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‘Women’s Imprisonment, Self-Harm and Emancipatory Research: Developing a Framework for Transformative Research in a Women’s Prison’

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Abstract

For many women in prison self-harm is a significant feature of daily life. The research into self-harm in prison has largely mirrored that of community based research, in the search of evidencing interventions that are effective in preventing or stopping self-harming behaviour. The prevailing medical discourse around self-harm, and the sometimes poor or damaging treatment that people who self-harm receive, has been challenged by a coherent, feminist informed, community based survivor movement. This however has not been realised in prisons and examination of the literature reveals a lack of feminist research or service user involvement in prison research in general, and particularly in the case of self-harm. This is likely to be due to the challenges that the prison environment creates in conducting research based upon emancipatory principles, such as equality in relationships and the empowerment of participants.

This research explores whether emancipatory research within a prison environment is possible with the aim of developing such a framework for future research in prisons. This was tested by women in prison, and prison staff, engaging in research to produce transformative change in the care for self-harm. The research utilised the theoretical framework of both feminist participatory action research, and service user involvement to achieve practical results within the constraints of the prison environment – a process which the thesis refers to as 'achieving praxis[1]. The triangulation of mixed methods in information collection reveals dialectics between women, staff and procedures in the care for women who self-harm in prison. The extent to which emancipatory research is possible is explored in relation to institutional change, the experiences of women involved in the project, and the degree of consciousness raising achieved through involvement.

I conclude that, whilst compromises have to be made, emancipatory research using feminist and service user involvement is possible within a prison environment. This thesis therefore sets out the framework with which future transformative research can be conducted in secure settings.

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List of Figures and Tables

Glossary of Terms and Acronyms

ACCT – Assessment Care in Custody and Teamwork, the prison service management strategy for prisoners at risk of self-harm and/or suicide.

Achieve/Achieving Praxis – In the context of the constraints of the prison environment this has been defined as the implementation of practical changes through a feminist informed methodology.

Constant Observations (Constant Obs) – The continuous observation of a prisoner who is considered to be high risk of suicide or life threatening self-harm. Observation is usually carried out by prison officers.

EBW – Escorted Bed Watch, the escort by prison officers of a prisoner from prison to a hospital to receive medical care that cannot be provided in the prison. This can be for a whole range of medical reasons but this report concentrates solely upon treatment after self-harm.

KTP – Knowledge Transfer Partnership, the organisation that facilitates the development of a project between academic and business partners. In this case between Durham University, North East Offender Health Commissioning Unit and HMP YOI Low Newton. To reflect the multiple stakeholder of the project in Low Newton it was labelled the KTP throughout.

MHFA – Mental Health First Aid a training package aimed at increasing awareness and reducing stigma around mental health as well as providing guidance on early intervention to promote recovery to good mental health.

NEOHCU – North East Offender Health Commissioning Unit commissions a full range of primary, community, secondary and tertiary care services for the seven prisons in the North East of England and is a major stakeholder in the KTP project.

NICE – National Institute for Health and Clinical Excellence a Special Health Authority providing clinical guidance for evidence based practice. Guideline No. 16 is relevant to the care of people who self-harm.

NOMS – National Offender Management Service, an executive agency of the Ministry of Justice responsible for the delivery of prison and probation services.

PAR – Participatory Action Research, the method adopted by the project to engage key relevant stakeholders in the process of identifying areas for improvement and producing change.

Products - Tied into the notion of this thesis' definition of 'achieving praxis' products are tangible interventions implemented as a result of enquiry which enhance the health and well-being of those who are involved in the enquiry.

PSI – Prison Service Instruction, prior to 2009 these were used to convey short-term instructions for operation, usually standing no longer than 12 months. Since 2009 PSI's have replaced PSOs (see below).

PSO – Prison Service Order, a long term and mandatory set of rules or regulations governing the running of prisons. PSO2700 relates to the care and management of prisoners who are at risk of self-harm or suicide.

Self-Harm – For the purpose of this project self-harm has been defined as '*a non-fatal act, whether physical, drug over dosage or poisoning, done in the knowledge that it was potentially harmful'* (Morgan, 1979). This definition was chosen to be inclusive of the full range of self-harming behaviours whilst being neutral as to the motivation of the person as this is not always known.

Service User Involvement (SUI) – ***'****the active involvement of service users (patients, carers and the public) in health and social research'* (Smith *et al.,* 2009). This can take many different forms and include different levels of involvement. The KTP project involved service users (prison staff and women in prison) through the PAR process.

