. Personal experiences of suicide and the process of gaining ethical approval from the National Health Service Multi-centre Research Ethics Committee (NHS MREC) for Wales were clearly outlined. No major ethical issues were experienced in the collection of data.

In the research methods discussion, the traditional epistemological divides that have long plagued social research were refuted (Redfield Jamison, 2000). Two methods were selected, based on their suitability to best provide data that would allow me to address specific research questions. Specifically, my research takes the form of two linked case studies. The first case study (chapter 5) was a secondary analysis of the Adult Psychiatric Morbidity Survey (2007). Here, a multi-nomial logistic regression was used to explore the first of seven research questions:

RQ 1 - In what circumstances do suicidal people come into contact with social workers?

In the second case study, a series of semi-structured interviews with social workers (*n*=17) (chapters 6 and 7), service users (*n*=3) and community psychiatric nurses (CPNs) (*n*=3) (chapter 8) explored my six remaining research questions:

RQ 2 – How do social workers understand suicide and suicidal behaviour?

RQ 3 – What approaches to assessment are currently used by social workers? To what extent does research evidence impact on the practice of social workers in this context?

RQ 4 – What roles are currently played by social workers in suicide prevention? Do social workers have a distinct role in suicide prevention or has the increase in multi-agency working blurred the roles of different professionals?

RQ 5 – What sorts of social care provision are available to suicidal service users and what is the nature and frequency of their engagement with these services?

RQ 6 – How are social workers supported when working with suicidal service users?

RQ 7 – How do suicidal people perceive the role of social workers in suicide prevention, particularly when situated in multi-agency/Interdisciplinary teams?

The findings so far have been presented in isolation, with chapters 5, 6, 7 and 8 each focusing on different aspects of the role social workers play in suicide prevention; in this concluding chapter the finding are drawn together.

The conclusion is divided into four parts: the first brings together the findings from the previous four empirical chapters (chapters 5, 6, 7 and 8); the second part clearly sets out the limitations of this study; in the third, I examine the implications of my findings for further research, policy makers and practitioners; finally I make closing remarks about the research and its implication.

9.1 - Findings

RQ 1 – In what circumstances do suicidal people come into contact with social workers?

In chapter 5 a secondary analysis of the Adult Psychiatric Morbidity Survey (2007) found a significant relationship existed between the variables 'social worker contact in the last year' and 'lifetime suicide attempt'. To explore this relationship a multinomial logistic regression was used to establish which variables were important in explaining the relationship between social worker contact and suicidality.

Variables associated with suicide (irrespective of social worker contact) included 'self-harm, with no intention of killing self', and 'thoughts of suicide'. These findings seem consistent with existing research which has highlighted the strong association between self-injurious behaviour and suicidality (Hawton *et al.,* 2003). Other factors

that affected suicidality included religion and age. These findings were again largely consistent with existing knowledge; for example, being Christian or Muslim decreased the odds of social worker contact, suggesting that the 'sin' of suicide is, for some, an effective deterrent (Stack and Kposowa, 2011).

Age was found to have some effect on social worker contact, with certain age ranges, 34-46 and 58-69, being less likely to have contact with social workers. One explanation for this was that social constructs of vulnerability mean that some adult age ranges are less likely to have social worker contact (Parton, 1996). In chapter 3.1 it was established that social workers are there to assist those in need (Sheldon and MacDonald, 2009). However, those in need were identified as being a diverse group that was constantly being redefined by wider society. Parton (1996) discusses how the concepts of who is in need are closely correlated with those who are perceived to be 'vulnerable'. Essentially he suggests that wider concepts about the vulnerability of children, disabled people or older persons mean services are more likely to be orientated to meet the needs of these groups. The construction of such ideas can be seen through the media scandals that result when vulnerable children die (Warner, 2014; Ayre, 2001). Subsequently many adults are not felt to be vulnerable and so certain age ranges are less likely to have contact with services.

Having a drug dependency, irrespective of suicidality, was also found to be a significant predictor of social worker contact. People with a drug dependency seem to have contact with a social worker, which is encouraging, given the strong link between substance misuse and suicide (Appleby *et al.,* 1999).

The strong association between substance misuse and social worker contact identified in the AMPS07 was a topic that also came up during the social worker interviews (see chapter 7.1 and 7.3). For my participants, substance misuse was associated with suicide, but it was also perceived to be a problematic issue. Social workers reported difficulties in getting CMHTs to engage with service users who had a history of substance misuse. Dual-diagnosis seemed to act as a hindrance to accessing support, with service users being pigeonholed into either receiving support from substance misuse teams or CMHTs. Further exploration of how substance misuse and mental health services can work together more effectively is strongly recommended.

We should however be cautious not to see suicide as just an issue for those social workers operating in the areas of substance misuse and mental health. The social workers in my sample were drawn from various areas of practice, and all had

experienced working with suicidal service users. Suicide is an issue that affects all areas of social work practice.

RQ 2 – How do social workers understand suicide and suicidal behaviour?

In chapter 6 I established that social workers recognise the multi-faceted nature of suicide. They expressed an understanding of the biological, psychological and social factors that are associated with suicide (Pritchard, 2006). Adopting a holistic approach to assessment was therefore thought to be essential. This is discussed more in the next section.

Amongst the social workers interviewed there was a feeling that suicide could be a rational act, a concept that has resonance with wider debates on euthanasia or assisted dying (Schildmann and Schildmann, 2013; Seale, 2006; Yashiro *et al.,* 2001). Some, such as Dee (see chapter 6.2), were empathetic to the plight of particular service users; feeling that if they were in similar situations to the service users they might also have suicidal thoughts. In these instances there was a sense that the social workers in my sample were trapped between the desire to change service users' lives for the better, and the service users' right to choose whether to end their life (Gerdes and Segal, 2009).

It was also evident that social workers struggled with the relationship between DSH and suicide. This is unsurprising given the debates in contemporary research exploring the relationship between parasuicide and suicide (Brausch and Muehlenkamp, 2013; Zahl and Hawton, 2004; and Cooper *et al.,* 2005). Specifically, the social workers in my sample spoke of those who were making 'genuine' (see chapter 6.2) attempts, and those they felt were displaying attention-seeking behaviour.

The discovery of discussions about attention-seeking behaviour in instances of DSH amongst social workers is perhaps unsurprising given that such attitudes are found to be present in health professionals (Bolton, 2012; McGrath and Dowling, 2012). Further to this, Joiner (2010) and Nock and Kessler (2006) have observed the prevalence of such attitudes in the general population.

For the social workers in my sample it seemed that this was in part a reaction to stress that could result from working with risk and uncertainty (Ruch *et al*., 2012). An example of the pressures faced by social workers can be seen in the work of Ting, *et al.,* (2011) who observed that social workers engaging with suicidal service users were at an elevated risk of both stress and secondary trauma. To help manage

uncertainty faced in working with suicidal service users the social workers often spoke about the 'inevitability' of suicide.

The theme of inevitability seemed to allow social workers to manage working with risk and uncertainty, and the blame/shame that might result in instances of a service user's death (Bride and Figley, 2007; Smith *et al.,* 2003). Specifically, it enabled them to create a professional distance between themselves and their service users (Glaser and Strauss, 1964). By creating this distance social workers are able to construct emotional boundaries that help them to cope with the stress of working with uncertainty (O'Leary *et al.,* 2013; Hayward and Tuckety, 2011). This is also linked to issues of defensive social work that are discussed in the next section.

The existence of the theme of inevitability also implies an implicit endorsement of the process of professionalisation (Evetts, 2003; Abbott and Wallave, 1990). Social workers draw on their privileged position as 'experts' to create and maintain some distance from their service users (Green *et al*., 2006). In doing so they are able to manage incidents of crisis by maintaining sentimental order to ensure their own ontological security (Giddens, 1984).

In addition to the importance of the theme of inevitability it was also apparent that formal training on suicide prevention was highly limited. Worryingly, none of those interviewed had received any formal training about suicide, or its prevention, during their qualifying social work training. Only a minority of social workers had undertaken relevant training since qualifying via the Applied Suicide Intervention Skills Training – ASIST (Ramsay *et al.,* 1999). Those who had been on the training typically felt that it was of limited use. This was in part due to the social workers appearing to be trapped by wanting simple answers whilst recognising the complexity of the issues under discussion (Burke and Cooper, 2007; Stalker, 2003). Again this appears to be linked to wider issues about the management of uncertainty in social work practice (White, 2009). It might also be an expression of social workers being caught between social work as a practical-moral activity on the one hand and as a technical-rational activity on the other (Taylor and White, 2001).

Experiences of the AMHP training were generally positive, although there was some suggestion that it was too heavily focused on mental health law, rather than being focused on assessment and intervention to prevent suicide.

Further to the lack of training on suicide prevention the social workers interviewed lacked an awareness of suicide prevention strategy in Wales (Welsh Government,

2008). However, this is perhaps unsurprising given that much policy is often filtered and interpreted by both social workers and their managers (Evans, 2010; Evans and Harris, 2004).

As a substitute for formal learning, peer learning and tacit knowledge were employed as the main form of knowledge acquisition (Eraut, 2000). The social workers in my sample spoke about the importance of peers in their learning. Their accounts seemed to resonate with Samson's concept of 'practice wisdom' (2014:1). This according to Samson allows workers to draw on both formal and informal information in the process of decision making.

RQ 3 – What approaches to assessment are currently used by social workers and to what extent does research evidence impact on the practice of social workers in this context?

In chapter 6.2 I noted that the social workers in my sample often struggled to identify assessments specifically designed to assess suicidality. In the few instances where there was an awareness that such assessments existed, or were available, social workers were unable to name these assessments. Given the centrality of assessments in social work practice (Crisp *et al.,* 2007) this might seem surprising. However as O'Melia and Miley (2002) note, risk assessment and management is often heuristic in nature. Practitioners may draw on empirical evidence in the course of their work and we cannot understand assessment without examining their own processes of knowledge production. As discussed in the previous section, social workers were able to draw on an understanding of evidence in the form of the bio-psycho-social model but they primarily relied on practice wisdom and peer learning in the course of their work (Samson, 2014; Horlick-Jones, 2005; Eraut, 2000).

Despite being unable to identify specific suicide risk assessments the social workers interviewed did speak about more general assessments such as Core Assessment (children services) and the Unified Assessment (adult services). The Care Programme Approach (CPA), an assessment frequently used by CMHTs, was the most common form of assessment identified by social workers. While this assessment does contain information about suicide, it is not specifically designed for suicide prevention.

The generic assessments used were felt by both social worker and CPN participants (see chapters 6.2 and 8.2) to borrow heavily from social work concepts and the social model (Carpenter *et al*., 2003; Yuill *et al.,* 2012). Of central importance to all

these assessments was the need to adopt a holistic approach (Coulshed and Orme, 2012; Lloyd and Taylor, 1995). The importance of holistic assessment and the use of the social model seemed to feed into wider discussions about the blurring of roles in CMHTs, as will be discussed later.

The importance of a holistis assessment was, however, also accompanied by the use of such assessments and case notes as part of defensive practice (Harris, 1987). The social workers described how assessments and case notes became a method of justifying their actions in order to avoid any blame and subsequent shame, that might result from a service user's suicide (Gibson, 2014; Smith *et al.,* 2003). This was felt to be of particular importance given the lack of formal support social workers received (see question 6).

Similarly both the social workers and the CPNs highlighted how they used AMHP status social workers to help them in their work. Rather than carrying out full assessments under the Mental Health Act(s) (1983/2007) they would first ask AMHP status workers to do joint visits or carry out mini pre-Mental Health Act assessments. The existence of such informal mechanisms not only suggests the use of defensive social work but also highlights how professional discretion is being enacted (Evan and Harris, 2004; Webb, 2001). Essentially practitioners are using their own judgements and ideas amidst wider more formal processes and structures.

A final theme that emerged from my discussions about assessment was the difficulty in addressing the topic of suicide. Talking about suicide for the first time was often described as challenging and difficult (Grant and Kinman, 2012). However, after a while it became routinized and practitioners became desensitised to the issue (O'Leary *et al*., 2013; Bride and Figley, 2007).

RQ 4 – What roles are currently played by social workers in suicide prevention? Do social workers have a distinct role in suicide prevention or has the increase in multi-agency working blurred the roles of different professionals?

In chapter 7.2 the diverse nature of the social worker role (Sheldon and MacDonald, 2009) was identified as potentially problematic, with social workers highlighting two areas of conflict between different sectors of the profession: first, the relationship between substance misuse social work and CMHTs; and second, a divide between children services and CMHT.

As noted in question 1, a complex relationship was felt to exist between substance misuse services and mental health services. The existence of a gap between these

services is well established (Lawrence-Jones, 2010; Schulte *et al.,* 2008) and might be partially explained by wider debates about issues of causality in dual diagnosis (Rosenthal, 2003; Appleby *et al.,* 2000). These debates have arguably manifested themselves in structure, legal and cultural differences between the services (Lowe and Abou-Saleh, 2004). What was apparent from the interviews with social workers was that these divides were impacting on the support service users received.

The second divide, between social workers in children services and those in CMHTs, proved to be complex, with both sides reporting a lack of understanding and engagement. Social workers in children services, responding to issues of suicidality amongst parents (or guardians), felt they were often quicker to respond to the needs of service users than staff in CMHTs. Subsequently this meant that they would often end up supporting adult service users with issues of suicidality without the assistance of adult mental health services.

Conversely social workers in CMHTs felt there was a lack of awareness and understanding of suicide, and mental illness more generally, amongst those working in children services. The lack of understanding held by social workers in children's services, combined with the child protection processes (such as case conference – Connolly, 2006) were felt to be highly alienating for service users.

This was further reinforced by the three service users in their interviews, where Francine, for example, spoke about her experiences of having one social worker from children services and one from mental health services (see chapter 8.7). Here the understanding of and attitudes to mental illness displayed by social workers from children services were felt to be largely negative. Francine felt that the social workers from children services did not work with her in a way that promoted a positive relationship, unlike the social workers from the mental health team.

In addition to the division within the social work profession, the rise of multi-agency and interdisciplinary working raises further complexities in understanding the social worker role in suicide prevention. Social workers rarely work in isolation, particularly in the area of mental health, and are required to negotiate multi-agency and interdisciplinary working practices (Morris, 2008).

Both social workers and CPNs felt there was some blurring of roles (see chapters 7.1 and 8.2) (Bailey and Liyanage, 2012; Robinson and Cottrell, 2005). However, the social workers interviewed maintained that their focus on the social needs of service users combined with a holistic approach to assessment made their roles

distinct. The CPNs interviewed refuted the social worker claims that a holistic approach to understanding suicide was exclusive to the social work profession. Carpenter *et al.,* (2003) have also noted that there has been an increased adoption by health professionals of holistic assessments in CMHTs suggesting that there has been some blurring of roles.

The CPNs interviewed also felt that they were more likely to be allocated suicidal service users than social workers. This in part seemed to be down to the ability of social workers to better regulate the boundaries of their profession (Abbott and Wallace, 1990). The allocation of suicidal cases by professional discipline in CMHTS would be an interesting topic for further exploration.

As previously indicated the CPNs interviewed noted that AMHPs had extensive legal knowledge that was felt to be of particular importance. Implicit within the discussions about the use of AMHPs was an acceptance of the expert nature of AMHPs (Beresford, 2002; Abbott and Wallace, 1990). This suggests that notions of profession within CMHTs are highly complex and would warrant further inquiry.

The service users felt that a distinction could be made between their experiences of social workers and CPNs (see chapter 8.5 and 8.7). CPNs were seen at the clinic and were perceived to do little more than administer medication. For the service users individual relationships with professionals (both CPNs and social workers) were viewed as the most important factor in their effectiveness to prevent suicide. The importance of service user-social worker relationships is discussed further in the coming questions.

In addition to the CPNs, the interviews with social workers also identified the complexities of working with services such as crisis teams. These teams were often felt to have unclear and changing eligibility criteria, which led to considerable frustration for the social workers. The fluctuating needs of service users were not felt to be easily accommodated by such criteria (Pritchard, 2006; Martin, 2010).

The social workers interviewed also expressed frustration over the lack of clear information provided to them by other professionals; specifically support workers, housing officers and those working in the third sector. These groups were often felt not to have provided the necessary information in order for social workers to make an informed decision (see chapter 7.3). There was also a feeling that some of those referring cases to social workers were doing so to pass on the responsibility.

This passing on of responsibility might be conceptualised as part of the professionalisation of social work (Evetts, 2003). For example Huxley *et al.,* (2009b) have commented that support workers often fulfil many of the roles that were previously associated with social workers. Further to this, Huxley and colleagues suggest that support workers are less likely to change roles than social workers and so are able to build and nurture relationships with service users and are more aware of their needs on a day to day basis. This was a point discussed with one service users who felt their support worker was their first point of contact. However, they also noted that for anything important then they would have to speak to the social worker. This again suggests an acceptance of the expertise of social workers and their professional status (Abbott and Wallace, 1990).

Being able to negotiate the complex multi-agency and interdisciplinary issues that underpin social work practice is an important skill for all social workers (Golightley, 2008). Yet this is far from the only role social workers have in preventing suicide. Social workers spoke about the importance of assessing and designing packages of care to assist service users. Being able to work with existing support networks (friend and family), arrange for services to be brought in to assist service users (such as the crisis team, or a support worker) and intervening in a period of crisis were felt to be particularly important.

The social workers in my sample were divided between those who advocated a case management approach to their work and those who spoke of community social work (see chapter 6.3). Yet there was common ground in these approaches, specifically the importance of having a good relationship with service users and an awareness of the service users support networks, a point that will be explored in the next section and in question 7.

Some confusion was noted by both the CPNs and service users interviewed, regarding what social workers do. In the CPN interviews there was a belief that social workers protected their role by not taking on cases; however, the CPNs found it hard to know exactly what social workers did (see chapter 8.2). This might be partly because social work has become more professionalised (Huxley *et al*., 2009b; Abbott and Wallace, 1990).

The service user interviews also demonstrated some confusion over the role of the contemporary social worker. They clearly felt that assistance with benefit forms and housing were part of the social worker role, and in some instances they had received support from social workers with these issues.

RQ 5 – What sorts of social care provision are available to suicidal service users and what is the nature and frequency of their engagement with these services?

The social workers found it difficult to specify particular suicide intervention strategies, but did talk about how they would normally work with suicidal service users. Regular contact and visits to service users were seen as useful tools in preventing suicide (see chapter 7.4). This was something that the service users seemed to appreciate (see chapter 8.7).

Perhaps the most common form of intervention identified was the monitoring of service users (Gray, 2012; Hoult, 1986). In chapter 7.4 the effectiveness of such approaches was discussed and it was noted that by monitoring service users professionals are able to improve service user engagement with mental health services and potentially reduce instances of hospitalisation (Burns *et al.,* 2007; Catty *et al.,* 2002; Tyrer *et al.,* 1995). This appears to enable social workers to manage risk posed to service users, and associated uncertainty, potentially reducing the stress posed to them as professionals (Littlechild, 2013; Littlechild and Hawley, 2010; Acker, 1998).