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I am very grateful to the prison service, and particularly the generosity of the governing governor of the prison in which the research has been based. Despite an austere climate of cost savings that could easily undermine prisoner welfare he was willing to pilot a number of initiatives (not all!) that the research suggested and was patient when I pushed for even more. I am also indebted to my colleagues and friends within the prison who have become involved, given their time and who I have learnt a lot from. Finally however I am most grateful to those women in prisons who gave their time, trusted in the project and were brave enough to become involved. It would be easy for women in prison to be cynical about their ability to influence change in their environment and be fatigued by the amount of research that is asked of them. Yet despite this an unprecedented proportion of women were willing to talk to me and a number committed significant amounts of time to the project. As a result I believe we have contributed something unique to prison research and I hope those involved are as proud of themselves as I am of them. It goes without saying that without these women there would be no thesis and I cannot adequately express my gratitude.

Chapter 1

Introduction

Rationale

Self-harm is, unfortunately, a significant feature of day-to-day life for women in prison. Reported rates of self-harm are four times higher in women's prisons than the general population[2] whilst the methods employed by women in prison are potentially more lethal (Towl *et al*., 2000). To date the study of the use of self-harm in prison has almost exclusively focussed upon either psychiatric symptomology (Fagan and Western 2003; Vollm and Dolan, 2009), the assessment of risk (Blaauw & Kerkhof, 2006) or effective interventions or treatment with the aim of preventing repetition of the behaviour (Dear, 2006). These studies invariably conceptualize self-harm within a medical model fixing attention upon the behaviour and measureable outcomes such as repetition and severity. Whilst this compliments both prison and healthcare provider's model of 'evidence based' practice it has been to the detriment of hearing and beginning to understand the lived experiences and perspectives of women who self-harm in prison. This oversight of the individual invariably results in a lack of understanding and subsequent poor care. Whilst this practice has been challenged in community settings by survivor/service user groups the voices of women in prison who self-harm have largely been overlooked. Service user involvement in the development of prison services is virtually non-existent and prison policy does not necessitate involvement despite a back drop of non-prison based policy and guidance recommending its incorporation in the commissioning and evaluation of mental health and self-harm services (e.g. Mainstreaming Gender, 2003; NICE clinical guidance 16, 2004).

Effective involvement of service users in the development of healthcare services requires the emancipation and empowerment of groups of people (who have been historically disempowered by medicine) through the recognition of their experiential expertise (Beresford, 2000). These principles share a number of similarities with the political agenda of feminism and the emancipation of women from patriarchal hegemony. Involvement in healthcare services resulted in increased service user confidence, knowledge and service uptake as well as

more effective research and services (Rhodes *et al.,* 2002). Such empowerment, however, presents challenges in the prison environment where service users (prisoners) are purposefully disempowered on the grounds of public safety and punishment for crimes committed. Public, and consequently political, opinion around the empowerment of prisoners and their ability to exercise choice (thus providing truly equivalent care) is also likely to impact upon the active involvement of prisoners. Given that involvement will always be balanced against the security constraints of a prison environment this thesis seeks to explore the extent to which emancipatory research, with the aim of praxis, is possible within a prison.

Contexts

The Research

This thesis ran concurrently with a Knowledge Transfer Partnership[3] (KTP) project. As such they are inextricably linked in that they were both based within the same women's prison in England, engaged the women in prison and prison staff in the same ways and were both carried out by the author. It is however in the aims of these two pieces of work (the KTP and this PhD thesis) that they diverge.

The KTP project was funded for three years by a Primary Care Trust (PCT) and the Economic and Social Research Council. The major stakeholders at the outset were the PCT, Durham University and the prison in which the project was based. The objectives of the KTP project were to i) reduce the incidents of self-harm within the prison, ii) reduce the associated costs of self-harm, and iii) improve outcomes and welfare for women who self-harm in the prison. As such, and as is generally the result of research receiving funding of this nature, the KTP was focussed upon the outcomes rather than by the method in which they were achieved[4]. Arguably these outcomes may have been achieved in different ways, for example the introduction of a cognitive-behaviourally based therapy and evaluated through randomised control trials or quasi-experimental methodologies. Had the KTP research been ethically conducted in such a fashion I have no doubt that the commissioners would have been satisfied as

long as the targets were achieved. Although as will become clear throughout this thesis I do not believe they would have.

The aims of this thesis however are not outcome focussed and these will not be reported here. In contrast to the KTP this thesis holds that it is the approach used that is critical and not necessarily the outcomes. This thesis is concerned with the use of empowering methods to engage those who are disempowered by the prison system (i.e. prisoners and to a lesser extent prison staff), that have not previously been used in English prisons. The thesis used self-harm as a convenient, but entirely justifiable and necessary, example topic to explore the practicalities of using such methods.