To effectively monitor, social workers have to work with service users' existing family and informal support networks (Topor *et al.,* 2006). Both the social workers and service users interviewed felt that this was highly important to successful practice.

In addition to being embedded within service users' informal networks it was also important that social workers develop positive relationships with service users (Lymbery, 2001). For the social workers and service users interviewed it was only possible to gain an effective insight into the perspective of service users when positive relationships existed.

In addition to monitoring service users two behaviour modifying tools were identified in the course of my interviews (Maluccio and Marlow, 1974). First was the use of a 'no-suicide' contract (Motto, 1999). This was essentially an agreement between a service user and social worker setting out a series of parameters about what both parties can expect (Range, 2005). These contracts are not legally binding but both the social worker and service user reported that it was working effectively. In addition to the contract the social worker also regularly sought to build up the service users self-esteem by reminding them of the things that were going well for them and highlighting how long it had been since they last self-harmed.

An additional behaviour modifying tool used was the substituting of pills with sweets (in this case tic-tacs). This strategy was designed to help the service user to manage their urges to DSH. As noted in chapter 8.8, this approach to risk minimisation has been traditionally associated with the self-help strategies and voluntary organisations (Harrison and Sharman, 2005). However Pengelley *et al*., (2008) have highlighted that it can also be used effectively by professionals (NICE, 2004).

In addition to these basic behaviour modifying interventions we have also seen how social workers also spoke about being able to request that service users be assessed by an AMHP. These assessments could, as discussed in question three, be either assessments under the Mental Health Act(s) (1983/2007) with a view to possible detainment for treatment or pre-assessments. The latter of these two options was primarily framed as defensive social work but it seems likely that it might also support service users (Gibson, 2014; Lipsky, 1980).

Social workers and CPNs both spoke about being able to refer on to more specialist services, such as crisis teams, however as has already been noted this was complicated by issues of access. (see chapter 7.4). These teams provided regular visits and intensive support for service users.

It seems that social workers are able to draw on a several different approaches to intervening and assisting suicidal service users. However the interventions used seemed to depend largely on the individual social workers skills and ability.

RQ 6 – How are social workers supported when working with suicidal service users?

Previously (in questions 2 and chapter 6.1) it was highlighted that the social workers received little formal training on suicide and were largely reliant on peer learning (Healy, 2014; Eraut, 2000). Similarly we find that peer support also comprises a large amount of the support social workers get in the course of their work with suicidal service users.

Many of the social workers interviewed spoke about the fear of being blamed for a service user death and were uncertain about the reviews and processes that might result from such a death (Broadhurst *et al.,* 2010). The fear of what might result from these deaths and the stigma, or shame that might result from them was palpable in several of the social worker interviews (Gibson, 2014; Harris, 1987). Rather than serving as a source for learning and development (Brandon *et al.,* 2012) the reviews were largely seen as objects of fear.

The social workers who had been through such processes reported being supported by colleagues but they had often not received any feedback from reviews (positive or negative). In addition to reviews that would most likely only take place in a small minority of cases, social workers also spoke about formal supervisions as a source of support. Supervisions, however were more often linked to issues of practice and did not necessarily focus on the wellbeing of social workers. This is concerning, and perhaps unsurprising given the high levels of stress in the profession (Evans *et al.,* 2006) and the consequent foreshortened career span of some social workers (Curtis *et al.,* 2010; 2012).

Peers were identified by participants as being the main source of emotional support in the event of a service user suicide. The reliance on peer learning and support was generally felt to be positive, but it could also prove to be problematic. For example, Anna's experience of not being informed of a second service user suicide until she contacted the office on the way to visit the client, shows how reliance on uncoordinated peer networks alone could have placed her in a potentially difficult and distressing situation (see chapter 6.2).

An additional source of quasi informal support came from AMHPs. As previously discussed in questions 4 and 5, AMHPs were identified by both CPNs and social workers as being of particular importance as it gave those social workers who were AMHPs expert legal knowledge, which the CPNs particularly felt added value to the social work role.

The reported lack of support afforded to social workers in their work with suicidal service users is concerning and it seems that the social workers interviewed were using defensive social work practice to help them manage the fear of working in such a high pressured environment (Gibson, 2014). An example of this is the extensive use of case notes as a way to record and justify their actions (Smith *et al.,* 2003).

RQ 7 – How do suicidal people perceive the role of social workers in suicide prevention, particularly when situated in multi-agency/interdisciplinary teams?

The three service users who participated all had varied histories, however, all had made multiple attempts to end their lives and all had been involved with multiple social workers. For the service users the relationship they had with their social worker was the most important factor (Lymbery, 2001) Similarly social workers also recognised the importance of having a positive relationship with service users (see

question 5) (Huxley *et al.,* 2005). A positive relationship was characterised by knowledge of the service user's past, an awareness of their current needs and the ability to listen to the needs of service users.

Challenges to positive relationships primarily came from regular changes of worker (Carpenter, 2012; Huxley *et al.,* 2005). This meant that service users often had to repeat their history to each new social worker, something that can be emotionally challenging (see chapter 8.7) (Speirs, 2002). Further compounding this was the scarcity of effective handovers (which should include service users) between social workers.

Some confusion about the role of social workers was noted during my interviews with service users. Specifically the divide between support worker and service user proved to be confusing (Huxley *et al.,* 2009b). In contrast the service users felt that the way CPNs and social workers interacted with them was different. Social workers visited service users in their homes and CPNs saw service users in clinics. The approach of the social workers was important for service users as a home visit meant they were seen in their own environment.

Fundamentally the service users in my sample all discussed how important social workers had been in preventing suicide. They all identified that social workers had assisted them in a multitude of ways ranging from behaviour modification interventions through to assistance with housing. The support provided by social workers was felt to be invaluable.

9.2 - Limitations of my research

The findings of this study help to provide an insight into an area that has previously been largely neglected (Joe and Neidermeier, 2008). Before considering the implications of these findings for practice, policy or further research it is important to acknowledge the limitations of the study.

First and foremost, this research does not examine the role social workers play in assisting those under the age of eighteen. Whilst child care social workers have participated in the study, their input has been from the perspective of working with children and young people where a parent or adult figure in their life has been suicidal. Caution is therefore urged in relating the findings of this study to social workers working specifically with suicidal children and young people.

In addition to the exclusion of suicidality amongst those below the age of eighteen, different components of the study take place in different home nations within the United Kingdom. The Adult Psychiatric Morbidity Survey 2007 was conducted with households in England, whilst my own primary data collection (interviews) was conducted in Wales. The process of devolution in Wales means that there is increasing divergence from England in the practices, policy and legislation underpinning health and social care. This might at first seem problematic but as Scourfield *et al.,* (2008) note, the two home nations have more in common than that which separates them. Further to this, the decision to use a data set from England was borne out of necessity, as no comparable source with appropriate variables was available for Wales at the time. The findings from the secondary analysis are best seen as indicative, rather than representative, of the contexts in which social workers come into contact with suicidal individuals in Wales.

The lack of data available on social work and suicide in Wales is symptomatic of a general dearth of data sets on this topic, a point previously identified by Joe and Neidermeier (2008). Where data sets with variables on social worker contact and suicide do exist, they are invariably not the prime focus of the studies (as illustrated in chapter 5.2). The peripheral nature of data on social worker contact, in data sets addressing suicidality, means secondary analysis is often plagued with complications. As such, in my secondary analysis (in chapter 5) issues of under-dispersion, combined with a disparity in the time frames (i.e. 'contact with social workers in the last year versus, 'ever making attempt on own life') of the two variables merged to create the dependent variable and limit how far the findings can be generalised. Further to this the model struggled to correctly predict three of the values in my dependant variable. Subsequently we must conclude that the model is only able to provide a highly limited insight into the context under which social workers come into contact with suicidal individuals. For a more detailed discussion of the limitations of my secondary analysis see chapter 5.6.

In addition to the above caveats, the relatively low number of interviews conducted with service users (n=3) and CPNs (n=3) self-evidently is also limiting. While it is difficult to state decisively when a sample size is sufficient in qualitative research, it is clear that much further work is be needed to develop service user and CPN perspectives on the role social workers play in suicide prevention (Sandelowski, 1995). Despite this, the findings from the three CPNs and three service users do seem to resonate strongly with the findings from the seventeen social worker interviews suggesting a high level of credibility (or internal validity) (Shenton, 2004).

While the number of social workers interviewed was notably higher than the service users and CPNS, the difficulty of locating professionals who had experience working with suicidal service users meant I was reliant on a self-nominating sample population (Emmel, 2013; Berg, 2006). This was a particular issue for the service user sample, as social workers were relied upon to identify and recruit participants. This may have potentially led to some bias towards service users with positive experiences being selected. Professionals participating in the study might also have had particular reasons for wanting to take part, such as a desire to voice their frustration with their employer or a policy/procedure.

One other potential issue with this study is the diversity of the social work role (Sheldon and MacDonald, 2009). While I was careful to include social workers from varied areas of practice, I only selected statutory social workers in my primary research. This potentially excludes social workers operating in private and third sector settings.

There is also a disparity between primary and secondary research. Respondents from the APMS07 were asked about social worker contact, but it was not specified if they worked in statutory services or other agencies. As such there are limitations in how much we can read across the APMS07 results to the primary research.

The limitations of the study highlighted in this section emphasise that, while the findings from this study provide an insight into a largely neglected area, we should be cautious of making too bold a claim about the value and validity of the findings. Yet these limitations do not mean that we cannot use this study to inform future research, practice and policy. Indeed we can note that some of the limitations, such as a lack of data sets with information on social worker contact and suicidality, are in themselves a finding that could be addressed by future research.

9.3 - Research implications

The implications of the research are divided into the following three areas: (i) further research; (ii) policy; and, (iii) practice.

Further research

In my literature reviews (chapters 2 and 3) it was noted that the fields of (UK) social work research and suicidology were dominated by two contrasting epistemological perspectives. Social work research in the UK is predominately orientated towards qualitative methods (McCambridge *et al.,* 2007; Huxley *et al.,* 2009a), whilst

suicidology is heavily skewed towards quantitative methods (Hjelmeland and Knizek, 2011). By drawing on both qualitative and quantitative methods, I have used both approaches to help inform an exploration of the role social workers play in suicide prevention. Consequently the recommendations made for further research have implications for both perspectives.

In exploring the limitations of the study, it is clear that there is a lack of appropriate data sets with variables addressing suicidality and social work. Conducting a large scale survey, specifically designed to explore the circumstances under which social workers come into contact with suicidal individuals, would greatly aid service design and delivery. These studies may include: the relationship between being in local authority care and suicide (chapter 5.5); issues of dual-diagnosis (chapter 7.2); and the importance of understanding DSH in suicide prevention (chapter 5.5 and chapter 6.2).

Another limitation of this study that could be addressed by further research is that of the perspectives of service users and CPNs. Their input into the study has greatly helped to inform our understanding of the role social workers play in suicide prevention, but the low number of participants in this study means that we are likely to have at best only a partial understanding of their perspectives. A wider study into their views and experiences and those of significant others, such as carers support workers and the police would be of benefit.

A study focusing on those working with social workers might also help highlight further multi-agency and interdisciplinary issues (identified in chapter 7.3) that affect suicide prevention more generally. Such research could focus on systemic issues, such as referral processes and eligibility criteria across agencies, but might also examine how different disciplines understand and relate to one another. For example; does professional language, such as the topics, terms and acronyms used, affect the weighting given to referrals or understandings of risk?

In terms of the tasks social workers undertake in suicide prevention, further research should focus on exploring two areas: (i) the process of relationship-building between social workers and suicidal service users and (ii) the role of peer learning and peer support when working with suicidal service users.

The first of these was highlighted by service users to be of particular importance (see chapter 8.7). Likewise the ability to build a good relationship with users was felt to be pivotal by social workers in order to assess needs and have more frank

conversations with them during periods of crisis. What has not been explored in depth is how this relationship is built and maintained, additional research on this matter is required to optimise interventions.

Turning to the second point of peer learning and support, it was evident that social workers were heavily reliant on their peers for their understanding of, and emotional resilience to, suicide. While this is felt to have both positive and negative impacts (see chapter 6.2), a further study may wish to look at how peer learning and support interact with more formal processes of learning and consultations. Specifically, such research might focus on how these two forms of learning and support could be effectively integrated with one another.

The lack of support social workers receive when they experience the loss of a service user to suicide (chapter 7.5) has been noted. In chapter 6.2 and 6.3 it was suggested that social workers seek to distance themselves from service users as a result. An examination of what support social workers might need, and how this could best be delivered, would be advantageous. Given the stressful nature of social work, such research could have the potential to improve the mental well-being of social workers, and thereby moderate the high turnover of staff in some fields of practice (see chapter 3).

Finally, future research could focus on using different methods, such as case file analysis or observations of practice, to validate whether the practise of social workers is consistent with their self-reporting. These methods might also help to explore whether there are any other significant issues that have not been identified in social workers' self-reported accounts.

Policy

It is apparent that while further research is needed on the social worker role in suicide prevention, the findings from this study also have implications for policy makers (both at local and national levels). First amongst these is the point that government strategies for suicide prevention (such as *Talk to Me,* Welsh Government, 2008) were largely unknown to front line professionals in this study. This is perhaps not surprising, as much strategy focuses on giving guidance to different governmental organisations (such as local authorities) about what they can best do to prevent suicide, rather than directly advising practitioners about case management (Evans and Harris, 2004). Although policy makers might also wish to

consider carefully how policies might be interpreted and used by practitioners, their managers and strategically (Evans, 2010).

What is perhaps of concern is that the training advocated in this strategy, specifically the Applied Suicide Intervention Skills Training (ASIST) (Welsh Government, 2008), was not known to all professionals in my sample. Raising awareness of training opportunities, according to participants, should be a priority for policy makers (Feldman and Freedenthal, 2006).

Whilst data on attendance of social workers at the ASIST programme is available (Evans and Price, 2013), what proportion of social workers this represents is less clear. In addition to this, it seems that the current training does not consider the relevance and significance of peer learning as a valid form of knowledge acquisition (Eraut, 2000). Helping social workers to understand how tacit knowledge, policy, regulations, procedures, moral dilemmas/judgements, practical considerations and relationships all interact in decision making would likely be of great benefit (Broadhurst *et al*., 2010). Training that promotes effective reflection on the topic of suicide might aid social workers to consider how they could better assess and intervene (White *et al.,* 2006).

Further to this, the reliance on peer learning in my sample suggests that training should be designed with peer dissemination in mind. Having resources and information that could be easily replicated and shared might help to improve social worker knowledge of suicide prevention.

Training in suicide prevention was also found to be neglected during the qualifying training of social workers (chapter 6.2). Whilst the sheer diversity of the social work remit makes it difficult for social workers to be experts on all issues, it is felt that greater training in suicide and associated behaviours is needed. The Care Council for Wales and its partners in training may wish to review what instruction is mandated on such a difficult topic during social worker training.

As well as the lack of training received by social workers on suicide prevention, it appears that there is no uniformity or coherence to suicide risk assessment. This not necessarily problematic, risk assessment is often heuristic in nature, with professionals drawing on both empirical knowledge and their own experiences to inform their decision making (O'Melia and Miley, 2002). Additionally the social workers were often able to recognise many factors associated with suicide and its prevention. However, it is likely that an awareness of validated tools might assist

them to better frame their work in a more evidence-based manner. Policy makers should carefully consider how information can be more effectively disseminated to best help practitioners.

In addition to training, there is also a greater need for professionals to be supported after suicides. The *Talk to Me* (Welsh Government, 2008) strategy correctly emphasises the importance of working with those bereaved by suicide (Ting *et al*., 2011; Ting *et al*., 2006). However, it is clear that social workers, and other professionals, often receive little support after the death of a service user. Future strategies should consider promoting support for professionals who suffer the loss of a service user to suicide. Guidance for employers on what services exist, or could be offered, might help to improve the wellbeing of professionals in stressful occupations.

The lack of support afforded to social workers is compounded by the lack of clarity regarding official reviews of a service user suicide. Social workers who have experienced the loss of a service user have noted that where external reviews/investigations have been held they have often received little or no feedback. These processes appear to be predominately health led, and many participants seemed unsure as to how these reviews were conducted (chapter 7.5). Clear guidance should exist to explain to social workers and other professionals the review process and protocols. Reviews should also report conclusions to professionals in a timely manner. This would reduce anxieties for professionals and would hopefully enhance service delivery (Gibson, 2014; Broadhurst *et al.,* 2010; Harris, 1987).

Finally, it seems evident that there are structural issues in service delivery that need to be addressed. The relationships experienced between different areas of service indicated that there are inequalities in response times and complexities in eligibility criteria. As noted in chapter 7.2, those working in children's services felt that their service structure allowed for them to respond more rapidly than those in mental health services. It was also clear that they, at times, lamented a lack of effective communication with mental health services.

Similarly, the complexity of dual diagnosis seemed to lead to service users struggling to get support. This well established gap in service provision appears to continue to be problematic (Lawrence-Jones, 2010; Schulte *et al.,* 2008; Lowe and Abou-Saleh, 2004). Further guidance on how dual diagnosis cases are best managed and shared, or the establishment of joint specialist services, could help to

resolve such conflicts and improve outcomes for service users (Lowe and Abou-Saleh, 2004).

Additionally specialist services such as crisis teams should have transparent and durable criteria. The social workers interviewed often lamented the unclear and regularly changing eligibility criteria used by specialist services (chapter 7.4). Policy makers should emphasise the need for transparent eligibility criteria that does not change frequently.

Practice

Despite the need for further training for practitioners, it was evident from interviewees that a holistic approach to understanding the circumstances of service users was embedded in social work practice (chapter 6.3). Social workers demonstrated an appreciation of the biological, psychological and social factors that affect suicidality (Pritchard, 2006). Despite this social workers were often unsure of the evidence base to their practice. Social workers are encouraged to engage in research to better evidence and inform their practice. This might include the use of validated tools such as the Beck Suicide Ideation Scale (BSIS) (Beck *et al.,* 1979). Additionally, social workers should also consider the importance of formal learning opportunities to help them understand and prevent suicide.

The importance of positive relationships with service users, and their support networks, was identified by social workers and service users (see chapter 8.7). One issue that was particularly disruptive to the relationship building process was the frequent change of social workers, especially when coupled with no handover process taking place between the outgoing and incoming professional. Social workers should endeavour to ensure that a handover takes place wherever possible and should include the service user. This would reduce the anxiety experienced by service users and would also help with relationship building.

The social workers identified monitoring as the primary means of supporting service users. Some evidence of basic psychosocial therapeutic interventions focused upon harm minimisation were also noted (Shaw, 2012). However, social workers generally seemed to lack any detailed knowledge of other interventions that might assist them in their practice in the field. Further exploration of validated interventions is strongly encouraged.