It can be considered therefore that the KTP and the PhD are almost symbiotic in their relationship. The KTP has provided the topic (self-harm) through which the PhD can be explored (emancipatory, transformative research), whilst the PhD has provided the means to deliver the outcomes that the KTP sought.

Language

It is important to define self-harm as this will not only determine the women that were eligible to be involved but also establish the approach and perspective taken of the behaviour. For the purpose of this study Morgan's (1979) definition of self-harm was slightly adapted to *"a non-fatal act, whether physical, drug over dosage or poisoning, done in the knowledge that it was potentially harmful"* (p.88). The adaptation being the removal of the word deliberate due to its negative connotations (see Pembroke, 1994). This definition was chosen for two reasons. Firstly it is inclusive of the full range of self-harming behaviours that are found within prison including self-poisoning or self-injury commonly through cutting, ligaturing, burning, interfering with wounds, punching or banging heads against hard objects etc. Secondly the definition is neutral in terms of possible motivation for the self-harm whilst excluding fatal acts. It is important to distinguish between self-harm and suicide given the differences in the function and intentions of the two behaviours (Solomon & Farrand, 1996; Brown Comtois & Linehan, 2002; Chapman, Gratz & Brown, 2006). This therefore also excludes acts where the intention may have been to end life

although it is acknowledged that for some women the intention might be ambiguous. The definition also excludes women whose self-harm is limited to behaviours such as substance misuse or eating disorders unless these co-occur with behaviour that fits the definition above.

The prison

The research took place in a single women's prison in England. Being the only prison for women within a considerable geographic area women are both remanded and sentenced, are serving a range of sentences from weeks to life sentences and any age 18 or over. Although women's prisons are not categorised as men's (e.g. A, B, etc) in 2007 the prison became one of 'high security' in order to accommodate women who are of media interest or a risk of escape. There were several such women in the prison at the time of this research. Having worked in the prison since 2004 it has been my experience that the change in security has resulted in a shift in culture in which the consequences of media attention and a greater focus upon security has resulted in increased suspicion and a caution towards change. The implications for this research are discussed through the thesis but included preventing the involvement of certain women and consideration of possible media attention, sometimes before the needs of the women. Parsloe (1976) identified three ideologies that individuals or institutions may hold which subsequently impact upon the way in which offenders are treated. Parsloe described these as the Welfare, Justice and Community approaches. It is clear that the ideology most aligned to the culture of this specific prison is, perhaps unsurprisingly, that of Justice. The Justice model set out by Parsloe holds crime to result from free choice, as opposed to social disadvantage as set out by the Welfare model. That this was the predominate belief is borne out by the prison rejecting suggestions that could be seen as providing desirable or privilege items. One specific example being the rejection of providing waxing strips to women (to cause non-injurious pain) as they may be seen as valuable items.

The average number of women detained in the prison between 2007 and 2007 was 270. As with most, if not all, women's prisons self-harm was a significant feature of daily life. The average number of reported incidents of self-harm

during the same time frame was 625 ranging from a peak of 960 in 2007 to 378 in 2010. The two most common forms of self-harm in the prison were cutting and ligaturing[5] which account for around 82% of all recorded incidents. Most women report self-harming when alone and confined to their cell. These figures depict a profile that is not unusual from that of other women's prisons in England and Wales (Corston, 2007) in which approximately one in three women in the prison self-harm and a small minority of these women account for a large proportion of the total number of incidents. For example between 2007 and 2008 just 7 women accounted for 35% of all recorded incidents of self-harm. The profile is also one in which self-harm is dangerous (34% of all incidents 2007-2008 were ligatures) and, despite decreasing rates, persistent.

Aim

It is worth reiterating that this thesis examines the extent to which emancipatory and transformative research can be achieved within a prison environment. This is achieved through the consideration of what such a framework would look like given i) the principles of feminist research, ii) the characteristics of service user involvement and iii) the realities of the prison environment. Whether emancipatory research can be achieved in prison is then 'tested' through the development of care for women who self-harm in a prison. Through such consideration and subsequent testing a framework will be developed that will aim to inform future research in prisons. Ultimately the PhD aims to develop a framework for future emancipatory research that can be employed to explore a range of issues that arise in the prison environment.

Chapter outline

Chapter two reviews the existing literature around self-harm. This is broadly broken down in to three areas, i) the prevailing medical/positivist literature, ii) survivor and service user literature and iii) feminist literature. The medical model has failed to identify interventions or treatment for self-harm that meet its own standard of evidence and, according to service users, healthcare practitioners often fail to meet the fundamental principles of care when dealing

with people who have self-harmed. The review starts by exploring the extent to which service users have influenced current medical practices and considers what could be gained from increased involvement. This is then compared to the survivor and feminist literature that exists which provides first hand testimony. How well the self-harm of women in prison is accounted for is considered in light of this review.

Chapter three establishes the theoretical underpinnings of the thesis and compares feminist and service user principles. Feminist research aims to understand women's life experience through the use of inclusive, experiential, and socially relevant enquiry (Reinharz, 1983). It is fundamentally linked to the notion of feminist praxis (Lather, 1991) or feminist action research (Reason & Bradbury (eds) 2008) which calls for such understanding to effect change – hence, the feminist mantra that 'the personal is political' (e.g. Hanisch, 2006). The principles of feminist research are discussed in the context of its use within the mental health field (Ballou & Brown, 2002) and its aim of empowering those who come in to contact with mental health services. Feminist research is compared and contrasted to that of service user involvement (SUI). SUI is a movement that, at face value, appears to have similar objectives to feminism such as the empowerment of individuals in their experience of service provision (Foster et al, 2005). The psychiatric survivor literature, emancipatory research and SUI overlap (Beresford & Wallcraft, 1997) but SUI is much more prominent than feminist research within health policy and health governance. Consideration is given to whether this is due to SUI being more pragmatic than feminist emancipatory research in the context of institutional settings, or whether it is only a tokenistic gesture (van Wersch & Eccles, 2001) towards emancipation.

Chapter four follows this by establishing the policy frameworks that exist within health and prison services. Consideration is given to the discrepancies and different approaches utilised by each of these services in the 'management' of self-harm and the impact of them in relation to the principles of equivalence of care. The involvement and neglect of service user experience in each of these areas and how this has shaped the respective policies is also discussed.

Chapter five introduces the controversial concept of harm minimisation for self-harm. Harm minimisation represents the meeting of theory, policy and feminist and psychiatric survivor activism. Despite harm minimisation being an established practice in fields such as substance misuse and sexual behaviour it is little used in relation to self-harm. The legal and ethical debates around the practice and the seemingly contradictory prison policy are also discussed.

Chapter six explores the ethical considerations of the research in relation to both feminist and service user ethics of power and how these can be realised within such a hierarchical structure as a prison. This research has been ethically complex and three specific aspects of this are considered. Firstly, the practicalities of obtaining ethical approval through the prison and NHS governance processes. Secondly, the inherent ethical dilemmas faced when working with women in prison, particularly in relation to power dynamics, confidentiality and security restrictions. The ability to conduct feminist emancipatory research in a prison environment is explored and the question considered as to whether the practicalities of such research necessitates a compromise for, or a re-orientation of, the original paradigm (Levinson, 1998). Finally, ethics surrounding gender and the implications of a man undertaking feminist action research are explored through the use of reflexive autoethnography.

Chapter seven outlines the mixed methodological approach used in the research and argues that the 'triangulation' (Denzin, 1970) that this provides may not only cross-validates the information gleaned from 'lived experience' but provides a broader and more detailed understanding of the topic being studied (Olsen, 2004). The purposive sampling strategy for both women and staff is described and the inclusion of staff is justified in relation to both feminist theory and the dialectic with women's accounts that this produces.

Chapter eight presents the findings of the research offering examples of how successful the approach has been with regards to engaging both women in prison and staff whilst developing knowledge in the process. The narratives of

both women and staff are given the primacy that they warrant but are triangulated with the data gained from the use of questionnaires, prison records and other sources of information. A number of themes are identified from women's and staff's accounts. These include the impact of imprisonment upon self-harm, the importance of relationships in the care for self-harm and identified courses of action to take in order to improve services and care for women in prison.

Finally, chapter nine critically analyses the theoretical and policy frameworks in relation to the research findings. Conclusions are drawn as to whether emancipatory research practices are achievable within a prison setting and the limitations on these. There is discussion around the development of products through praxis as opposed to consciousness raising towards political action. These are considered in relation to the experiences of two women who were actively involved in the project. The research implications for service user involvement, praxis and policy are considered and future research opportunities are identified.

Chapter 2

Literature Review

The literature around self-harm can be roughly divided along political and epistemological lines. Contemporary medical literature on the subject uses a positivistic methodology to examine self-harm in terms of clinical characteristics and psychopathology (e.g. Claes, Vandereycken, & Vertommen, 2007), assessment (e.g. Fliege *et al.,* 2006) and treatment or intervention (e.g. Hawton & Kirk, 1998; Evans *et al.,* 1999). In contrast the service user literature is grounded in both the feminist health activism movement of the late 80's (see Wilton, 1995) and the psychiatric survivor literature (e.g. Pembroke, 1994) of the 1980/90s. Both are characterised and linked (ibid) by a feminist approach expounding the life-experiences of those who enter the mental health system or use self-harm respectively. This literature review will explore the extent to which each of these approaches involves service users and harnesses the experiential expertise that involvement can bring to further the knowledge around effective care for self-harm. The extent of emancipatory research in prisons will then be explored to ascertain to what degree, if any, feminist principles have been applied in the custodial setting and whether this has been in relation to self-harm.