Service users with dual diagnosis issues (substance misuse and mental illness) do at times seem to struggle to get support from either both these services. Some

systemic adjustment to service function and alignment would likely help with this, but professionals could themselves seek to engage more readily with one another to improve outcomes for this highly vulnerable group that are at an elevated risk of suicide.

9.4 - Final words

In conclusion, it is important to emphasise that this study does not claim to be some definitive evaluation of the role(s) social workers play in suicide prevention. Instead it is intended to explore and generate insights and understandings and identify themes around practice improvement and areas for future research.

The three main findings from this study are as follows:

1) Suicide is an issue for social workers in all areas of practice, not just those working in mental health.
2) Social workers get insufficient training in how to assess and work with suicidal service users. Further to this, they appear to get little or no support after the loss of service user to suicide. Peer support and informal advice often fill the gap in both these situations.
3) Despite the lack of training and support afforded to social workers there are indications that they continue to utilise a holistic approach to understanding suicide. In doing so they show an appreciation of the multi-faceted nature of suicide and how it might be prevented.

References

A

Abbott, P. A. and Wallace, C. 1990. *An introduction to Sociology: Feminist Perspectives*. London: Routledge

Acker, G. M. 1998. The Impact of Clients' Mental Illness on Social Worker's Job Satisfaction and Burnout. *Health and Social Work*, **24**(2), pp.112-119

Adler, P.A and Adler, P. 2011. *The Tender Cut: Insider the hidden world of self-injury*, New York, New York University Press.

Adult Psychiatric Morbidity Survey. 2007. Available at http://discover.ukdataservice.ac.uk/catalogue?sn=6379 (Accessed 01.02.2011)

Allen, C. 1995. Helping with deliberate self-harm: Some practical guidelines. *Journal of Mental Health*, **4**(3), pp. 243-250

Al-Shahi, R. and Warlow, C. P. 2000. Differentiating between audit and research. Undue protection of patient confidentiality jeopardizes both research and audit. *British Medical Journal,* **320(**7236), pp. 713

American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders (fifth edition)*. Arlington: American Psychiatric Publishing

Anderson, L. 2008. Reflexivity. In Thorpe, R. and Hold, R (eds), *The SAGE Dictionary of Qualitative Management Research*, London: Sage

Andover, M. S. and Gidd, B. E. 2010. Non-suicidal self-injury, attempted suicide and suicidal intent among psychiatric inpatients. *Science Direct*, **178**(1), pp. 101-105

Antaki, C., Billig, M., Edwards, D., & Potter, J. (2002). Discourse analysis means doing analysis: A critique of six analytic shortcomings. *DAOL Discourse Analysis Online [Electronic Version],* **1**(1).

Appleby, L., Cooper, J., and Faragher, B. 1999. Psychological autopsy study of suicides by people aged under 35. *The British Journal of Psychiatry* **175**(2), pp. 168-174

Appleby, L., Shaw, J., Sherratt, J., Amos, T., Robinson, J. and McDonnell, R. 2001. *Safety First: Five-year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: Department of Health

Appleby, L., Shaw, J., Kapur, N., Windfuhr, K., Ashton, A., Swinson, N. and While, D. 2006. *Avoidable Deaths. Five-Year Report of the Nation Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: Department of Health

Arber, S. and Ginn, J. 1995. Gender Differences in the Relationship between Paid Employment and Informal Care. *Work, employment and society*, **9**(3), pp. 445-471

Arensmand, E., Corcoran, P. and Fitzgerald, A. P. 2011. Deliberate self-harm: Extent of the problem and prediction of repetition. In O'Connor, R., Platt, S. and Gordon, J. (eds.). *International Handbook of Suicide Prevention: Research, Policy and Practice,* Chichester: Wiley-Blackwell, pp. 119-131

Atkinson, M., Wilkin, A., Stott, A., Doherty, P. and Kinder, K. 2002. *Multi-Agency Working: a Detailed Study* (LGA Research Report 26). Slough: NFER

Atkinson, M. J. 1978. *Discovering suicide: Studies in social organization of sudden death*, London: Macmillan

Atkinson, P., Coffey, A. and Delamont, S. 2003. *Key Themes in Qualitative Research Continuities and Changes.* Walnut Creek CA: Altamira Press

Attride-Stirling, J. 2001. Thematic networks: an analytic tool for qualitative research. *Qualitative Research,* **1**(3), pp. 385-405

Ayre, P. 2001. Child Protection and the Media: Lessons from the Last Three Decades. *British Journal of Social Work*, **31**(6), pp. 887-901

B

Baechler, J. 1979. *Suicides*, Oxford: Basil Blackwell

Bagley, S. C., Munjas, B. and Shekelle, P. A. 2010. A systematic review of suicide prevention programs for military veterans. *Suicide and Life Threatening Behaviour*. **40**(3), pp, 257-265

Bailey, D. and Liyanage, L. 2012. The Role of the Mental Health Social Worker: Political Pawns in Reconfiguration of Adult Mental Health Social Care. *British Journal of Social Work*, **42**(6), pp. 1113-1131

Baldessarini, R. J. and Hennen, J. 2004. Genetics of suicide: an overview. *Harvard Review of Psychiatry*, **12**(1), pp. 1-13

Balloch, S. Pahl, J. and McLean, J. 1998. Working in the social services: Job satisfaction, stress and violence. *British Journal of Social Work*, **28**(3), pp. 329-350

Balloch, S. and Taylor, M. 2001. *Partnership working: Policy and Practice*. London: Policy Press

Barr, B., Taylor-Robinson, D., Scott-Samuel, A., McKee, M. and Stuckler, D. 2012. Suicides associated with the 2008-10 economic recession in England: time trend analysis. *The British Medical Journal,* **345**(5142)

Barr, W. and Huxley, P. 2002. The impact of community mental health reform on service users: a cohort study. *Health and Social Care*, **7**(2), pp. 129-139

Bates, N., Immins, T., Parker, J., Keen, S., Rutter, L., Brown. and Zsigo, S. 2010. 'Baptism of Fire': The First Year in the Life of a Newly Qualified Social Worker. *Social Work Education*, **29**(2)

Beck, A. T., Kovacs, M., and Weissman, A. 1979. Assessment of suicidal intention: The scale for suicide ideation. *Journal of Consulting and Clinical Psychology*. **47**(2), pp. 343–352

Beck, U. 1992. *Risk Society: Towards a New Modernity*. London: Sage

Beresford, P. 2002. Thinking about 'mental health': Towards a social model. *Journal of Mental Health*, **11**(6), pp. 581-584

Beresford, P., Croft, S. and Adshead, L. 2008. 'We don't see her as a social worker': A service user case study of the importance of the social worker's relationship and humanity. *British Journal of Social Work,* **38**(7), pp. 1388-1407

Berg, S. 2006. Snowball Sampling. In Samuel, K., Campbell, R., Balakrishnan, N. and Hoboken, B. V. (eds) *Encyclopedia of Statistical Sciences* NJ: John Wiley and Sons, Inc. pp. 7817–7821

Bickley, H., Hunt, I., Windfuhr, K. Shaw, J., Appleby, L. and Kapur, N. 2013. Suicide within two weeks of discharge from psychiatric inpatient care: a case-control study. *Psychiatric services*, **64**(7)

Biestek, F. P. 1957. *The Caseworker Relationship*. Lonon: Allen and Unwin

Bill-Brahe, U. 2000. Sociology and Suicidal Behaviour. In Hawton, K. and van Heeringen, K. (eds.). *The International Handbook of Suicide and Attempted Suicide.* Chichester: Wiley, pp. 193-207

Bloor, M. 2010. The researcher's obligation to bring about good. *Qualitative Social Work*, **9**(1), pp. 1720.

Boden, R., Epstein, D. and Latimer, J. 2009. Accounting for ethos or programmes for conduct? The brave new world of research ethics committees. *The Sociological Review*, **57**(4), pp. 727-749

Bogolub, E. 2010. The obligation to bring about Good in social work research: a new perspective. *Qualitative Social Work*, **9**(1), pp. 9-15

Bolton, J. 2012. 'We've got another one for you!' Liaison psychiatry's experience of stigma towards patients with mental illness and mental health professionals. *The Psychiatric Bulletin*, **36**, pp. 450-454

Bovin, J. and Schmidt, L. 2009. Use of complementary and alternative medicines associated with a 30% lower ongoing pregnancy/live birth rate during 12 months of fertility treatment. *Human Reproduction*, **24**(7), pp. 1626-1631

Bowen, G. A. 2008. Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research*, **8**(1), pp. 137-152

Bower, M. 2005. Psychoanalytic theories for social work practice. In Bower, M. *Psychoanalytic Theory for Social Work Practice: Thinking Under Fire*. London: Routledge, pp. 3-15

Boyatzis, R. E. 1998. *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: SAGE

Boyce, N. 2011. Suicide clusters: the undiscovered country. *The Lancet*, **378**(9801), pp. 1452

Brady, J. 2006. The Association between alcohol misuse and suicidal behaviour. *Alcohol and Alcoholism*, **41**(5), pp. 473-478

Brandon, M., Bailey, S. and Belderson, P. 2010. Building on the learning from serious case reviews: a two year analysis of child protection database notifications 2007-2009. Available at https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ca

d=rja&uact=8&ved=0CCIQFjAA&url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fuploads%2Fsystem%2Fuploads%2Fattachment_data%2Ffile%2F181651%2FDFE-RR040.pdf&ei=1EizVLG-D8TnapfFgPgP&usg=AFQjCNFB000twuMgrGXchHeGa8omIuwiPw&sig2=Z-tAhKe0NdQGwzk6vNH6XA&bvm=bv.83339334,d.d2s (Accessed 10.11.14)

Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C. and Megson, M. 2012. New Learning form Serious Case Reviews: A two-year report for 2009-2011. Available at https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&uact=8&ved=0CCIQFjAA&url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fuploads%2Fsystem%2Fuploads%2Fattachment_data%2Ffile%2F198919%2FDFE-RB226_Research_Brief.pdf&ei=okizVPaqMM_dapLegogJ&usg=AFQjCNGXgZb8o_BBqFtElWmubbpd3FHNtA&sig2=fBNDoiwFBapzgJ-NS2UckA&bvm=bv.83339334,d.d2s (Accessed 10.11.14)

Brausch, A. M. and Muehlenkamp, J. J. 2013. Self-Harm and Suicide. In Lester, D. and Rogers, J. R. (eds) *Suicide: A Global Issue,* Oxford: Praeger

Bressington, D. T., Wells, H. and Graham, M. 2011. A concept mapping exploration of social workers' and mental health nurses' under the role of the Approved Mental Health Professional. *Nurse Education Today*, **31**, pp.564-570

Bride, B. E. and Figley, C. R. 2007. The Fatigue of Compassionate Social Workers: An Introduction to the Special Issue on Compassion Fatigue. *Clinical Social Work Journal*, **35**(3), pp. 151-153

British Sociological Association (BSA). 2002. *Statement of ethical practice for the British Sociological Association*, Available at http://www.britsoc.co.uk/media/27107/StatementofEthicalPractice.pdf (Accessed 20.03.11)

Broadhurst, K., Hall, C., Wastell., D., White, S. and Pithouse, A. 2010. Risk, Instrumentalism and the Humane Project in Social Work: Identifying the Informal Logics of Risk Mangement in Children's Statutory Services. *British Journal of Social Work*, **40**(4), pp 1046-1064

Brown, B. 2000. Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. *Health and Social Care in the Community*, **8**(6), pp. 425-435

Brown, R. 2013. *The approved mental health professionals guide to mental health law.* London: Sage/ Learning Matters

Brown, R. 2008. Changes in mental health law, *The Journal of Mental Health Training*, **3**(4), pp. 4-10

Bruce, H. and Evans, N. 2008. The transition into adult care. *Psychiatry*, **7**(9), pp. 399-402

Bryman, A. 2007. Barriers to integrating quantitative and qualitative research. *Journal of Mixed Methods Research*, **1**(1), pp. 8-22

Bryman, A. and Cramer, D. 2011. *Quantitative data analysis with IBM SPSS Statistics 17, 18 and 19: A guide for social scientists*. Hove: Psychology Press.

Buckley, P. F. 2006. Prevalence and consequences of the dual diagnosis substance abuse and severe mental illness. *The Journal of Clinical Psychiatry*, **67**(7)

Burgess, P., Pirikis, J., Morton, J. and Croke, E. 2000. Lesson from a comprehensive audit of psychiatric service users who committed suicide. *Psychiatry Online*, **51**(12), pp. 1555-1560

Burgess, R.G. 1984. *In the field.* London: Alan and Unwin

Burke, C. and Cooper A. 2007. Dialogues and developments in social work practice: Applying a systematic and psychoanalytic ideas in real world contexts. *Journal of Social Work Practice*, **21**(2), pp. 193-196

Burnham, L. 2001. Welfare reform, family hardship and women of color. *The annals of the American Academy of Political and Social Science*, **577**(1), pp. 38-48

Burns, T. 2004. Community Mental Health Teams. *Psychiatry*, **3**(1), pp. 11-14

Burns, T., Catty, J., Becker, T., Dash, M. Roberts, C Marshall, M. 2007. Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *British Medical Journal*, 335:336

Burns, T., Catty, J., Becker, T., Drake., R. E., Fioritte, A., Knapp, M., Lauber, C., Rossler, W., Tomov, T., van Busschbach, J., White, S. and Wiersma, D. 2007. The

effectiveness of supported employment for people with severe mental illness: a randomised controlled trial. *The Lancet*, **370**(9593), pp. 1146-1152

Bury, M. and Monaghan, L. F. 2013. Chronic Illness. In Gabe, J. and Monaghan L. F. (eds) *Key Concepts in Medical Sociology.* London: Sage

Butler, A. M. and Malone, K. 2013. Attempted suivide v. non-suicidal self-injury: behaviour, syndrome or diagnosis? *The British Journal of Psychiatry: The Journal of Mental Science,* 202, pp.324-325

Butler, I. 2002. A code of ethnic for social work and social care research. *British Journal of Social Work*, **32**(2), pp. 239-248

Bywaters, P. 1986. Social Work and the Medical Profession – Arguments Against Unconditional Collaboration. *British Journal of Social Work*, **16**(6), pp. 661-667

C

Canetto, S. S. 1995. Men who survive a suicidal act: successful coping or failed masculinity? In Sabo, D. and Gordon, D.F. (eds.). *Men's Health and Illness: Gender, Power and the Body*. Thousand Oaks, CA: Sage, pp. 292-304

Canetto, S. S. and Sakinofsky, I. 1998. The gender paradox in suicide. *Suicide and Life-Threatening Behaviour,* **28**(1), pp. 1-23

Cantor, C. H. 2000. Suicide in the Western World. In: Hawton, K. and Heeringen, K.v. (eds.). *The international handbook of suicide and attempted suicide*. Chichester: Wiley, pp. 9-28

Care Council for Wales. 2001. *Code of Practice for Social Care Workers*. Available at http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CC0QFjAA&url=http%3A%2F%2Fwww.ccwales.org.uk%2Fedrms%2F70186%2F&ei=QlovU7vjJ4mqhAe7ooDICg&usg=AFQjCNHRtyR9GYIPYhhtz6IyfBOfxknfiA&bvm=bv.62922401,d.ZG4 (Accessed 23.03.14)

Care Council for Wales. 2012. *Social Work Degree*. Available at http://www.ccwales.org.uk/social-work-degree/ (Accessed 07.12.14)

Catty, J and Burns, T. 2001. Mental health day centres: Their clients and role. *The Psychiatric Bulletin*, **25**, pp. 61-66

Catty, J., Burns, T., Knapp, M., Watt, H., Wright, C., Henderson, J. and Healey, A. 2002. Home treatment for mental health problems: a systematic review. *Psychological Medicine*, **32**(3), pp. 383-401

Catty, J., Goddard, K. and Burns. T. 2005. Social Services Day Care and Health Services Day Care in Mental Health: Do they Differ? *International Journal of Social Psychiatry*, **51**(2), pp. 151-161

Carpenter, J., Schneider, J., Brandon T., and Wooff, D. 2003. Working in Multidisciplinary Community Mental Health Teams: The Impact o Social Workers and Health Professionals Of Integrated Mental Health Care. *British Journal of Social Work*, **33**(8), pp. 1081-1103

Cavanagh, J. T. O., Carson, A. J., Sharpe, M. and Lawrie, S. M. 2003. Psychological autopsy studies of suicide: a systematic review. *Psychological Medicine*, **33**(3), pp. 395-405

Center, C., Davis, M., Detre, T., Ford, D. E., Hansbrough, W., Hendin, H., Laszlo, J., Litts, D. A., Mann, J., Mansky, P. A., Michels, R., Miles, S. H., Proujansky, R., Reynolds, C. F. and Silverman, M. M. 2003. Confronting depression and suicide in physicians: A consensus statement. *Journal of the American Medical Association*, **289**(23), pp. 3161-3166

Chakraborty, A., McManus, S., Brugha, T. and Bebbington, P. 2011. Mental health of the non-heterosexual population of England. *The British Journal of Psychiatry*, **198**(3), pp. 143-148

Chamberlin, J. and Jenkinson, A. 2014. *Defining both social work and the role of social workers in adult social care in England*. Available at http://www.tcsw.org.uk/uploadedFiles/TheCollege/_CollegeLibrary/Policy/Business_case/KingstonMainReportBusinessCase.pdf (Accessed 05.12.14)

Charmaz, K. 2004. Premises, principles, and practices in qualitative research: Revisiting the foundations. *Qualitative Health Research*, ***14***, pp. 976-993.

Chew-Graham, C., Slade, M., Montana, C., Stewart, M. and Gask, L. 2007. A qualitative study of referral to community mental health teams in the UK: exploring the rhetoric and the reality. *BMC Health Services Research*, **7**:117

Chowdhury, N. L., Hicks, R.G. and Kreitman, N. 1973. Evaluation of an aftercare service for parasuicide (attempted suicide) patients. *Social psychiatry*, **8**, pp. 67-81

Cipriani, A., Pretty, H. Hawton, K. and Geddes, J. R. 2005. Lithium in the prevention of suicidal behaviour and all-cause mortality in patients with mood disorders: a systematic review of randomized trials. *American Journal of Psychiatry*, **162**(10), pp. 1805-1819

Clarke, L. and Whittaker, M. 1998. Self-mutilation: culture, context and nursing responses. *Journal of Clinical Nursing,* **7**(2), pp. 129-137

Clarke, R. V. and Lester, D. 1989. *Suicide: Closing the exits*. New York: Springer: Verlag.

Coffey, A. and Atkinson, P. 1996. *Making sense of qualitative data: Complemantory Strategies*. London: Sage

Coffey M., Dugdill L., and Tattersall A. 2009. Designing a Stress Management Intervention in Social Services. *International Journal of Workplace Health Management,* 2(2), pp 98-114

Coid, J., Kahtan, N., Gault, S., Cook, A. and Jarman, B. 2001. Medium secure forensic psychiatry services: Comparison of seven English health regions. *The British Journal of Psychiatry*, **178**(1), pp. 55-61

College of Social Work. 2012. *Reforming social work qualifying education – The social work degree*. Available at http://www.tcsw.org.uk/uploadedFiles/TheCollege/_CollegeLibrary/Reform_resources/ReformingSWQualifyingEducation(edref1)(1).pdf (Accessed 07.12.14)

College of Social Work. 2014. *The business case for the Approved Mental Health Professional (AMHP) lead role: A discussion paper*. Available at http://www.tcsw.org.uk/uploadedFiles/TheCollege/_CollegeLibrary/Policy/Business_case/AMHPBusinessCase.pdf (Accessed 09.12.14)

Collins, S. 2008. Statutory Social Workers: Stress, Job Satisfaction, Coping, Social Support and Individual Differences. *British Journal of Social Work*, **38**(6), pp. 1173-1193

Connolly, M. 2006. Up Front and Personal: Confronting Dynamics in the Family Group Conference. *Family Process*, **45**(3), pp. 345-357

Coulshed, V. and Orme, J. 2012. *Social Work Practice*. London: Palgrave MacMillan

Cook, J. A. and Jonikas, J. A. 2002. Self-determination among mental health consumers/survivors: using lesson from the past to guide the future. *Journal of Disability Policy Studies*, **13**(2), pp. 88-96

Cooper, J., Kapur, N., Webb, R., Lawlor, M., Guthrie, E., Mackway-Jones, K. and Appleby, L. 2005. Suicide After Deliberate Self-Harm: A 4-Year Cohort Study. *American Journal of Psychiatry*, **162**(2), pp.297-303

Couch, W. and Wright, J. 2004. Deliberate self-harm at an adolescent unit: A qualitative Investigation. *Clinical Child Psychology and Psychiatry*, **9**(2), pp. 185-204

Coyle, D., Edwards, D., Hannigan, B., Fothergill, A. and Burnard, P. 2005. A systematic review of stress among mental health social workers. *International Social Work*, **46**(2), pp. 201-211

Craig, Y. 1977. The bereavement of parent and their search for meaning. *British Journal of Social Work*, **7**(1), pp. 41-54

Creswell, J. W. and Plano Clark, V. L. 2007. *Designing and conducting mixed methods research*. London: Sage

Crisp, B. R., Anderson, M. A., Orme, J. and Lister, P. G. 2007. Assessment Frameworks: A Critical Reflection. *British Journal of Social Work*. **37**(6), pp. 1059-1077

Csikai, E. L. 1999. Euthanasia and assisted suicide: issues for social work practice. *Journal of Gerontological Social Work*, **31**(3/4), pp. 49-63

Curtis, L., Moriarty, J. and Netten A. 2010. The expected working life of a social worker. *British Journal of Social Work*. **40**(5), pp. 1628-1643

Curtis, L., Moriarty, J. and Netten A. 2012. The costs of qualifying a social worker. *British Journal of Social Work*. **42**(4), pp. 706-724

Cvinar, J. G. 2005. Do suicide survivors suffer social stigma: A review of the literature. *Perspective in psychiatric care*, **41**(1), pp. 14-21

D

Dahlberg, L., Demack, S. and Bambra, C. 2007. Age and gender of informal carers: a population-based study in the UK. *Health and Social Care in the community*, **162**(5), pp. 439-445

Dale, A., Arber, S., and Proctor, M. 1998. *Doing Secondary Analysis*. London, Allen and Unwin

Das, J., Quy-Toan, D., Friedman, J., McKenzie, D. and Scott, K. 2007. Mental health and poverty in developing countries: Revisiting the relationship. *Social science & Medicine*, **65**(3), pp. 467-480

Daube, D. 1977. The linguistics of suicide. *Suicide and Life Threatening Behavior,* **7**(3) pp.132-182

D'Cruz, H. and Jones, M. 2004. *Social Work Research: Ethical and Political Contexts*. London: Sage

Decker, S. and van Winkle, B. 1996. *Life in the Gang*: *Family, Friends and Violence*. Cambridge: Cambridge University Press

Denzin, N. K. 1978. *The research art: A theoretical introduction to sociological methods*, New York: McGraw-Hill

Denzin, N. K and Lincoln, Y. S. 2000. (eds). *The handbook of qualitative research (second edition)*. London: Sage

Denzin, N. K. and Lincoln, Y. S. 2011. (eds). *The SAGE handbook of qualitative research*. London: Sage

Denzin, N. K. and Lincoln, Y. S. 2013. *Strategies of Qualitative Inquiry*. London: Sage

Department of Health. 2012. *Preventing suicide in England – A cross-governmental outcomes strategy to save lives*, London: Department of Health

Department of Health, Social Service and Public Safety. 2012. *The Northern Ireland Suicide Prevention Strategy 2012*. Available at http://www.dhsspsni.gov.uk/suicide-prevention (Accessed 20.11.13)

Department for Transport. 2012. *Reported road casualties Great Britain: main results 2011*. Available at https://www.gov.uk/government/publications/reported-road-casualties-great-britain-main-results-2011 (Accessed 20.11.13)

Deykin, E. Y., Hsieh, C. C., Joshi, N. and McNamarra, J. J. 1986. Adolescent suicidal self-destructive behaviour: results of an intervention study. *Journal of Adolescent Health Care*, **7**, pp. 88-95

Dingwall, R. 2008. The ethical case against ethnical regulation in humanities and social science research. *Twenty-First Century Society: Journal of the Academy of Social Sciences*, **3**(1), pp. 1-12

Dodsworth, J. 2012. Pathways through sex work: Childhood experiences and adult identities. *British Journal of Social Work*, **42**(3), pp. 519-536

Dolgoff, R., Harrington, D. and Loewenberg, F. M. 2011. *Brooks/Cole Empowerment Series: Ethical Decisions for Social Work Practice (Ethics and Legal Issues)*. London: Wadsworth Publishing

Douglas, J. D. 1967. *The social meaning of suicide*. Princeton: Princeton University Press

Dransart, D. A. C. 2013. From sense-making to meaning-making: understanding and supporting survivors of suicide. *British Journal of Social Work*, **43**(2), pp. 317-335

Droogas, A., Siiter, R. and O'Connell, A. N. 1982. Effects of Personal and Situational Factors on Attitudes Towards Suicide. *Journal of Death and Dying*, **13**(2), pp. 127-144

Durkheim, E. 2002 (original 1897). *Suicide,* London: Routledge

Dyregrov, K. and Dyregrov, A. 2008. *Effective grief and bereavement support: The role of family, friends, colleagues, schools and support professionals*. London: Jessica Kingsley Publishers

E

Economic and Social Data Service (ESDS). 2010. *SN 6379 – Adult Psychiatric Morbidity Survey.* Available at http://www.ic.nhs.uk/pubs/psychiatricmorbidity07 (Accessed: 06.06.11)

Edwards, D., Burnard, P., Coyle, D., Fothergill, A. and Hannigan, B. 2000. Stress and burnout in community mental health nursing: a review of the literature. *Journal of Psychiatric Mental Nursing*, **7**, pp. 7-14

Edwards, S. and Harries, M. 2007. No-suicide contracts and no-suicide agreements: a controversial life. *Australian Psychiatry*, **15**(6), pp.484-489

Engel, G. L. 1977. The need for a new medical model: a challenge from biomedicine. *Science*, **196**(4286), pp. 129-136

Ellis, K. 2014. Professional Discretion and Adult Social Work: Exploring Its Nature and Scope on the Front Line of Personalisation. *British Journal of Social Workers*, **44**(8), pp. 2272-2289

Emmel, N. 2013. *Sampling and Choosing Cases in Qualitative Research: A Realist Approach*. London: SAGE

Eraut, M. 2000. Non-formal learning, implicit learning and tacit knowledge in professional work. In Coffield, F. (ed) *The necessity of informal learning*. Bristol: The Policy Press

Etzersdorfer, E. and Sonneck, G. 1998. Preventing suicide by influencing mass-media reporting. The Viennese experience 1980-1996. *Archives of suicide research*, **4**(1), 67-74

Evans, R. and Price, S. 2013. Exploring Organisational Influences on the Implementation of Gatekeeper Training: A Qualitative Study of the Applies Suicide Intervention Skills Training (ASIST) Program in Wales. *Critical Public Health*, **23**(2), pp. 213-224

Evans, R., Scourfield, J. and Moore, G. 2012. Gender, relationship breakdown and suicide risk: A systematic review of research in western countries. In Wyllie, C., Platt, S., Brownlie, J., Chandler, A., Connolly, S., Evans, R., Brendan, K., Kirtley, O., Moore, G., O'Connor, R., and Scourfield, J. (eds). *Men, Suicide and Society: Why disadvantaged men in mid-life die by suicide*. Surrey: Samaritans, pp. 36-55

Evans, S., Huxley, P., Baker, C., White, J., Madge, S., Onyett, S. and Gould, N. 2012. The social care component of multidisciplinary mental health teams; a review and national survey. *Journal of Health Services Research and Policy*, **17**(2), pp. 23-29

Evans, S., Huxley, P., Gately, C. Webber, M., Mears, A., Pajak, S., Medina, J., Kendall, T. and Katona, C. 2006. Mental health, burnout and job satisfaction among mental health social workers in England and Wales. *British Journal of Psychiatry*, **188**(1), pp. 75-80

Evans, T. 2010. *Professional Discretion in Welfare Services: Beyond Street-Level Bureaucracy.* Aldershot: Ashgate.

Evans, T. and Harris, J. 2004. Street-Level Bureaucracy, Social Work and the (Exaggerated) Death of Discretion. *British Journal of Social Work*, **34**(6), pp. 871-895

Evetts, J. 2003. The construction of professionalism in new and existing occupational contexts: promoting and facilitating occupational change. *International Journal of Sociology and Social Policy*, **23**(4/5), pp. 22-35

F

Feldman, B. N., and Freedenthal, S. 2006. Social work education in suicide intervention and prevention: An unmet need? *Suicide and Life-Threatening Behavior*, **36**(4), pp. 467–480

Fereday, J. and Muir-Chochrane, E. 2006. Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding Theme Development. *International Journal of Qualitative Methods*, **5**(1), pp. 1-11

Ferguson, H. 2005. Trust, Risk and Expert Systems: The Case of Child Protection. In Moran, A. and Watson, S. (eds) *Trust, Risk and Uncertainty*. Palgrave Macmillan.

Field, A. 2009. *Discovering statistics using SPSS (third edition)*. London: Sage

Field, S. and Bramwell, R.1998. An investigation into the relationship between caring responsibilities and the levels of perceived pressure reported by female employees. *Journal of Occupational Organizational Psychology*, **71**(2), pp. 165-170

Fincham, B., Scourfield, J and Langer, S. 2008. The impact of working with disturbing secondary data: reading suicide files in a coroner's office. *Qualitative Health Research*, **18**(6), pp. 853-862

Finlay, L. 2002. Negotiating the swamp: the opportunity and challenge for reflexivity in research practice, *Qualitative Research*, **2**(2), pp. 209-230

Firestone, W. A. 1987. Meaning in method: The rhetoric of quantitative and qualitative research. *Educational Researcher*, **16**(7), pp. 16-21

Fish, D. and Coles, C. 1998. Professionalism eroded: professionals under siege. In Fish, D. and Coles, C. (eds). *Developing professional judgement in health care: learning through the critical appreciation of practice*. Oxford: Butterworth-Heinemann

Fliege, H., Lee, J., Grimm, A. and Klapp, B. F. 2009. Risk factors and correlates of deliberate self-harm behaviour: A systematic review. *Journal of Psychosomatic Research*, **66**(6), pp. 477-493

Ford, E., Clark, C. McManus, S. Harris, J., Jenkins, R., Bebbington, P., Brugha, T. Meltzer, H and Stansfeld, S. A. 2010. Common mental disorders, unemployment and welfare benefits in England. *Public Health*, **124**(12), pp. 675-681

Fossey, E., Harvey, C., McDermott, F. and Davidson, L. 2002. Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry*, **36**, pp.717-732.

Foster, T., Gellespie, K. and McClelland. 1997. Mental disorder and suicide in Northern Ireland, *The British Journal of Psychiatry*, **170**(5), pp. 447-452

Foucault, M. 1979. *Discipline and Punish: The Birth of the Prison*. London: Penguin Books

Fournier, V. 2000. Boundary work and the (un)making of the professions. In Malin, N. (ed) *Professionalism, boundaries and the workplace***,** London: Routledge

Freud, S. 2012 (original 1920). *Beyond Pleasure and Principles*, Washington: Pacific Publishing Studios

Freidson, E. (2001) *Professionalism: The Third Logic.* London: Polity Press

Fuller, D. 2004. Going Native. In Lewis-Beck, M. S., Bryman, A. and Liao T. F. (eds) *The SAGE Encyclopaedia of Social Science Research Methods*. London: SAGE

Fowler, D., Hodgekins, J., Howells, L., Millward, M., Ivins, A., Taylor, G., Hackmann, C., Hil, K., Bishop, N. and Macmillan, I. 2009. Can targeted early intervention improve functional recovery in psychosis?, *Early Intervention in Psychiatry*, **3**(4), pp. 282–288

G

Galpin, D. 2009. Who really drives the development of post-qualifying social work education and what are the implications of this? *Social Work Education*, **28**(1), pp. 65-80

Galpin, D. and Bates, N. 2009. *Social work practice with adults*. Exeter: Learning Matters Limited

Gerdes, K. E. and Segal, E. A. 2009. A Social Work Model of Empathy. *Advances in Social Work*, **10**(2), 114-127

Ghaffar, W., Manby, M. and Race, T. 2012. Exploring the Experiences of Parents and Carers whose Children Have Been Subject to Child Protection Plans. *British Journal of Social Work*, **42**(5), pp. 887-905

Gibbons, J. S., Butler, J., Urwin, P. and Gibbon, J. L. 1978. Evaluation of social work service for self-poisoning patients. *British Journal of Psychiatry,* **133**, pp. 111-118

Gibson, M. 2014. Social Worker Shame: A Scoping Review. *British Journal of Social Work*, Advanced Access. Available at http://bjsw.oxfordjournals.org/content/early/2014/11/28/bjsw.bcu140.full (Accessed on 20.12.14)

Giddens, A. 1966. A typology of suicide. *European Journal of Sociology*, **7**(2), pp. 276-295

Giddens, A. 1979. *Central problems in social theory: Action, structure, and contradiction in social analysis*. Berkley CA: University of California

Giddens, A. 1984. *The Constitution of Society.* Cambridge: Polity Press

Giddens, A. 1990. *The Consequences of Modernity*. Cambridge: Polity Press

Giddens, A. 1994. *Beyond Left and Right: The Future of Radical Politics*. Cambridge: Polity Press

Gilburt, H., Rose, D. and Slade, M. 2008. The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research*, **8**:92

Gillingham, P. 2013. The Development of Electronic Information Systems for the Future: Practitioners, 'Embodied Structures' and 'Technologies-in-Practice'. *British Journal of Social Work*, **43**(3), pp. 430-445

Gillingham, P. 2011. Computer based information systems and human service organizations: Emerging problems and future possibilities*. Australian Social Work;* **64**(3), pp. 299-312

Glasby, J and Lester, H. 2005. On the inside: a narrative review of mental health inpatient services. *British Journal of Social Work*, **35**(6), pp. 863-879

Glaser, B. G. and Strauss, A. L. 1968. *Time for dying*. Chicago: Aldine Publishing Company

Glaser, B. G. and Strauss, A. L. 1964. *Awareness of dying*. Chicago: Aldine Publishing Company

Glover, G., Arts, G. And Babu, K.B. 2006. Crisis resolution/ home treatment teams and psychiatric admission rates in England. *British Journal of Psychiatry,* **189**, pp. 441-445

Goddard, M. and Smith, P. 2001. Equity of access to health care services: theory and evidence from the UK. *Social Science and Medicine*, **53**(12), pp. 1149-1162

Goldney, R. D. 2000. Prediction of Suicide and Attempted Suicide. In: Hawton, K. and Heeringen, K.v. (eds). *The international handbook of suicide and attempted suicide*. Chichester: Wiley, pp. 585-595

Goldney, R. D. and Bottrill, A. 1980. Attitudes to patients who attempt suicide. *Medical Journal Australia*, **2**(13), pp717-720

Goldstein, R. B., Black, D. W., Nasrallah, A. and Winokur, G. 1991. The prediction of suicide. *Archives of General Psychiatry*. **48**(5), pp. 418-422

Golightly, M. 2008. *Social work and mental health (third edition)*. Exeter: Learning Matters

Gomm, R., Hammersley, M. and Foster, P. 2000. Case study and generalization. In Gomm, R., Hammersley, M. and Fosterm P. (eds). *Case study method*. London: Sage.

Grant, L and Kinman, G. 2012. Enhancing Wellbeing in Social Work Students: Building Resilience in the Next Generation. *Social Work Education The International Journal*, **31**(5), 605-621

Granvold, D. K. 2000. The crisis of divorce: Cognitive-behavioural and constructivist assessment and treatment. In Roberts, A. R. (ed) *Crisis intervention handbook: Assessment, treatment and research* (2nd Edition). Oxford: Oxford University Press

Gray, M. 2010. Moral sources and emergent ethical theories in social work. *British Journal of Social Work*, **40**(6), pp. 1794-1811

Gray, R. 2012. Physical health and mental illness: a silent scandal. *International Journal of Mental Health Nursing*, **21**(3), pp.191-192

Green, R., Gregory, R. and Mason, R. 2006. Professional Distance and Social Work: Stretching the Elastic? *Australian Social Work*, **59**(4), pp. 449-461

Grzybowska, P. and Finlay, I. 1997. The incidence of suicide in palliative care patients. *Palliative Medicine*, **11**(4), pp. 313-6

Guba, E. G. 1981. Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology Journal*, **29**, pp.75-91

Guest, G. 2012. *Applied Thematic Analysis*, London: SAGE

H

Hammersley, M. (1996). The relationship between qualitative and quantitative research; Paradigm loyalty versus methodological eclecticism. In Richardson, J. T. E. (ed), *Handbook of Research Methods for Psychology and the Social Sciences*. Leicester: BPS Books

Hammersley, M. and Atkinson, P. 2003. *Ethnography: Principles in practice (second edition)*. London: Routledge

Hannigan, B. 2014. 'There's a lot of tasks that can be done by any': findings from an ethnographic study into work and organisation in UK community crisis resolution and services. *Health: an Interdisciplinary Journal for the Social Study of Health, Illness and Medicine,* **18**(4), pp. 406-421

Hannigan, B. 1999. Joint working in community mental health: prospects and challenges. *Health and Social Care in the Community*, **7**(1), pp. 25-31

Harrington, R., Kerfoot, M., Dyer., McNiven, F., Gill, J., Harrington, V., Woodham, A. and Byford, S. 1998. Randomized trial of home-based family intervention for children who have deliberately poisoned themselves. *Journal of the American Academy of Child and Adolescent Psychiatry*, **37**(5), pp. 517-517

Harris, J. 2008. State Social Work: Constructing the Present from Moments in the Past. *British Journal of Social Work*, 38(4), pp. 662-679

Harris, N. 1987. Defensive Social Work. *British Journal of Social Work*, **17**(1), pp. 61-69

Hatfield, B. 2008. Powers to detain under mental health legislation in England and the role of the Approved Social Worker: An analysis of patterns and trends under the 1983 Mental Health Act in six local authorities. *British Journal of Social Work,* **38**, pp. 15553-1571

Hartman, A. 1992. In search of subjugated knowledge, *Social Work*, **37**, pp. 483–4.