The Medical Literature

By medical literature I mean to include the all those disciplines which work within the overall dominant discourse of medicalization. This is likely to include, but not limited to, psychiatry, nursing, psychology, pharmaceuticals, and emergency and physical clinical practice. These professions dominate the discourse of health and ill-health by virtue of their position within major societal institutions and mainstream practice. The medical literature pertaining to self-harm is vast, the search of 'self-harm' returns over 6,800 articles in the database Web of Knowledge alone. In order to reduce the literature to a manageable amount and make it as relevant and comparable to the service user and feminist literature as possible it was necessary to limit the literature searches and narrow the field of enquiry. This has been done in a number of ways. Firstly the decision to limit searches to adults from western cultures was

based upon the focus of this thesis being upon adult females based in an English prison which detains predominantly white British women. Searches were not limited by gender however so as not to create artificial gender discrepancies or represent self-harm as a 'women's issue'[6]. In addition searches were limited to literature focussing upon interventions and care for people who self-harm. It was hoped that this criteria would offer the best opportunity for meaningful comparison with feminist literature given feminisms' inextricable link with praxis (Lather, 1991) and this thesis' aim of transformative research. In this respect both sets of work should be towards effecting meaningful change for people who self-harm, even if the method of realising the change is markedly different. The full criterion for inclusion is given in figure 1.

Figure 1 Criteria for Article Inclusion to Guide Selection of Studies

a) Human Adults (18+)
b) Sample from countries in which a 'western culture' is the dominant culture (i.e. European Countries and Countries marked by European immigration such as North America and Australasia)
c) Post 1979 (consistent with Morgan's definition of self-harm)
d) Self-harm (as defined by Morgan) is the primary focus of the article (i.e. the focus is not substance misuse, eating disorders, personality disorders or suicide/attempted suicide)
e) Self-harm was not a result of organic or developmental disorders
f) Articles written in English
g) Related to psychosocial interventions. (Given the possible positive impact of opportunities to discuss issues around self-harm (Read, 2007) 'interventions' include psychosocial assessment and have not been limited to therapies)

There is a wealth of literature exploring the efficacy of treatments for self-harm and a number of meta-analysis exist (e.g. Hawton *et al.,* 2000) which do not need repeating. There is also no benefit in this review identifying 'effective' interventions for self-harm as this is not relevant to the question in hand. What is relevant, and increases relevance for comparison to the feminist literature, is the way in which service users are involved in the design and evaluation of

care. NICE (2004) guidelines for the short-term management of self-harm call for qualitative methods to be employed (p.34) and for service user led research into the benefits and adverse consequences of services received (p.72). To date however the recommendations for service user led research do not appear to have been fulfilled. Instead the focus upon service user's experiences has been the traditional investigation, by academics or practitioners, of healthcare provider's attitudes towards self-harm, and how these impacts upon primary care (Treloar & Lewis, 2008; McAllister *et al.,* 2002). The findings of which have merely confirmed the experiences that service users highlighted ten years prior to the NICE guidelines (Pembroke, 1994).
Therefore, for the consideration of the medical literature a systematic review[7] was undertaken with the specific aim of answering two objectives:

1. In what ways have service users been involved in the design and/or evaluation of psychosocial interventions for self-harm?

2. By what methods have service users been involved?

Involvement of service users or people who self-harm was given the widest definition possible in acknowledgement that action or emancipatory research in this field is likely to be limited. Involvement therefore was taken to be anything from user led projects (Rose, 2003) to simply talking about the research or experience of intervention with the individual involved through interview or similar qualitative methods.

Electronic database searches from January 1979 to January 2011 were completed on the 28th January 2011 in Ovid MEDLINE (1950-present), Web of Science (1898-Present), Psychinfo (1979-present), Web of Science (including Science Citation Index and the Social Science Citation Index) and the Cochrane database of systematic reviews. The start date of 1979 was used to correspond with the development of Morgan's (1979) definition of self-harm as previously outlined. The search was completed using multiple combinations of the keywords Self-harm*, Self-injur*, Deliberate self-harm* Parasuicid*, Self-mutilation*, Intervention*, Psychosocial, Cognitive Behavioural Therapy (CBT),

Dialectical Behaviour Therapy (DBT), Family Therapy, Counselling, Psychother*, Art Therapy. This resulted in 45 searches being completed in each database.