Hassiotis, A., Tanzarella, M., Bebbington, P. and Cooper, C. 2011. Prevalence and predictors of suicidal behaviour in a small sample of adults with estimated borderline intellectual functioning: Results from a population survey. *Journal of Affective Disorders*, **129**(1-3), pp. 380-384

Hawton, K. 2001. Effects of legislation restricting pack sizes of paracetamol and salicylate on self-poisoning in the United Kingdom: before and after study, *British Medical Journal*. **322**(1203)

Hawton, K., Bancroft, J. H. J., Catalan, J., Stedeford, A. and Welch, N. 1981. Domicilary and outpatients treatment of self-poisoning patients by medical and non-medical staff. *Psychological Medicine*, **11**, pp169-177

Hawton, K., Daniel, Z. and Weatherall, R. 2003. Suicide following deliberate self-harm: long-term follow-up of patients who presented at a general hospital. *The British Journal of Psychiatry*, **182**(6), pp.537-542

Hawton, K., Houston, K. and Shepperd, R. 1999, Suicide in young people: a study of 174 cases, aged under 25 years based on coroners' and medical records, **175**(1), pp. 1-6

Hawton, K. and van Heeringen, K (eds.). 2000. *The international handbook of suicide and attempted suicide*, Chichester: Wiley

Hayes, D. 2005. Social work with asylum seekers and others subject to immigration controls. In Adams, R., Dominelli, L and Payne, M. (eds.). *Social work futures: crossing boundaries, making connections*. London, Palgrave Macmillan, pp.182-194

Hayward, R. M. and Tuckey, M. R. 2011. Emotion in uniform. How nurses regulate emotion at work via emotional boundaries. *Human Relations*, **64**(11), pp. 1501-1523

Health and Care Professions Council (HCPC). 2013. *Approved mental health professional (AMHP programmes*. Available at http://www.hpc-uk.org/education/providers/postregistration/ (Accessed 11.12.13)

Healy, K. 2014. Social Work Theories in Context: Creating Frameworks for Practice. London: Palgrave

Healy, L. M. and Meagher, G. 2004. The reprofessionalization of social work: Collaborative approaches to achieving professional recognition. *British Journal of Social Work*, **34**(2), pp. 243-260

Hedgecoe, A. 2008. Research ethics review and sociological research relationship. *Sociology*, **42**(5), pp. 873-886

Hedgecoe, A. 2012. Trust and regulatory organizations: the Role of Local Knowledge and Facework in Research Ethics Review. *Social Studies of Science*, **42**(5), pp. 662-683

Heidegger, M. 1996 (originally 1962). Being and Time. London: Harper and Row

Herron, J., Ticehurst, H., Appleby, L., Perry, A. and Cordingley, L. 2001. Attitudes toward suicide prevention in front-line health staff. *Suicide and Life-Threatening Behaviour*, **31**(3), pp. 342-347

Hertz, R. 1997. *Reflexivity and Voice*. London: Sage

Hill, K. 1995. *The long sleep – young people and suicide*. London :Virago Press Limited

Hjelmeland, H. and Knizek B. L. 2010. Why we need qualitative research in suicidology, *Suicide and Life-Threatening Behavior*, **40**(1), pp. 74-80

Hjelmeland, H. and Knizek B. L. 2011. What kind of research do we need in suicidology today? In O'Connor, R., Platt, S. and Gordon, J. (eds.). *International Handbook of Suicide Prevention: Research, Policy and Practice,* Chichester: Wiley-Blackwell, pp. 591-608

Holdaway, S. 1982. The police – an issue of trust. *Audenshaw Papers*, **85** (July), pp. 1-3

Hollway, W. and Jefferson, T. 2000. *Doing qualitative research differently: free association, narrative and the interview method*. London: Sage

Homan, R. 1991. *The Ethics of Social Research.* Longman: London.

Horlick-Jones, T. 2005. Informal logics of risk: Contingency and modes of practical reasoning. *Journal of Risk Research*, **8**(3), pp.253-272

Hothersall, S and Maas-Lowit, M. 2010. Need, risk and protection in social work practice. Exeter: Learning Matters.

Hoult, J. 1986. Community care of the acutely mentally ill. *The British Journal of Psychiatry*, 149, pp. 137-144

Housley, W. 2003. *Interaction in Multidisciplinary Teams*. Aldershot: Ashgate

Howe, D. 1991. Knowledge, power, and the shape of social work practice. In Davies, M. (ed) *The Sociology of Social Work*. London: Routledge.

Hugman, R. 1998. *Social Welfare and Social Value*. Basingstoke: Macmillan

Humphries, B. 2004. An unacceptable role for social work: Implementing immigration policy. *British Journal of Social Work*, **34**(1), pp. 93-107

Hunt, I. M., Kapur, N., Robinson, J., Shaw, J., Flynn, S., Bailey, H., Meehan, J., Bickley, H., Burns, J., Amos, T. and Appleby, L. 2006. Suicide within 12 months of mental health service contact in different age and diagnostic groups. *British Journal of Psychiatry*, **188**, pp. 135-142

Hutchinson, S. A., Wilson, M. E. and Wilson, H. S. 1994. Benefits of participating in research interviews. *Journal of nursing scholarship*, **26**(2), pp.161-166

Huxley, P., Ball, W. and Mayo, R. 2009a. Social care research priorities and capacity in Wales: A Consultation Exercise. Swansea: Centre for Social Work and Social Care Research

Huxley, P., Evans, S., Beresford, P., Davidson, B. and King, S. 2009b. The principles and provisions of relationships: Findings from an evaluation of support, time and recovery workers in mental health services in England, *Journal of Social Work*, **9**(1), pp. 99–117.

Huxley, P., Evans, S., Gately, C., Webber, M., Mears, A., Pajak, S., Kendall, T., Medina, J. and Katona, C. 2005. Stress and Pressures in Mental Health Social Work: The Worker Speaks. *British Journal of Social Work*, **35**(7), pp. 1063-1079

I

Isacsson, G., Bergman, U. and Rich, C. L. 1996. Epidemiological data suggest antidepressants reduce suicide risk among depressives. *Journal of Affective Disorders*, **41**, pp.1-8

J

Jacobson, J. M., Osteen, P. J., Sharpe, T. L. and Pastoor, J. B. 2012. Randomized Trial of Suicide Gatekeeper Training for Social Worker Students. *Research on Social Work Practice*, **22**(3), pp. 270-281

Jacobson, J., Ting, L., Sanders, S., Harrington, D. 2004. Prevalence and reactions to fatal and nonfatal client suicidal behaviour: A national study of mental health social workers. *Omega*, **49**(3), pp. 237-248

Jenkins, R. and Singh, B. 2000. General Population Strategies of Suicide Prevention. In Hawton, K. and Heeringen, K.v. (eds). *The international handbook of suicide and attempted suicide*. Chichester: Wiley, pp. 597-616

Joe, S. and Neidermeier, D. 2008. Preventing Suicide: A Neglected Social Work Research Agenda. *British Journal of Social Work* **38**(3), pp. 507-530

Joiner, T. E. 2010. *Myths about suicide*. Harvard: Harvard College Press

K

Kapur, N., Cooper, J., O'Connor, R. C. and Hawton, K. 2013. Non-suicidal self-injury v. attempted suicide: new diagnosis or false dichotomy? *British Journal of Psychiatry*, **202**, pp. 326-328

Kelly, S. and Bunting, J. 1998. Trends in suicide in England and Wales, 1982-96. *Population Trends*, **92**, pp. 29-41

Kemshall, H., Parton, N., Walsh, M. and Waterson, J., 1997. Concepts of risk in relation to organisational structure and functioning within the personal social services and probation. *Social Policy Administration*, **31**(3), pp. 213-232

Kendrick, T., Burns, T. Garland, C., Greenwood, N. and Smith, P. 2000. Are specialist mental health services being targeted on the most needy patients? The effects of setting up special services in general practice. *The Pritish Journal of General Practice,* **50**(451), pp. 121-126

Kerkhof, J. F. M., 2000. Attempted Suicide: Patterns and Trends. In: Hawton, K. and Heeringen, K.v. (eds). *The international handbook of suicide and attempted suicide*. Chichester: Wiley, pp. 49-77

King, C. 2001. Severe mental illness: Managing the boundary of a CMHT. *Journal of Mental Health*, **10**(1), pp. 75-86

King, N. and Horrocks, C. 2010. *Interviews in Qualitative Research*. London: Sage

Kinman, G. and Grant, L. 2011. Exploring Stress Resilience in Trainee Social Workers: The Role of Emotional Social Competencies. *British Journal of Social Work*, **41**(2), pp. 261-275

Klonsky, D. E., May, A. M. and Glenn, C. R. 2013. The relationship between nonsuicidalself-injury and attempted suicide: Converging evidence from four samples. *Journal of Abnormal Psychology*, **122**(1), pp.231-237

Kondrat, D. and Teater, B. 2009. An anti-stigma approach to working with persons with severe mental disability, *Journal of Social Work Practice*, **23**(1), pp. 35–47.

Kposowa, A. J. 2000. Marital status and suicide in the National Longitudinal Mortality Study. *Journal of Epidemiological Community Health*, **54**(4), pp254-61

Kvale, S. and Brinkmann, S. 2008. *InterViews: Learning the craft of qualitative research interviewing (second edition)*. London: Sage

L

Labovitz, S. and Hagedorn, R. 1971. An analysis of suicide rates among occupational categories. *Sociological Inquiry*, **41**(1), pp. 67-72

Laming, W. H. 2009. *The Protection of Children in England: A Progress Report*. London: HMSO

Lash S. 2002. *Critique as Information.* London: Sage

Lawrence-Jones, J. 2010. Dual Diagnosis (Drug/Alcohol and Mental Health): Service User Experiences. *Practice: Social Work in Action*, **22**(2), pp.115-131

Leigh, J. T. 2014. The process of professionalisation: Exploring the identities of child protection social workers. *Journal of Social Work*, **14**(6), pp.625-644

Lewis, J. and Glennerster, H. 1996. *Implementing the New Community Care*. Buckingham: Open University

Lewis, G. and Sloggett, A. 1998. Suicide, deprivation and unemployment: record linkage study. *British Medical Journal*, **317**(1283)

Lincoln, Y. S. and Guba, E. G. 1985. *Naturalistic Inquiry*. London: Sage

Linsley, K. R., Schapira, K., Kelly, T.P. 2001. Open verdict v. suicide – importance to research, *The British Journal of Psychiatry*, **178**(5), pp. 465-468

Lipshitz, R. and Strauss, O. 1996. Coping with Uncertainty: A Naturalistic Decision-Making Analysis. *Organisational Behaviour and Human Decision*, **69**(2), pp.149-163

Lipsky, M. 1980. *Street-level Bureacracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation

Littlechild, B. 2013. Safety First. *Social Work Matters: Journal of the College of Social Work,* pp. 14-17

Littlechild, B. and Hawley, C. 2010. Risk assessments for mental health service users: Ethical, valid and reliable? *Journal of Social Work,* **10**(2), pp. 211-229

Lloyd, C., King, R. and Chenoweth, L. 2002. Social work, stress and burnout: A review. *Journal of Mental Health*, **11**(3), pp. 255-265

Lloyd, M. and Taylor, C. 1995. From Hollis to the Orange Book: Developing a holistic Mode of Social Work Assessment in the 1990s. *British Journal of Social Work*, **25**(6), pp. 691-710

Lowe, A. L. and Abou-Saleh, M. T. 2004. The British experience of dual diagnosis in the nation health service. *Acta Neuropsychiatrica*, **16**(1), pp. 41-46

Lymbery, M. 2001. Social Work at the Crossroads. *British Journal of Social Work*, **31**(3), pp. 369-384

M

MacDonald, E., Herman, H., Hinds, P., Crowe., J. and McDonald, P. 2002. Beyond Interdisciplinary Boundaries: Views of Consumers, Carers and Non-Government Organisations on Teamwork. *Australian Psychiatry*, **10**(2), pp. 125-129

Macdonald G. 1990. Allocating Blame in Social Work. *British Journal of Social Work*, **20**(6), pp.525-546

Macdonald, G. and Macdonald, K. 2010. Safeguarding: A Case for Intelligent Risk. *British Journal of Social Work*, **40**(4), pp1174-1191

Macdonald, K. M. 1995. *The Sociology of Professionals*. London: Sage

Mackay, K. 2011. A parting of ways? The diverging nature of mental health social work in the light of the new Act in Scotland, and in England and Wales. *Journal of Social Work*, **12**(2), pp. 179-193

Malinowski, B. 1922. *Argonauts of the Western Pacific: An account of native enterprise and adventure in Archipelagos of Melanesian New Guinea*. London: Routledge

Malone, D., Marriott, S., Newton-Howes, G., Simmonds, S and Tyrer, P. 2007. *Community mental health teams (CMHTs) for people with severe mental illness and disordered personality (review) – The Cochrane Collection*. Available at http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000270.pub2/pdf/standard (Accessed 10.11.14)

Maluccio, A. N. and Marlow, W. D. 1974. The case for the contract. *Social Work*, **19**(1), pp. 28-36

Mann, J. J. Apter, A., Bertolote, J. Beautrais, A., Currier, D., Hass, A., Hegerl, U., Lonnqvist, J., Malone, K., Marusic, A., Mahlum, L., Patton, G., Phillips, M., Rutz, W., Rihmer, Z., Schmidtke, A., Shaffer, D., Silverman, M., Takahashi, Y., Varnik, A., Wasserman, D., Yip, P. and Hendin, H. 2005. Suicide Prevention Strategies – A Systematic Review. *Journal of the American Medical Association* **284**(16), pp. 2064-2074

Mann, J. J. and Currier, D. M. 2010, Stress, genetics and epigenetic effects on the neurobiology of suicidal behaviour and depression, *European Psychiatry*, **25**(5), pp. 268-271

Maris, R., Berman, A. and Silverman, M. 2000. *Comprehensive Textbook of Suicidology,* New York: The Guilford Press.

Marshall, C. and Rossman, G. B. 1999. *Designing Qualitative Research (third edition)*. Newbury Park: Sage

Marshall, M. N. 1996. Sampling for qualitative research. *Family Practice,* **13**(6), pp. 522-525.

Marston, G. 2004. *Social Policy and Discourse Analysis.* Aldershot: Ashgate

Maxwell, N., Scourfield, J., Huxley, P. and Gould, N. 2012. UK panel data on social work service users. *British Journal of Social Work* **42**(1), pp. 165-184.

McAllister, M., Creedy, D., Moyle, W. and Farrugia, C. 2002. Nurses' attitudes towards clients who self-harm. *Journal of Advanced Nursing,* **40**(5), pp. 578-586

McCambridge, J., Waissbein, C., Forrester, D. and Strang, J. 2007. What is the extent and nature of quantitative research in British social work? *International Social Work*, **50**(2), pp. 265–71

McClellend, C.E. 1990. Escape from freedom? Reflections on German professionalization 1870-1933. In Torstendahl, R. and Burrage, M. (eds) *The Formation of Professions: Knowledge, State and Strategy*. London: Sage, pp. 97-113.

McCormick, A. J. 2011. Self-determination, the right to die, and culture: A literature review. *Social Work*, **56**(2), pp. 119-128

McHale, J. and Felton, A. 2010. Self-harm: what's the problem? A literature review of the factors affecting attitudes towards self-harm. *Journal of Psychiatric and Mental Health Nursing*, **17**(8), pp. 732-740

McGirr, A. and Turecki, G. 2011. Schizophrenia, other psychotic disorders, and suicidal behaviour. In O'Connor, R., Platt, S. and Gordon, J. (eds.). *International Handbook of Suicide Prevention: Research, Policy and Practice,* Chichester: Wiley-Blackwell, pp. 75-92

McGrath, B. and Dowling, M. 2012. Exploring registered psychiatric nurses responses towards service users with a diagnosis of borderline personality disorder. *Nursing Research and Practice*, **Vol 2012**, Article ID 601918

McKenzie, K., Bui, K., Nanchahhal, K. and Blizzard, B. 2008. Suicide rates in people of South Asian origin in England and Wales: 1993-2003. *British Journal of Social Psychiatry*, **193**(5), pp. 406-409

McLaughlin, K. 2014. Empowering the people: 'empowerment' and the British Journal of Social Work 1971-99, *Critical and Radical Social Work*, **2**(2), pp. 203-216.

McManus, S. Meltzer, Brugha, T., Bebbington, P. and Jenkins, R. 2007. *Adult psychiatric morbidity in England, 2007: Results of a household Survey*, London: Department of Health

McPherson, S. and Armstrong, D. 2009 Negotiating Depression Labels in Primary Care. *Social Science and Medicine*, **69**(8), pp. 1137-1143.

Mehlum, L., Friis, S., Vaglum, P. and Karterud, S. 2007. The longitudinal pattern of suicidal behaviour in borderline personality disorder: a prospective follow-up study. *Acta Psychiatrica Scandinavia*, **90**(2), pp. 124-130

Mehlum, L. and Mork, E. 2011. After the suicide attempt – the need for continuity and quality of care. In O'Connor, Platt, S. and Gordon, J. (eds) *International Handbook of Suicide Prevention: Research and Practice.* London: Wiley Blackwell

Miles, M. B., and Huberman, A. M. 1994. *An expanded sourcebook: Qualitative Data Analysis (Second Edition)*. London: Sage

Miller, L. L., Harvath, T. A., Ganzini, L., Goy, E. R., Delorit, M. A. and Jackson, A. 2004. Attitudes and experiences of Oregon hospice nurses and social workers regarding assisted suicide. *Palliative Medicine,* **18**(8), pp. 685-691

Mitchell, A. M., Yookyung Kim, R. N., Pigerson, H. G. and Mortimer, M. K. 2005. Complicated grief and suicidal ideation in adult survivors of suicide. *Suicide and Life-Threatening Behaviour*, **35**(5), pp. 498-506

Morgan, D. L. 2008. Snowball Sampling. In Given, L. M. (ed). *The Sage Encyclopaedia of Qualitative Research Methods*, London: SAGE

Morris, K. 2008. (eds). *Social Work and Multi-Agency Working: Making a Difference*. Bristol: The Policy Press

Motto, J. A. 1999. Critical points in the assessment and management of suicide rist. In Jacobs, D. G. (ed) *The Harvard Medical School guide to suicide assessment and intervention,* San Francisco: Jossey-Bass

Munro, E. 1996. Avoidable and unavoidable mistakes in child protection work. *British Journal of Social Work*, **26**(6), pp. 793-808

Munro, E. 2011. The Munro Review of Child Protection Part One: A systems analysis. London: Department for Education.

Murphy, D, Duggen, M and Stephen, J. 2012. Relationship-based Social Work and Its Compatibility with Person-Centred Approach: Principled versus Instrumental Perspectives. *British Journal of Social Work*, **43**(4), pp. 703-719

Murphy, E and Dingwall, R. 2007. Informed Consent, Anticipatory Regulation and Ethnographic Practice. *Social Science and Medicine*, **65**(7), pp. 2223-2234

Murphy, G. E. 2000. Psychiatric aspects of suicidal behaviour: substance abuse. In: Hawton, K. and Heeringen, K.v. (eds). *The international handbook of suicide and attempted suicide*. Chichester: Wiley, pp. 135-146

N

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCIHS). 2011. *Annual Report: England, Wales and Scotland 2011*. Available at http://www.medicine.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/annual_report_2011.pdf (Accessed 25.06.12)

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCIHS). 2013. *Annual Report England, Northern Ireland, Scotland and Wales for 2011*. Available at http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/AnnualReport2013_UK.pdf (Accessed 22.03.14)

National Institute for Health and Clinical Excellence (NICE). 2004. *Self-harm: the short-term Physical and Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary Care*. Clinical Guideline 16

Nathan, J. and Webber, M. 2010. Mental health social work and the bureau-medicalisation of mental health care: Identity in a changing world. *Journal of Social Work Practice*, **24**(1), pp. 15-28

Neeleman, J., and Wessely, S. 1999. Ethnic minority suicide: a small area geographical study in south London. *Psychological Medicine*, **29**(2), pp. 429-436

Newman, S. C., Thompson, A. H. 2003. A population-based study of the association between pathological gambling and attempted suicide. *Suicide and Life-Threatening Behaviour*, **33**(1), pp. 80-87

Nock, M. K. and Kessler, R. C. 2006. Prevalence of and risk factors for suicide attempts versus suicide gestures: Analysis of the National Comorbidity Survey. *Journal of Abnormal Psychology*, **115**(3), pp. 616-623

Norman, I. J. and Peck, E. 1999. Working together in adult community mental health services: An inter-professional dialogue. *Journal of Mental Health*, **8**, pp. 217-230.

O

Obang, D. 1997. Reviewing policies and procedures in new CMHTs. *Mental Health Review*, **2**(3), pp. 16-17

O'Brien, A., Fahmy, R., and Singh, S. P. 2008. Disengagement from mental health services. *Social Psychiatry and Psychiatric Epidemiology*, **44**(7), pp. 558-568

O'Byrne, P. 2007. The Advantages and Disadvantages of Mixing Methods: An Analysis of Combining Traditional and Autoethnographic Approaches. *Qualitative Health Research*, **17**(10), pp. 1381-1391

O'Connor, R., Platt, S. and Gordon, J. 2011. (eds.). *International Handbook of Suicide Prevention: Research, Policy and Practice,* Chichester: Wiley-Blackwell

Office for National Statistics (ONS). 2011. *Leading causes of death in England and Wales, 2009.* Available at http://www.ons.gov.uk/ons/rel/subnational-health1/leading-causes-of-death/2009/leading-causes-of-death-in-england-and-wales---2009.html (Accessed 25.06.12)

Office for National Statistics (ONS). 2012. *Statistical Bulletin: Suicide rates in the United Kingdom, 2006 to 2010*. Available at http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2010/stb-statistical-bulletin.html (Accessed 25.06.12)

Office for National Statistic (ONS) 2013. *Statistical Bulletin: Suicide rate in the United Kingdom 2011*. Available at http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2011/stb-suicide-bulletin.html (Accessed 10.11.13)

O'Hare, P. and Davidson, G. 2014. The Role of the Nearest Relative. In Matthews, S., O'Hare, P. and Hemmington, J. (eds) *Approved Mental Health Practice: Essential Themes for Students and Practitioners,* London: Palgrave MacMillan

O'Leary, P., Tsui, M. S. and Ruch, G. 2013. The boundaries of the social work relationship revisited: Towards a connected, inclusive and dynamic conceptualisation. *British Journal of Social Work*, **43**(1), pp. 135-153

Oliver, P. 2006. Purposive sampling. In Jupp, V. (ed), *The SAGE Dictionary of Social Research Methods*, London: Sage

O'Melia, M. and Miley, K. 2002. Pathways to power: Readings in contextual social work practice. Boston: Allyn and Bacon

Onyett, S. 2003. *Teamworking in mental health*. Basingstoke: Palgrave.

Onyett, S. 1998. *Case Management in Mental Health*. Cheltenham: Nelson Thornes Limited

O'Reilly, M. and Parker, N, 2013. 'Unsatisfactory Saturation': a critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research*, **13**(2), pp. 190-197.

O'Sullivan, M. Lawlor, M., Corcoran, P. and Kelleher, M. 1999. The Cost of Hospital Care in the Year Before and After Parasuicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, **20**(4), pp. 178-183

P

Palmer, S. 2008. Suicide: strategies and interventions for reduction and prevention: an introduction. In Palmer, S. (ed), *Suicide: strategies and interventions for reduction and prevention*. Hove: Routledge.

Palmer, C. S., Revicki, D., Halpern, M. and Hatziandreu, M. 1995. The cost of suicide and suicide attemptes in the United States. *Clinical Neuropharmacology*, **18**(6), pp. 25-33

Palmer, L., Blackwell, H. and Strevens, P. 2007. *Service Users' Experience of Emergency Service Following Self-harm: A National Survey of 509 patients*. London: Royal College of Psychiatrists

Paris, J. and Zweig-Frank,H. 2001. A 27-year followup of patients with borderline personality disorder. *Comprehensive Psychiatry*, **42**, pp. 482-487.

Parton, N. 2008. Changes in the form of knowledge in social work: from the 'social' to the 'informational'? *British Journal of Social Work,* **38**(2), pp. 253-269

Parton, N. 1996. Social work, risk and ‘the blaming system, in Parton, N. (eds). *Social Theory, Social Change and Social Work*, London: Routledge

Paykel, E. S., Myer, J. K., Lindenthal, J. J. and Tanner, J. 1974. Suicidal feelings in the general population: a prevalence study. *The British Journal of Psychiatry*, **124**(582), pp. 460-469.

Payne, M. 1996. *Social work: A reader*. Oxon: Routledge

Payne, M. 2001 Knowledge Bases and Knowledge Biases in Social Work. *Journal of Social Work*, **1**(2), pp. 133-136

Pease, B. 2002. Rethinking Empowerment: A Postmodern Reappraisal for Emancipatory Practice. *British Journal of Social Work*, **32**(2), pp. 135-147

Pengelly, N., Ford, B., Blenkiron, P. and Reilly, S. 2008. Harm minimisation after repeated self-harm: development of a trust handbook. *The Psychiatric Bulletin*, **32**, pp.60-63

Petrakis, M. and Joubert, L. 2013. A social work contribution to suicide prevention through assertive brief psychotherapy and Community Linkage: Use of the Manchester Short Assessment of Quality of Life. *Social Work in Health Care*, **52**(2-3), pp. 239-257

Philips, D. P., Welty, W. R. and Smith, M. M. 1997. Elevated suicide levels associated with legalized gambling. *Suicide and Life-Threatening Behaviour*, **27**(4), pp. 373-378

Pirkis, J. and Burgess, P. 1998. Suicide and recency of health care contacts. A systematic review. *The British Journal of Psychiatry*, **173**(6), pp. 462-474

Pirkis, J. and Nordentoft, M. 2011. Media influences on suicide and attempted suicide. In O’Connor, R., Platt, S. and Gordon, J. (eds.). *International Handbook of Suicide Prevention: Research, Policy and Practice,* Chichester: Wiley-Blackwell, pp. 531-544

Platt, S., Billie-Brahe, U., Kerkhof, A., Schmidtke, A., Bjerke, T., Crepet, P., De Leo, D., Harring, C., Lonnqvist, J., Michel, K., Philippe, A., Pommereau, X., Querejeta, I., Salander-Renberg, E., Temesvary, B., Wasserman, D. and Sampaio Faria, J. 1992. Parasiticide in Europe: the WHO/EURO multicentre study on parasuicide.

Introduction and preliminary analysis for 1989. *Acta Psychiatrica Scandinavica*, **85**(2), pp. 97-104

Platt, S. and Hawton K. 2000. Suicidal behaviour and the labour market. In: Hawton, K. and van Heeringen, K. (eds). *International Handbook of Suicide and Attempted Suicide*. John Wiley and Son: London, pp. 309-384.

Pokorny, A. D. 1983. Prediction of suicide in psychiatric patients: Report of a prospective study. *Archives of General Psychiatry,* **40**(3), pp. 249-257.

Pokorny, A. D. 1993. Suicide Prediction Revisited. *Suicide and Life-Threatening Behavior,* **23**(1), pp. 1-10

Pompili, M., Mancinelli, I. and Tatarelli, R. 2003. Stigma as a cause of suicide, *The British Journal of Psychiatry*, **183**(2), pp. 173-174

Pope, C. 2005. Conducting ethnography in medical setting. *Medical Education*, **39**(12), pp. 1180-1187

Posner, K., Brent, D., Lucas, C., Gould, M., Stanley, B. Brown, G., Fisher, G., Zelazny, J., Burke, A., Oquendo, M. and Mann, J. 2008. Columbia Suicide Severity Rating Scale (C-SSRS). Available at http://www.bcbst.com/providers/Behavioral-Health-Toolkit/PDFs/Columbia%20Suicide%20Scale%20-%20Since%20last%20visit.pdf (Accessed 30.03.13)

Pridemore, W. A. and Spivak, A. L. 2003. Patterns of Suicide Mortality in Russia. *Suicide and Life-Threatening Behavior,* **33**(2), pp. 132-150

Pritchard, C. 2006. *Mental Health Social Work: Evidence-Based Practice*. Oxon: Routledge

Pugh, R. 2007. Dual Relationships: Personal and Professional Boundaries in Rural Social Work. *British Journal of Social Work*, **37**(8), pp. 1405-1423

R

Rajan-Rankin, S. 2013. Self-Identity, Embodiment and the Development of Emotional Resilience. *British Journal of Social Work*, **4**(8), pp. 2426-2442

Rajan-Rankin, S. 2013. Self-Identity, Embodiment and the Development of Emotional Resilience. *British Journal of Social Work*, **4**(8), pp. 2426-2442

Ramsay, R., Tanney, B., Tierney, R., Lang, W., Kinzel, T. and Turley, B. 1999. *Suicide Intervention Handbook* (3rd Edition). Calgary, AB: Living Works Education/ authors

Range, L. M. 2005. No-Suicide Contracts. In Yufit, R. I. and Lester, D. (eds) Assessment, Treatment and Prevention of Suicidal Behaviour. London: John Wiley & Sons

Rapaport J. 2006. New roles in mental health: The creation of the Approved Mental Health Practitioner. *Journal of Integrated Care,* **14**(5), pp.37-46

Rapaport, J. and Manthorpe, J. 2008. Family matters: developments concerning the role of the nearest relative and social worker under mental health law in England and Wales. *British Journal of Social Work,* **38**, pp. 1115-1131

Redfield Jamison, K. 2000. *Night falls fast: understanding suicide*. New York: Vintage

Reed, A. 2014. Homicide Investigation Report into the death of a child – Executive Summary. Available at http://bhamcrosscityccg.nhs.uk/our-workmm/2013-12-27-09-47-20/miscellaneous/1364-executive-summary-september-2014/file (Accessed 31.12.14)

Reed, K. 2007. Bureaucracy and beyond: the impact of ethics and governance procedures on health research in the social sciences. *Sociological Research Online*, **12**(5)

Reed, K. 2010. The spectre of research ethics and governance and the ESRC's 2010 FRE: Nowhere left to hide? *Sociological Research Online*, **15**(4)

Rees, G., Huby, G, McDade, L and Kechnie, L. 2004. Joint working in community mental health teams: implementation of an integrated care pathway. *Health and Social Care in the Community*, **12**(6), pp. 527-536

Rehkopf, D. H. and Buka, S. L. 2006. The association between suicide and the socio-economic characteristics of geographical areas: a systematic review. *Psychological Medicine*, **36**(2), pp. 145-157

Renekema, J. 2004. *Introduction to Discourse Studies*, New York: John Benjamin Publishing

Renold, E., Holland, S. Ross, N and Hillman, A. 2008. 'Becoming participant': Problematizing 'informed consent' in participatory research with young people in care. *Qualitative Social Work*, **7**(4), pp. 427-447

Research Assessment Exercise. 2008. UOA 40 subject overview report. Available at www.rae.ac.uk/pubs/2009/ov/ (Accessed 01.08.12)

Riach, K. 2009. Exploring Participant-centred Reflexivity in the Research Interview. *Sociology,***43**(2), pp. 356- 370

Rihmer, Z. 2011. Depression and Suicidal Behaviour. In O'Connor, R., Platt, S. and Gordon, J. (eds.). *International Handbook of Suicide Prevention: Research, Policy and Practice,* Chichester: Wiley-Blackwell, pp. 75-92

Ritchie, J., Lewis, J., and Elam, G. 2003. Designing and selecting samples. In Ritchie, J. and Lewis, J. (eds), *Qualitative research practice*. Thousand Oaks, CA: SAGE, pp. 77-108

Robinson, M. and Cottrell, D. 2005. Health professionals in multi-disciplinary and multi-agency teams: Changing professional practice. *Journal of Interprofessional Care*, **19**(6), pp. 546-560

Rose, G. 1992. *The Strategy of Preventative Medicine*. Oxford: Oxford University Press

Rose, N. 2000. Government and Control. *British Journal of Criminology*, **40**(2), pp.321-339

Rosenthal, R. N. 2003. *Dual diagnosis.* New York: Brunner-Routledge

Roy, A., Rylander, G., and Sarchiapone, M. 1997. Genetics of Suicide, *The Neurobiology of Suicide*, **836**, pp. 135-157

Roy, A., Sarchiapone, M. and Carli, V. 2007. Low Resilience in Suicide Attempters. *Archives of Suicide Research*, **11**(3), pp. 265-269

Roy, A., Gorodetsky, E., Yuan, Q., Goldman, D. and Enoch, M. 2010. Interaction of FKBP5, a Stress-Related Gene, with Childhood Trauma increases the risk for attempting suicide, *Neuropsychopharmacology*, **35**, pp. 1674-1683

Rubin, J. and Rubin, I. 2005. *Qualitative Interviewing: The art of hearing data*. London: Sage

Ruch G., Turney D., Ward A. 2010. *Relationship-Based Social Work: Getting to the Heart of Practice.* London: Jessica Kingsley Publishers

Rutter, M. and Smith, D. J. 1995. Towards causal explanations of time trends in psychosocial disorders in youth. In Rutter, M. and Smith, D. J. (eds.). *Psychosocial Disorder in Young People: Time trends and their causes*, Chichester: Wiley, pp 782-809

S

Sacks, H. (1995) *Lectures on Conversation*, Oxford: Blackwell.

Salib, E. 1997 *Coroner's verdicts in the elderly: a suicide or an open verdict?, International Journal of Geriatric Psychiatry,* **12** 481-*483*

Samaritans. 2012. '*A Samaritan helped me find my strength'*. Available at http://www.samaritans.org/support_samaritans/campaigns/boxer_campaign_2010.aspx (Accessed 01.08.12)

Samson, P. L. 2014. Practice Wisdom: The Art and Science of Social Work. *Journal of Social Work Practice*. Advanced Access. Available at http://www.tandfonline.com/doi/abs/10.1080/02650533.2014.922058 (Accessed on 30.12.14)

Sandelowski, M. 1995. Sample size in qualitative research. *Research in nursing and health*, **18**(2), pp. 179-183

Sanders S., Jacobson J. M. and Ting L. 2008. *Preparing for the inevitable: Training social workers to cope with client suicide. Journal of Teaching in Social Work,* **28**(1), pp. 1-18

Schneidman, E. 2004. *Definition of suicide*. Oxford: Rowman and Littlefield Publishers Inc.

Schildmann, J. and Schildmann, E. 2013. Clinical and ethical challenges of palliative sedation therapy. The need for clear guidance and professional competencies. *International Journal of Clinical Practice*, **67**(11), pp. 1068-8

Schotte, D. E., Cools, J. and Payvar, S. 1990. Problem-solving deficits in suicidal patients: trait vulnerability or state phenomenon? *Journal of Consultant Clinical Psychology*, **58**(5): 562-4

Schulte, S. J., Meier, P. S., Stirling, J. and Berry, M. 2008. Treatment approaches for dual diagnosis in England. *Drug and Alcohol Review*, **27**(6), pp. 650-658

Schutz, A. 1976. "The Stranger". In Bowker, G. and Carrier, J. (eds.). *Race and Ethnic Relations*, London: Hutchinson

Scott, A and Guo, B. 2012. *For which strategies of suicide prevention is there evidence of effectiveness?* Available at http://www.euro.who.int/__data/assets/pdf_file/0003/168843/HEN-Suicide-Prevention-synthesis-report.pdf (Accessed 15.01.13)

Scottish Government. 2013. *Suicide Prevention Strategy 2013*. Available at http://www.scotland.gov.uk/Publications/2013/12/7616 (Accessed 10.12.13)

Scourfield, J., Holland, S. and Young, C. 2008. Social work in Wales since democratic devolution. *Australian Social Work*, **61**(1), pp. 42-56

Scourfield, P. 2013. Even Further beyond Street-level Bureaucracy: The Dispersal of Discretion Exercised in Decision Made in Older People's Care Homes Reviews. *British Journal of Social Work*. Advanced Access. Available at http://bjsw.oxfordjournals.org/content/early/2013/11/12/bjsw.bct175.abstract (Accessed 27.12.14)

Seale, C. F. 2002. Computer-assisted analysis of qualitative interview data. In Gubrium J. F., and Holestein, J. A (eds.). *Handboook of Interview Research. Context and Method*. London: Sage

Seale, C. L. 2006. National survey of end-of-life decisions made by UK medical practitioners, *Palliative Medicine* **20**(1), pp. 3-10

Seale, S. 1999. Quality in Qualitative Research. *Qualitative Inquiry*, **5**(4), pp. 465-478

Seddon, D., Robinson, C. A. and Perry, J. 2010. Unified Assessment, Implementation and Practice, *British Journal of Social Work*, **40**(1), pp. 207-225

Seguin,M., Lesage, A. and Kiely, M. C. 1995. Parental Bereavement After Suicide and Accident: A comparative study. *Suicide and Life-Threatening Behaviour*, **25**(4), pp. 489-498

Shaw, C. 2012. Harm-minimisation for self-harm: your guide to today's mental health issues. *mht insight*, September/October 2012

Shaw, I. and Gould, N. 2001. *Qualitative research in social work*: *introducing qualitative methods*. London: Sage

Shekelle P, Bagley S, Munjas B. 2009. *Strategies for suicide prevention in veterans Washington, DC, Department of Veterans Affairs Health Services Research and Development Service*. http://www.hsrd.research.va.gov/publications/esp/Suicide-Prevention-2009.pdf (Accessed 03.03.14)

Sheldon, B. and MacDonald, G. 2009. *A Textbook of Social Work*. Oxon: Routledge.