The initial searches returned 1440 references for which all of the abstracts were independently reviewed. Studies which sampled participants of mixed ages, for example adults and juveniles or adolescents were included. Abstracts were reviewed in relation to the criteria in figure 1. In total 65 papers were included.

Table 1 Summary of the Systematic Literature Review

Research methodology	**No. of studies**	**No. incorporating service user involvement or experience of treatment**	**Methods used to engage service users**
RCT	19	0	N/A
A-B design	14	6	Interviews (4 studies)
Mixed factorial design	9	0	N/A
Interview	6	N/A	N/A
Case study	5	N/A	N/A
Reviews of interventions	8 reviews	0	N/A
Other	4	1	Delphi Process (1) Staff based action research (1) Audit (2)

Table 1 illustrates that even with such a broad definition of involvement, the active contribution of service users or experts by experience is virtually non-existent. In the medical literature only six of the 42 papers were found to use experimental or quasi-experimental designs whilst also employing interviews to consider the individual amongst the participants. All of these involved participants in A-B[8] designs aiming to measure efficacy through pre and post treatment assessment. Whilst two of the A-B design papers included individual case studies, it was evident that these did not necessarily represent the active voice of the people involved but were 'professional opinions' of individuals in treatment. The opening line of Wallenstein & Nock's (2007) case study speaks of the objectification of the person in treatment by reducing her to a list of negative characteristics:

> *"Ms. A was an overweight 26-year-old woman with a 13-year history of ongoing psychological and pharmacological treatment for persistent nonsuicidal self-injury, including one inpatient hospitalization for nonsuicidal self-injury within the past year"* (p.350).

Even where individual's presented in case studies were treated with more respect and important context was given to the person's life (e.g. Low *et al.,* 2001; Levy Yeoman & Diamonds, 2007) it was not clear what role they had in the case conceptualizations that were presented or whether their opinions of what was useful in treatment was considered.

Of the four studies which used the mixed methodologies of A-B designs and interviews, two did not report the qualitative aspects of their research (Nee & Farman, 2005; Kripalani, Nag, Nag, & Gash, 2010). This left just two studies using mixed methodologies. Ecclestone, Sorbello, (2002) reported that women who undertook the 'RUSH' programme in a women's prison in Australia reported that the skills the programme taught them (similar to those of Dialectical Behaviour Therapy) were useful in helping them to manage emotions that usually preceded self-harming. Cremin, Lemmer and Davison (1995) in contrast reported that patients completing treatment reported that the relationship they had with nurses was, for them, the most significant factor in their management of self-harm. This reflects the findings of those studies which primarily used qualitative methods of enquiry. Non-coercive, non-judgemental and empowering relationships were reported by services users to be instrumental in effecting change, regardless of whether these relationships were with individual therapists (Brown & Bryan, 2007; Malon & Berardi, 1987) or with groups of peers (Corcoran, Mewse & Babiker, 2007; Katz & Levendusky, 1990). The importance of client-therapist relationships were also echoed by qualitative studies examining the reasons for desistance from self-harm (Kool, van Meijel & Bosman, 2009; Shaw, 2006; Zich, 1984). Shaw (2006) remarked that in addition to a sense of control over their life journey:

> *"key features women found useful in stopping self-injury included empathic relationship with a professional who sees strengths beyond diagnostic labels"* (p.167).

Shaw (2006) reported that this remained consistent regardless of personal preferences for more directive interventions such as DBT or more client centred approaches. The importance of relationships is not a new finding however and Nelson and Grunebaum (1971) reported an 'equal' patient-doctor relationship as being the most important aspect in the treatment of self-harm. The importance of empathic and non-judgmental attitudes also extends to Accident and Emergency (A&E) doctors (Hadfield, Brown, Pembroke, *et al.,* 2009) and nurses (McAllister *et al.,* 2002). This finding however appears to have been lost or overlooked in the majority of the medical literature. This is particularly evidenced by the way in which those who undergo intervention are excluded from the research into its efficacy.

It could, of course, be argued that the individual's subjective experience of treatment is not relevant to the positivistic epistemology that is the basis for Randomised Control Trials (RCT)[9] and quasi-experimental designs which seek verification through empirical evidence (Macionis and Gerber, 2011). However the pursuit of evidently effective interventions for self-harm through empiricism appears to have failed. Eight of the 65 papers reviewed were previous meta-analyses or literature reviews aimed to identify effective interventions for self-harm. These are summarized in table 2.