Shenton, A. K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, **22**, pp.63-75

Sheperd, D. M. and Barraclough, B. M. 1979. Help for those bereaved by suicide. *British Journal of Social Work*, **9**(1), pp. 67-74

Sher, L. 2005. Alcohol consumption and suicide. *QJM: An International Journal of Medicine,* **15**, pp. 57-61

Shier, M. L. and Graham, J. R. 2011. Work-related factors that impact social work practitioners' subjective well-being. Well-being in the workplace. *Journal of Social Work*, **11**(4), pp. 402-421

Shiner, M., Scourfield, J., Fincham, B. and Langer, S. 2009. 'When things fall apart: Gender and suicide across the life course'. *Social Science and Medicine*, **69**(5), pp. 738-746

Silverman, D. 2000. *Doing Qualitative Research: A Practical Handbook*. London: Sage.

Simmonds, S., Coid, J., Joseph P. and Marriott, S. 2001. Community mental health team management in severe mental illness: a systematic review. *British Journal of Psychiatry,* **178**, pp. 497-502

Simpson, A. Miller, C. and Bowers, L. 2003. The history of the Care Programme Approach in England: Where did it go wrong? *Journal of Mental Health*, **12**(5), pp. 489-504

Singh, S. P. 2009. Transition of care from child to adult mental health services: the great divide. *Current Opinion in Psychiatry*, **22**(4), pp.386-390

Singleton, N., Farrell, M. and Meltzer, H. 2003. Substance misuse among prisoners in England and Wales. *International Review of Psychiatry*, **15**(1-2), pp. 150-152

Skegg, K. 2005. Self-harm. *The Lancet*, **366**(9495), pp. 1471-1483.

Slater, T. Scourfield, J. and Greenland, K. (2013), Suicide Attempts and Social Worker Contact: Secondary Analysis of a General Population Study, *British Journal of Social Work*, Online Advance Access

Smith, M., McMahon, L. And Nursten, J. 2003. Social Workers'Experiences of Fear. *British Journal of Social Work,* **33**(5), pp. 659-671

Smith, R. 2009. *Doing social research*. Berkshire: Open University Press

Smokowski, P. R. and Wodarski, J. S. 1996. Euthanasia and physician assisted suicide; a social work update. *Social Work in Health Care*, **23**(1), pp. 53-65

Solas, J. 1996. The limits of empowerment in human service work. *Australian Journal of Social Issues*, **31**(2), pp. 147-56

Spicker, P. 1990. Social Work and Self-determination. *British Journal of Social Work*, **20**, pp 221-236

Stack, S. 2000a. Suicide: a 15-year review of the sociological literature part 1: cultural and economic factors. *Suicide and Life-Threatening Behaviour*, **30**(2), pp145-162

Stack, S. 2000b. Suicide: a 15-year review of the sociological literature part 2: modernization and social integration perspectives. *Suicide and Life-Threatening Behaviour*, **30**(2), pp163-176

Stack, S. 2001. Occupation and suicide. *Social Science Quarterly*, **82**(2), pp. 384-296

Stack, S. and Kposowa, A. J. 2011. Religion and Suicide Acceptability: A Cross-National Analysis. *Journal for the Scientific Study of Religion*, **50**(2), pp. 289-306.

Stalker, K. 2003. Managing Risk and Uncertainty in Social Work. *Journal of Social Work*, **3**(2), pp. 211-233

Stark, C. R., Riordan, V., O'Connor, R. 2011. A conceptual model of suicide in rural areas. *Rural and remote health*, **11**(2), pp. 1-11

Statham, D. J., Heath, A. C., Madden, P. A. F., Bucholz, K. K., Bierrut, L., Dinwiddie, S. H., Slutske, S., Dunne, M. P. and Martin, N. G. 1998. Suicidal behaviour: an epidemiological and genetic study. *Psychological Medicine*, **28**(4), pp. 839-855

Stone, M. H., 1990. *The fate of borderline patients: successful outcome and psychiatric practice*. New York: The Guildford Press

Strauss, A. 1987. *Qualitative analysis for social scientists*. Cambridge: Cambridge University Press

Strauss, A. and Corbin, J. 1990. *Basics of qualitative research: Grounded theory procedures and techniques*. London: Sage

Stuckler, D., Basu, S., Suhrcke, M., Coutts, A., McKee, M. 2011. 'Effect of the 2008 recession on health: a first look at European data'. *The Lancet*, 378, 124-125

Sudbery, J .2002. Key features of therapeutic social work: the use of relationship, *Journal of Social Work Practice*, **16**(2), pp. 149-162

T

Tashakkori, A. and Creswell, J. W. 2007. Editorial: The New Era of Mixed Methods. *Journal of Mixed Methods Research*, **1**(1), pp. 3-7

Tarrier, N., Taylor, K. and Gooding, P. A. 2008. Cognitive-behavioural interventions to reduce suicide behaviour: a systematic review and meta-analysis. *Behaviour Modification*, **32**(1), pp. 77-108

Taylor, C. and White, S. 2001. Knowledge, Truth and Reflexivity: The Problem of Judgement in Social Work. *Journal of Social Work*, **1**(1), pp 37-59

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J. and Le Boutillier, C. 2012. Social Factors and Recovery from Mental Health Difficulties: A Review of the Evidence. *British Journal of Social Work*, **42**(3), pp. 443-460

Tham, P. 2007. Why are they leaving? Factors affecting intention to leave among social workers in child welfare. *British Journal of Social Work*, **37**(7), pp.1225-1246

Tham, P and Meagher, G. 2009. Working in Human Services: How do experiences and working conditions in child welfare social work compare? *British Journal of Social Work*, **39**(5), pp. 807-827

Thompson, K. 1982. *Emile Durkheim: revised edition*, London: Routledge

Thompson, N. 2000. *Understanding social work: preparing for practice*. Basingstoke: MacMillan

Thompson, N. 2002. Social Movements, Social Justice and Social Work. *British Journal of Social Work*, **32**(6), pp. 711-722

Ting, L., Jacobson, J. M. and Sanders, S. 2011. Current Levels of Perceived Stress among Mental Health Social Workers Who Work with Suicidal Clients. *Social Work*, **56**(4), pp. 327-336

Ting, L., Sanders, S., Jacobson, J. M. and Power, J. R. 2006. Dealing with the Aftermath: A Qualitative Analysis of Mental Health Social Workers' Reactions after a Client Suicide. *Social Work*, **51**(4), pp. 329-341

Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I. and Davidson, L. 2006. Others: The role of family, friends and professionals in the recovery process, *American Journal of Psychiatric Rehabilitation*, **9**(1), pp. 17–37

Trevithick, P. 2003. Effective relationship-based practice: A theoretical exploration. *Journal of Social Work Practice*, **17**(2), pp. 163-176

Tuckett, A. G. 2005. Applying thematic analysis theory to practice: A researcher's experience. *Contemporary Nurse,* **19**(1-2), pp. 75-87.

Tunnard, J. 1991. Rights and duties. *Social Work Today,* pp.21

Turbett C. 2004 A decade after Orkney: Towards a practice model for social work in the remoter areas of Scotland*. British Journal of Social Work,* **34**(7), pp.981-995.

Turner, M. and Balloch, S. 2001. Partnership between service users and statutory social services. In S. Balloch and M. Taylor (eds) *Partnership working: Policy and practice*, Bristol: The Policy Press.

Tyrer, P., Morgan, J., Van Horn, E., Jayakody, M., Evans, K., Brummell, R., White, T., Baldwin, D., Harrison-Read, P. and Johnson, T. 1995. A randomised controlled study of close monitoring of vulnerable psychiatric patients. *The Lancet*, **345**(8952), pp. 756-759

V

van Herringen, K. 2000. Multidisciplinary approaches to management. In: Hawton, `K. and van Heeringen, K. (eds). *International Handbook of Suicide and Attempted Suicide*. John Wiley and Son: London, pp. 571-581

Varnik, A., Kolves, K., van der Feltz-Cornelis, C. M., Marusic, A., Oskarsson, H., Pamler, A., Reisch, T., Scheerder, G., Arensman, E., Aromaa, E., Giupponi, G., Gusmao, R., Maxwell, M., Pull, C., Szekely, A., Perez Sola, V. and Hegerl, U. 2008. Suicide methods in Europe: a gender-specific analysis of countries participating in the "European Alliance Against Depression". *Journal of Epidemiological Community Health*, **62**(6), pp. 545-551

Vinnerljung, B., Hjern, A. and Lindblad, F., 2006. Suicide attempts and severe psychiatric morbidity among former child welfare clients - a national cohort study. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, **47**(7), p.723-733.

W

Walby, S. 1989. Theorising patriarchy. *Sociology*, **23**(2), pp. 213-244

Walker, P. 2002. Selecting outcome measures for child welface settings: Lessons for use in Performance Management. *Children and Youth Services Review,* **23**, pp. 169-199

Wallace, C. D., and Abbott, P. A. 1998. Health Visiting, Social Work, Nursing and Midwifery: a History. In Abbott, P.A. and Meerabeau, L. (eds), *The Sociology of the Caring Professions.* (*2nd edition)*, UCL Press: London, pp. 20-53

Warm, A., Murray, C. and Fox, J. 2003. Why do people self-harm? *Psychology, Health and Medicine*, **8**(1), pp. 72-79

Warner, J. 2014. 'Heads Must Roll?' Emotional Politics, the Press and the Death of Baby P. *British Journal of Social Work*, **44**(6), pp. 1637-1653

Warren, J. (2007). *Service User and Carer Participation in Social Work*. Exeter: Learning Matters Limited

Waterson, J. (1999), Redefining community care social work: needs or risks led? *Health and Social Care in the Community*, **7**(4), pp. 276-279

Weaver, T., Madden, P., Charles, V., Stimson, G., Renton, A., Tyrer, P., Barnes, T., Bench, C., Middleton, H., Wright, N., Paterson, S., Shanahan, W., Seivewright, N., Ford, C. and Comorbidity of Substance Misuse and Mental Illness Collaborative (COSMIC) study team. 2003. Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatry*, **183**(4), pp. 304-313

Webb, A. and Wistow, G. 1987. *Social Work, Social Care and Social Planning: The Personal Social Services Since Seebohm*. Harlow: Longman

Webb, C. M. and Carpenter, J. 2012. What can be done to promote the retention of social workers? A systematic review of interventions. *British Journal of Social Work*, **42**(7), pp. 1235-1255.

Webb, S. A. 2006 *Social Work in a Risk Society: Social and Political Perspectives.* Basingstoke: Palgrave/Macmillan

Webb, S. A. 2001. Some considerations on the validity of evidence-based practice in social work. *British Journal of Social Work*, **31**(1), pp. 57-79

Wells, J. S. G. 1997. Priorities, “street level bureaucracy” and the community mental health team. *Health and Social Care in the Community*, **5**(5), pp. 333-342

Welsh Government. 2008. *Talk to me: A national action plan to reduce suicide and self-harm in Wales*. Available at http://www.wales.nhs.uk/documents/talktomee%5B1%5D.pdf (Accessed 03.08.10)

While, D., Bickley, H., Roscoe, A., Windfuhr, K., Rahman, S., Shaw, J., Applybe., and Kapur, N. 2012. Implementation of mental health service recommendations in England and Wales suicide rates, 1997-2006: a cross-sectional and before-and-after observational study. *The Lancet*, **379**(9820), pp.1005-1012

White, S. 2009. Fabled Uncertainty in Social Work – A Coda to Spafford et al. *Journal of Social Work*, **9**(2), pp. 222-235

White, S., Frook, J. and Gardner, F. 2006. *Critical Reflection in Health and Social Care*. London: Open University Press

Whitley, E., Gunnell, D., Dorling, D. and Davey Smith, G. 1999. Ecological study of social fragmentation, poverty and suicide. *British Medical Journal*, **319**(7216), pp. 1034-1037.

Wiles, R., Crow, G., Heath, S. and Charles, V. 2008. The management of confidentiality and anonymity in social research. *International Journal of Social Research Methodology*, **11**(5), pp. 417-428

Wilkinson, P. and Goodyer, I. 2011. Non-suicidal self-injury. *European Child & Adolescent Psychiatry*, **20**(2), pp. 103-108

Williams, J. M. G. 1997. *Cry of pain: understanding suicide and self-harm*. London: Penguin

Williams, J. M. G. and Pollock, L. R. 2000. The Psychology of Suicidal Behaviour, In: K Hawton and K van Heeringen (eds.). *International Handbook of Suicide and Attempted Suicide*. John Wiley and Son: London, pp. 309-384.

Williams, K. 1989. Research the powerful: Problems and possibility of social research. *Crime, Law and Social Change*, **13**(3), pp 253-274

Wilson, K. 2013. Social Work under Pressure: How to Overcome Stress, Fatigue and Burnout in the Workspace. *Practice: Social Work in Action*, **25**(2), pp. 145-146

Woodhead, C., Rona, R. J., Iversen, A. MacManus, D. Hotopf, K. Dean, K., McManus, S., Meltzer, H., Brugha, T., Jenkins, R., Wessely, S. and Fear, N. T. 2011. Mental health and health service use among post-national service veterans: results from the 2007 Adult Psychiatric Morbidity Survey of England. *Psychological Medicine*, **41**(3), pp. 363-372

World Health Organization (WHO). 2004. *Suicide huge but preventable public health problem*. Available at http://www.who.int/mediacentre/news/releases/2004/pr61/en/ (Accessed 06.10.12)

World Health Organization (WHO). 2011. *Suicide rates per 100,000 by country, year and sex (Table)*. Available at http://www.who.int/mental_health/prevention/suicide_rates/en/ (Accessed 10.01.12)

Y

Yang, K. 2010. *Making sense of statistical methods in social research*. London: Sage

Yasuhiro, K., Robinson, R. G. and Kosier, J. T. 2001. Suicidal Ideation among Patients with Acute Life-Threatening Physical Illness: Patients with Stroke Trauma

Brain Injury, Myocardial Infarction, and Spinal Cord Injury. *Psychosmatics*, **42**(5), pp. 382-390

Younghusband, E. L. 1981. *The Newest Profession: A short history of social work*, Sutton: Community Care

Yuill, C., Crinson, I. and Duncan, E. 2012. *Key Concepts in Health Studies*. London: Sage

Z

Zahl, D.L. and Hawton, K. 2004. Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11,583 patients. *The British Journal of Psychiatry*, **185**, pp. 70-75.

Appendices

Appendix A: Search of databases for literature on social workers in suicide prevention and associated interventions

Table 9 - Search of databases for literature on social workers in suicide prevention and associated interventions

Database	Search parameters	Terms searched					
		Social work suicide prevention	Social work suicide	Social work suicide intervention	Social care suicide prevention	Social care suicide	Social care suicide intervention
ASSIA	Peer review only	92	468	86	164	786	143
Embase	Journals	6	24	12	4	15	9
	Books	5	23	9	3	13	6
Psychinfo*	Total	37,431	93,848	93,848	30,552	27,809	70,939
Social Care Online	All	2,444	38,324	4,963	37,830	28,522	2,874
	UK	613	8,518	850	8,397	9,969	823
	Wales	61	678	81	663	868	60

* Results are from the 1806 to 2014 search data set. Results displayed are for total only. For Psychinfo further analysis was completed using additional filters and search options. I have not included these here as they are not easily presented.

Note: All searches listed here were completed between September and December 2014. As noted in chapter 2.1 a large number of false positives were returned in the results due to the nature of the topic area. For example, searches using the term prevention often returned results looking at how social work practice in a variety of different areas can aid with the prevention of numerous social ills. Refinement of the search terms and the search parameters, such as geographic location, had a marginal impact on the research. However, the reader is reminded that I have not undertaken a systematic review of the literature. For a more extensive review of the literature please refer to Joe and Neidermeier (2008).

Appendix B: Consent Form for Professional

CARDIFF UNIVERSITY PRIFYSGOL CAERDYDD	**Project Title: Exploring the role of social workers in suicide prevention.** **Document Name: Professional Interview Consent Form** **Document Version (and date): Version 2 (03.08.11)**

Social Workers and Suicide Prevention – Professional Interview Consent

Before starting the interview it is important to make sure that the purposes of the study are clearly understood and that you are aware of your rights.

Basic details about the study and information on who is conducting the research are given below:

Project Title -

Evaluating the role of social workers in suicide prevention.

Principal Researcher –

Tom Slater (PhD Student), Cardiff University School of Social Sciences - PhD Office, Floor 2, 1-3 Museum Place, Cardiff, CF10 3BG

Supervisors –

Jonathan Scourfield and Katy Greenland - Cardiff University School of Social Sciences, Glamorgan Building, King Edward VII Avenue, Cardiff, CF10 3WT

Project Contact Details –

slatertb1@cardiff.ac.uk (E-mail)

07547 046308 (Telephone)

This study has received NHS Ethical Approval from the Wales Multi-centre ethics committee [Reference: 11/WA/0133 Date of Approval: 09/06/11]

What is the purpose of the study?

The focus of the study is the role of social workers in suicide prevention. Through a series of interviews and an analysis of service users' case files, it is hoped that a greater understanding of what social workers are doing to assist service users with

suicidal thoughts and behaviours can be achieved. This research will highlight areas of practice that are positive as well as areas for further training and gaps in service provision.

Why have I been invited?

You have been identified as either having experience of working with suicidal service users or have experience of working with social workers in a mental health setting. As such we would like to talk to you about your experiences. All participation is strictly voluntary and you are under no obligation to participate in this research.

Who is conducting the research?

I'm Tom Slater and I'm a PhD student in the School of Social Sciences at Cardiff University. My funding comes from the National Institute for Social Care and Health Research (NISCHR).

What are the benefits and risks of participation?

This research is being carried out to gain an understanding of how social workers assist service users who are experiencing suicidal thoughts and behaviours. By participating in this research you will be able to contribute towards our understanding in a way that will provide feedback to policy developers.

The nature of suicide is distressing and there is a risk that participants may become upset during the course of interviews. To help minimise this risk each interview will have a brief debriefing period at its conclusion, details of support agencies will be also be provided in a debriefing letter.

Can I withdraw at any time?

You can withdraw at any time, but any data collected prior to your decision to withdraw may still need to be included in the research. You are under no obligation to answer any questions. All data are anonymous and are held in accordance with the Data Protection Act 1998.

The interview

The interview should last about an hour and you can stop the interview at any stage. If you want to take a short break then please ask. If you don't want to answer any questions then please feel free to state that you are unwilling to answer.

What happens when the study ends?

The results of this study will be analysed by me and will be used to write my thesis (an academic study) and other academic articles. A shorter accessible report will also be compiled for local authorities, research participants, NHS boards and the National Institute for Social Care and Health Research (NISCHR). I may also use this study to write articles for publication. No individual participants will be identifiable in any of these reports and the shorter accessible report will be available on request (if you want a copy of this report then please notify me during the interview or make contact with me later). The data itself will not be available to anyone other than me and my supervisors.

Confidentiality

These interviews are confidential, but it is important to note that this confidentiality may be discounted in the event that something of a serious nature is disclosed. Specifically issues pertaining to a dereliction of duty, neglect, abuse, exploitation or serious criminal misconduct would need to be reported to the relevant authorities. It is very unlikely that any of these issues would arise, but it is important to make you aware that while the interview is confidential there are inevitable limitations to this confidentiality.

Comments made about individual social workers, other professionals, service users, local authorities, health boards/trusts will be anonymised so participants have no fear of information being passed to these individuals or agencies.

To make sure that no one can identify you a false name (pseudonym) will be used. Your real identity will only be known to me and my two supervisors (Prof Scourfield and Dr Greenland).

All data will be held securely and in accordance with the Data Protection Act 1998. Information will be held for a period of five years in accordance with the Cardiff University School of Social Sciences guidelines. Interviews will be transcribed (written up) and analysed.

Thank you for taking the time to read this information sheet. Please complete the attached consent sheets.

Tom Slater

Cardiff University School of Social Sciences

Consent Form (participant copy) – Interviews with Professionals

This consent form has two parts (it is over four pages). One copy is to be kept by me and the other is for your records.

Please initial each box

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

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. I am aware that any information already obtained may still be included in the study. ☐
3. I agree to take part in the study. ☐

4. I agree to this interview being recorded and transcribed for analysis. ☐

5. I am aware that all information is treated as confidential and will be sorted in accordance with the Data Protection Act. ☐

6. I agree to direct (verbatim) quotations from this interview being used in reports, publications, etc. Please note that quotations will only be used where anonymity can be assured. ☐

PARTICIPANT DETAILS:	
Surname	
Forename(s)	
Job title/occupation	

Office address	
Contact number	

_____

Signature and date

Consent Form (researcher copy) – Interviews with Professionals

Please initial each box

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

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. I am aware that any information already obtained may still be included in the study. ☐
3. I agree to take part in the study. ☐

4. I agree to this interview being recorded and transcribed for analysis. ☐

5. I am aware that all information is treated as confidential and will be sorted in accordance with the Data Protection Act. ☐

6. I agree to direct quotations from this interview being used in reports, publications, etc.. Please note that quotations will only be used where anonymity can be assured. ☐

PARTICIPANT DETAILS:	
Surname	
Forename(s)	
Job title/occupation	
Office address	

Contact number	

Signature and date

FOR OFFICE USE ONLY	Date Filed	

Appendix C: Consent Form for Service Users

CARDIFF UNIVERSITY PRIFYSGOL CAERDYDD	**Project Title: Exploring the role of social workers in suicide prevention.** **Document Name: Service User Interview Consent Form** **Document Version (and date): Version 3 (03.08.11)**

Before undertaking the interview it is important to make sure that the purposes of the study are clearly understood and that you are aware of your rights.

What is the purpose of the study?

This study will look at the role of social workers in suicide prevention. The study will look at what social workers are doing to help people with suicidal thoughts and feelings, what they are doing well and where there things can be improved. To do this I will be interviewing service users/patients, social workers and other professionals.

Why have I been invited?

Social workers and health care professionals were asked to identify individuals such as you who have previously attempted suicide whilst under the care of a social worker. All participation is strictly voluntary and you are under no obligation to participate in this research. The NHS ethics committee and your local authority have both given permission for this study.

There are a few limitations on who can take part in the study. If you are subject to sections S35, S36, S37 or S41 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007), or are currently subject to a Community Treatment Order (or similar), I'm afraid you can't take part.

What will happen in the interview?

All interviews are voluntary and you can withdraw at any time (before or during the interview). The interview is expected to last about an hour. If you want to take a short break then please ask. If you don't want to answer any questions then please feel free to state that you are unwilling to answer.

All the information is anonymised (i.e. a false name like Mr A or Ms B is given) so no one apart from the researcher will know who you are.

Who is conducting the research?

My name is Tom Slater, I'm a PhD student in the School of Social Sciences at Cardiff University. I'm funded by the National Institute for Social Care and Health Research (NISCHR), part of the Welsh Assembly. I qualified as social worker in 2009 and worked as a social worker with a local authority children's service.

What are the benefits and risks of participation?

This study is looking at how social workers help service users who have suicidal thoughts and feelings. By taking part in an interview you can help us to better understand the role of social workers in suicide prevention. This study can then be used to help improve future policy and training for social workers.

Talking about suicide can be upsetting and there is a small risk that you might become upset talking about your experiences. At the end of the interview you will have the opportunity to discuss any worries and details of support agencies will be provided.

You have already provided me with your GP (doctor) or community mental health team (CMHT) information; if you became very upset then they may be contacted to provide you with help.

Can I withdraw at any time?

You can withdraw at any time. You don't have to answer any questions or discuss any topics that you don't want to. If you wish to stop the interview or take a break at any point then please feel free to do so.

What happens when the study ends?

I will use the results of this study to write my thesis (a large academic study) and academic publication. I will also write a shorter report for service user groups, local authorities, NHS organisations and the National Institute for Social Care and Health Research. (NISCHR). I may also use this study to write articles for publication. No individual participants will be identifiable in any of these reports. If you would like a copy of the shorter accessible report then please let me know.

Confidentiality

To make sure that no one can identify you a false name (pseudonym) will be used. Your real identity will only be known to me and my two supervisors (Prof. Scourfield and Dr. Greenland).

The interviews are confidential, but if something of a serious nature was mentioned/disclosed then it might be necessary for this information to be passed to the relevant authorities. Specifically issues of neglect, abuse, exploitation or serious criminal misconduct would need to be reported to the relevant authorities. Don't worry, it is unlikely that any of these issues would arise and I would tell you if something mentioned might need to be referred. It is important that I make you aware that while the interview is confidential there are inevitable limitations to this confidentiality.

All data collected will be held securely and in accordance with the Data Protection Act 1998. Any information collected in this study will be held for five years (in accordance with the Cardiff University School of Social Sciences guidelines).

Thank you for taking the time to read this information sheet. Please complete the attached consent sheets.

Tom Slater

Cardiff University School of Social Sciences

Key study information :

Key information about the study and the researcher are given below:

Project Title –

Exploring the role of social workers in suicide prevention

Principal Researcher –

Tom Slater (PhD Student), Cardiff University School of Social Sciences - PhD Office, Floor 2, 1-3 Museum Place, Cardiff, CF10 3BG

Supervisors –

Jonathan Scourfield and Katy Greenland - Cardiff University School of Social Sciences, Glamorgan Building, King Edward VII Avenue, Cardiff, CF10 3WT

Project Contact Details –

slatertb1@cardiff.ac.uk (E-mail)

07547 046308 (Telephone)

This study has received NHS Ethical Approval from the Wales Multi-centre ethics committee [Reference: 11/WA/0133 Date of Approval: 09/06/11]

Consent Form (participant copy) – Interviews with Service Users

This consent form has two parts (it is over five pages). One copy is to be kept by me and the other is for your records.

Please initial each box

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

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. I am aware that any information already obtained may still be included in the study. ☐
3. I agree to take part in the study. ☐

4. I agree to this interview being recorded and transcribed for analysis. ☐

5. I am aware that all information is treated as confidential and will be sorted in accordance with the Data Protection Act. ☐

6. I agree to direct (verbatim) quotations from this interview being used in reports, publications, etc. Please note that quotations will only be used where anonymity can be assured. ☐

PARTICIPANT DETAILS:	
Surname	
Forename(s)	

Date of birth	
Address	
Contact number	
GP or key worker name	
GP or Community Mental Health Team (CMHT) address	
Contact no. for GP or CMHT	

_____

Signature and date

Consent Form (researcher copy) – Interviews with Service Users

This consent form has two parts (it is over four pages). One copy is to be kept by me and the other is for your records.

Please initial each box

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

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. I am aware that any information already obtained may still be included in the study. ☐
3. I agree to take part in the study. ☐

4. I agree to this interview being recorded and transcribed for analysis. ☐

5. I am aware that all information is treated as confidential and will be sorted in accordance with the Data Protection Act. ☐

6. I agree to direct (verbatim) quotations from this interview being used in reports, publications, etc. Please note that quotations will only be used where anonymity can be assured. ☐

PARTICIPANT DETAILS:	
Surname	
Forename(s)	

Date of birth	
Address	
Contact number	
GP or key worker name	
GP or Community Mental Health Team (CMHT) address	
Contact no. for GP or CMHT	

_____

Signature and date

FOR OFFICE USE ONLY	**Date Filed**	

Appendix D: Interview schedule

CARDIFF UNIVERSITY PRIFYSGOL CAERDYDD	**Project Title: Exploring the role of social workers in suicide prevention.** **Document Name: Interview Schedule** **Document Version (and date): Version 2 (02.08.11)**

Interview Schedule (Social Worker):

Introduction:

Before we start the interview I just need to clarify a few points. As highlighted in the consent form this research is focused on exploring the role of social workers in suicide prevention. It is being carried out as part of my PhD which I am undertaking at Cardiff University. I'm funded by the National Institute for Social Care and Health Research (NISCHR) which is part of the Welsh Assembly. I am however, completely independent when it comes to carrying out this research; essentially I am free to choose the structure of the research and analyse the data using methods I think are appropriate.

This interview is entirely voluntary and you can stop the interview at any time without needing to give a reason. If you want to take a break at any time then please feel free to stop the interview. Your name and details will not be known to anyone other than me and my supervisors (Prof. Jonathan Scourfield and Dr. Katy Greenland). This interview will, with your agreement, be recorded and then written up for analysis. Any quotations used will remain anonymous, i.e. no one will know that it was you who said the statement, but direct quotes will, with your permission be used in research.

This interview is confidential, but I need to make you aware that if something of a serious nature was disclosed, i.e. gross misconduct, an abuse of power, etc. then I would have to notify the relevant agencies. I will tell you prior to doing so. I do not think this is likely to be an issue; it would have to be of a very serious nature.

Is there anything you'd like to ask me before the interview begins?

Questions:

General experience/background:

- Tell me about your professional experience (i.e. how long have you been qualified, what roles have you undertaken, why did you choose to train as a social worker)?

Role-specific experience:

- How long have you been in this role?
- Are you ASW/AMHP qualified or have you previously been?
- What do you enjoy about this role?
- What do you dislike?
- Do you feel your role is unique or different to other mental health care professionals (if so, how)?

Experience of suicide prevention:

- Tell me about your experiences working with suicidal service users.
- What do you believe suicidal means?
- Is suicide always preventable?
- How do you know or work out when someone if feeling suicidal?
- What do you feel causes suicidal behaviour?
- What factors/triggers do you look for? How do you assess suicidality (scales, assessments, etc.)?
- How did you learn to identify suicidal behaviour?
- If you believe a service user to be suicidal what do you do to assist them?
- Do you have specific interventions?
- What processes, if any, does your team have to assist suicidal service users?

Training:

- Have you received any training to help you identify, assist and/or treat service users?
- Was it helpful?
- What further training or support would you like, if any?
- What do you feel could be done to prevent suicide (generally)?

Conclusion:

Before we end the interview is there anything I haven't asked that you feel might be useful for the researchers to know (i.e. is there anything you feel I should have asked, but haven't)?

Do you have any questions for me?

Talking about suicide can be distressing: is there anything that you would like to discuss further?

When the research is completed a brief report on my the study and its findings will be made available, would you like to receive a copy? Please be aware that this will not be produced until early to mid-2013 at the earliest.

Interview Schedule (Other Professionals):

Introduction:

Before we start the interview I just need to clarify a few points. As highlighted in the consent form this research is focused on exploring the role of social workers in suicide prevention. It is being carried out as part of my PhD which I am undertaking at Cardiff University. I'm funded by the National Institute for Social Care and Health Research (NISCHR) which is part of the Welsh Assembly. I am however, completely independent when it comes to carrying out this research; essentially I am free to choose the structure of the research and analyse the data using methods I think are appropriate.

This interview is entirely voluntary and you can stop the interview at any time without needing to give a reason. If you want to take a break at any time then please feel free to stop the interview. Your name and details will not be known to anyone other than me and my supervisors (Prof. Jonathan Scourfield and Dr. Katy Greenland). This interview will, with your agreement, be recorded and then written up for analysis. Any quotations used will remain anonymous, i.e. no one will know that it was you who said the statement, but direct quotes will, with your permission be used in research.

This interview is confidential, but I need to make you aware that if something of a serious nature was disclosed, i.e. gross misconduct, an abuse of power, etc. then I would have to notify the relevant agencies. I will tell you prior to doing so. I do not think this is likely to be an issue; it would have to be of a very serious nature.

Is there anything you'd like to ask me before the interview begins?

Background/general information gathering:

- What is your current role? How long have you been in this role?
- How long have you been working in the mental health field and what other roles have you had? What first drew you to the mental health field?
- What experience do you have working with social workers?
- What do you do that is different to social workers?
- What roles do you believe are specific to the social worker role?

Working with social workers:

- What do you think the role of a social worker should be in a mental health setting?

Suicide prevention:

- Tell me about your experiences working with suicidal service users?
- What do you believe suicidal means?
- Is suicide always preventable?
- From your experience what do you feel social workers think about suicide?
- How do you know or work out when someone is feeling suicidal?
- What do you feel causes suicidal behaviour?
- What factors/triggers do you look for?
- Do you think social workers use the same criteria as you?
- Where did you get this information from?
- How did you learn to identify suicidal behaviour?
- How do you assess suicidality (scales, assessments, etc.), is this the same of different to social workers in your opinion?
- If you believe a service user to be suicidal what do you do to assist them?
- Do you have specific interventions?
- What processes, if any does your team have to assist suicidal service users?
- Are their differences between social workers and health in procedures and responses?
- What are you experiences of social workers working with suicidal service users?
- What do you feel the role of a social worker is for a suicidal service user, is this different or the same as other professionals?

Training:

- Have you or do you undertake joint training with social workers (determine context, funders, etc.)? What do you think of the training you have received?

Conclusion:

Before we end the interview is there anything I haven't asked that you feel might be useful for the researchers to know (i.e. is there anything you feel I should have asked, but haven't)?

Do you have any questions for me?

Talking about suicide can be distressing is there anything that you would like to discuss further?

When the research is completed a brief report on my the study and its findings will be made available, would you like to receive a copy? Please be aware that this will not be produced until early to mid-2013 at the earliest.

Interview Schedule (Service Users):

Introduction:

Before we start the interview I just need to clarify a few points. I'm Tom and I'm doing research on the role of social workers in suicide prevention; what they do that is unique to their role, if anything, what they do well, where they could improve, and so on. I asked to interview people who have felt suicidal at one time, so I know you've had this experience. I'm based at Cardiff University and funded by the Welsh Assembly. I am however, completely independent in how I do the research.

It's entirely up to you whether you take part in this interview or not and you can stop the interview at any time without needing to give a reason. If you want to take a break at any time then please feel free to stop the interview. There is no time limit to this interview so please feel free to take as long as you wish (as a rough guide it's anticipated to last about an hour). Your name and details will not be known to anyone other than me and my supervisors. If you are happy with this, the interview will, be recorded and then typed up. Any quotes used will remain anonymous, i.e. no one will know that it was you who said the statement.

Anything you say in this interview is confidential as long as no-one is at risk of serious harm. You've given me details of your GP or Community Mental Health Team and if you became very upset/distressed and I was really worried about you then I'd have to contact them. This doesn't mean that I would call them because of a few tears or upset words; I'd only do this if you became really very distressed. Again I would speak to you before doing this and I would only contact them as a last resort. Please don't worry about these issues, but I have to be honest with you about my role.

This interview is confidential, but I need to make you aware that if something of a serious nature was disclosed, i.e. child protection concerns, abuse of another person, etc. then I would have to notify the relevant agencies. I will tell you prior to doing so. I do not think this is likely to be an issue; it would have to be of a very serious nature.

Is there anything you'd like to ask me before the interview begins?

Personal history (questions in italics are expansion questions or rephrased versions of the same question):

I'm going to start with some general questions about you and your mental health.

- Tell me about yourself (age, family, brief history).
- When did you first become involved with mental health services?
- Do you still have some help from mental health services? Do you know what you current or previous diagnoses are/were?
- Do you know what a key worker is?
- What sort of job/role does your current key worker have (i.e. CPN, social worker, etc.)?
- Tell me about the support you currently have (frequency of contact with professionals, outreach groups, etc.).
- What sort of job/role did have your previous key workers had?
- Do you know how long you had a social worker when you started to think about suicide??

I'm going on now to ask you some questions about when you've felt suicidal and whether social workers have helped you at all.

- Have you attempted suicide? (if so, when did you last do this?
- Tell me about your experiences of social workers when you have been suicidal.
- When you've been suicidal who would be the first approach the topic (did the social worker first mention it or did you)?
- If the service user first mentioned it, what was the reaction of the social worker?
- What support was offered?
- Was this useful to you?

- Were you involved in making decision about any care or support your received (i.e. could you refuse or object)?
- Do you feel that the support you received was what you needed (too much, too little)?
- What do you think contributed to your feelings and thoughts of wanting to harm yourself?
- Do you think the social worker was aware of these problems?
- Do you think they (the social worker) were in a position to help with some or all of these problems/issues remedy some or all of these issues?

If suicide attempts are discussed then consider the following questions (some interviewees may only have had thoughts):

- *Have you always had support from mental health services when you've attempted suicide?*
- *Did you seek any support of help prior to attempting suicide (if so from whom)?*

Training:

- What would you have found helpful when you felt suicidal?
- What do you think could be done to improve training of social workers?

Conclusion:

Before we end the interview is there anything I haven't asked that you feel might be useful for the researchers to know (i.e. is there anything you feel I should have asked, but haven't)?

Do you have any questions for me?

Talking about suicide can be very difficult and I hope that this interview hasn't been too distressing. Is there anything you would like to discuss further? When the research is completed a brief report on my the study and its findings will be made available, would you like to receive a copy of this? Please be aware that this will not be produced until early to mid-2013 at the earliest.