Table 2 Summary of Existing Reviews of Psych-Social Intervention

Review authors	Type of Review conducted	No. of studies included	Type of method included	Key conclusions from the review
Arensman *et al.,* (2001)	Meta-analysis	31	RCT only	RCTs include too few participants
Royal Australian and New Zealand College of Psychiatrists., (2004)	Literature review & Meta-analysis	No information	Empirical including epidemiological	Evidence based on single RCT studies with no replication. Effect of psychiatric or community follow-up is poorly understood.
Comtois (2002)	Literature Review	5	Experimental and quasi-experimental control trials	Evaluation of outcomes and staff training is required
Crawford *et al.,* (2007)	Literature Review & Meta-analysis	18	RCT only	Many trials had too few participants.
Evans (2000)	Literature Review	No information	No information	Unlikely that a single intervention will prove effective for all. A number of trials should be further investigated.
Hawton *et al.,* (2000)	Meta-analysis	23	RCT only	Evidence is lacking to indicate effective treatment due to too few participants
Hawton *et al.,* (1998)	Meta-analysis	20	RCT only	Further larger trials are required.
Klonsky & Muehlenkamp (2007)	Literature Review	No information	No information	Given the heterogeneity of the behaviour psychotherapy will be most effective when self-harm is understood from the client's perspective. The key to effective treatment is the empathic relationship between therapist and client.

As can be seen from table 2 suggestions for the lack of empirical evidence include small sample sizes and that participants were too heterogeneous. Both of these criticisms are surprising given the large numbers of people who self-harm (Briere & Gill, 1998). Small sample sizes therefore may reflect the difficulty that scientific research has in engaging people who feel stigmatized either as a result of their behaviour (Balsam *et al.,* 2005) or the treatment that they receive (Pembroke, 1994). It may be understandable that attrition rates in some studies were high given some of the practices reported in some of the empirical research including the abuse reported by service users who have been placed in positions where they have to endure (rather than tolerate):

> *"Even patients whose lesions are particularly extensive and deep often do not acknowledge any pain and tolerate painful diagnostic procedures or treatment without analgesia"* (Myriam & Moffaert, 1991, p.62)

Arensman *et al's.,* (2001) finding that people who self-harm are too different and thus present confounding variables in studies of efficacy surely highlights the futility of attempting to treat people using a one size fits all approach. Notably, a review by Klonsky & Muehlenkamp (2007) again comes back to empathic relationships as being key to effective treatment.

Even where empirical studies report a treatment effect it was not always possible to explain why this was (Linehan *et al.,* 1991; Slee *et al.,* 2008; Spinhoven *et al.,* 2009; Weinberg *et al.,* 2006). Given the expertise and unique perspective of those with lived experience (Beresford, 2000; Maddock, Linehan and Shears, 2004) asking service users to answer the question of what is and what is not useful about intervention is likely to be enlightening for these studies. This is also consistent with Lamprecht *et al's.,* (2007) conclusion that solution focussed therapies have shifted the philosophy of interventions for self-harm towards *"the patient as expert on themselves"* (p.602). The argument that empirical studies should not include subjective experiences of individuals therefore seems weakened by its inability to provide objective 'evidence' of what is effective. This is reflected both in the NICE (2004) guidelines and the conclusions of a review of interventions by the Royal College of Psychiatry (RCP, 2010):

> *"Although an empathic approach is essential in dealing with people who self-harm, it is not clear that any one form of treatment is particularly effective, and in some cases, the most pressing need is to address the underlying social issues"* (p.37)

Finally it is worth noting that only one study actively involved service users in the development of a service. This was during the construction of mental health first aid guidelines for self-harm through a Delphi process[10] (Kelly, *et al.,* 2008). Again the priority concerns of service users were reported to be the right to make choices and respect for the right to injure themselves. This contrasted, sometimes sharply, with service providers perspectives which prioritised emergency treatment and risk assessment. Another significant finding of the process was that service users did not consider cessation of self-harm as a treatment goal, either because it was not a priority for them at that time or they hoped that therapy would support cessation in due course. This mirrors previous literature which has suggested that repetition of self-harm (or more commonly re-presentation at primary care services) should be just one measure amongst others that holistically consider how interventions impact upon other aspects of the service users' quality of life (Kapur, 2005). Despite this all the empirical studies included in this review measured repetition of self-harm as a treatment outcome. It is likely, therefore, that empirical research to determine effective interventions for self-harm is flawed due to its insistence upon using repetition of self-harm as an outcome measure thereby focussing upon the symptom rather than, as the RCP (2010) describe, the underlying social issues.

Prison Based Self-Harm Literature

Whilst there is a lot of literature about self-harm in the prison environment, only a relatively small amount has focussed upon the effectiveness of interventions (Borrill, 2002) with the focus more commonly upon predictive risk assessment (e.g. Perry & Gilbody, 2009) or aetiological studies (e.g. Vollm & Dolan, 2009; Liebling & Karup, 1993; see also Lloyd, 1990). Borrill (2002) reported that the effectiveness of interventions in the prison environment was seldom researched and that evaluations should be included in the introduction of all new schemes by prison staff. To date there is no evidence of these evaluations having taken

place although this may be due to pressures on prison staff and an inability to find the time to evaluate or at least publish findings.

A significant amount of research has focussed upon a prisoner's ability to 'cope' with incarceration and the social and personal consequences of this (Dear *et al.,* 2006; Mohino, Kirchner & Forns, 2004; Bigham & Power, 1999). Efforts to enhance coping strategies have led to the development of cognitive interventions such as problem solving in order to address deficits in *"poor copers"* (Dear *et al.,* 2006, p.135). Positive (i.e. not self-harming) coping strategies are reported to be positive reframing, problem solving and acceptance (Negy, Woods & Carlson, 1997, Dear *et al.,* 2006). As a result self-harm and poor coping become synonymous with each other in some of the prison literature resulting in those who do self-harm being given a further negative label of 'poor coper'. Theorising self-harm as a result of cognitive deficits has been criticised (Crighton, 2002) as being overly simplistic. Despite this cognitive behavioural interventions continue, to be the most widely practised therapy in prisons. Wilson and Borrill's (2005) evaluation of the Enhanced Thinking Skills programme reported significant reductions in self-harm pre and post treatment. Subsequent interviews with 15 people who had completed the course suggested that it had enabled them to ask for help or assert themselves differently. Dear *et al.,* (2006) however again caution that sample sizes were too small to draw definitive conclusions. Regardless, Wilson and Borrill's (2005) research is the only example of the use of a mixed methodology in evaluating an intervention, using the qualitative experiences of prisoners to compliment the quantitative results in the evaluation of an intervention.

The role of peer support has also been reported as beneficial in reducing self-harm in prisons (Snow and Biggar, 2006). Peer support schemes such as The Listeners were found to be more likely used by prisoners who were experiencing difficulties within the prison (possibly those labelled as poor copers) and those that used the scheme reported benefit from doing so (Snow, 2002). Power *et al.,* (2003) report that the Listeners scheme was respected and valued by prisoners and staff alike, whilst Snow (2002) highlights that

involvement in providing support for people in prison can be empowering and provides an additional option for prisoners in distress. Borrill (2002) reports support groups (as opposed to the one to one support offered by Listeners) were promising in reducing feelings of isolation and managing on-going problems outside of the prison such as trauma.

As in the community, the issue of attitudes towards self-harm has also been explored and it is in this aspect that service users have been more involved. Kenning *et al.,* (2010) compared women's accounts of self-harm and their reasons for it with the perceptions of prison staff. It was reported that whilst women used self-harm as a way of managing emotions, punishing herself, expressing anger or exerting control, staff commonly perceived self-harm as being used for manipulation or material gain. This is significant given that the majority of primary care is delivered by officers and reflects the reported moral judgements of A&E staff who are also more commonly involved in primary care. Kenning *et al.,* recommend from these findings additional training for staff and strategies to improve communication between staff and prisoners. These are further reflected in Gough's (2005) guidelines for 'managing' self-harm which focus upon interaction with people who self-harm and highlights the importance of remaining non-judgemental and avoiding placing pressure upon people not to self-harm. It is apparent through references to literature such as that of Louise Pembroke and Lois Arnold that these guidelines are informed by service user experience although there is no evidence of survivors being involved in the development of the guidelines.

It is clear that service users have not been systematically involved in the design or evaluation of psychosocial interventions for self-harm, either in prison or in the community, as reported through the mainstream medical literature. This has resulted in a failure to ask simple questions and uncover answers to provide meaningful care. This appears to be a result of the need for empirical research to be seen as removed from the subjective in an attempt to identify a universal objective truth. With this in mind the feminist literature will now be reviewed.

The Feminist and Survivor Literature

To provide as close a comparator with the medical literature as possible the same databases were searched for the slightly extended period of time January 1979 to April 2012. It was expected that the feminist and survivor literatures around self-harm would not be as extensive as the prevailing positivist epistemology, therefore the searches were not limited to psycho-social interventions but made as widely as possible. It was decided to 'combine' the feminist and survivor literature for pragmatic reasons on two grounds. Firstly the amount of literature each has produced relating to self-harm. Secondly, although feminism and survivor movements are distinct, their similarities both politically (Adame and Knudson, 2008) and in relation to praxis (as described in chapter 3) are complimentary and allow for comparison and contrast more naturally than paradigmatically opposing literature such as the medical approach.

I acknowledge that searching medical and scientific databases may not fully capture the full breadth of feminist literature, however I have chosen to restrict the searches for two reasons. Firstly, and solely for pragmatic reasons, it has already been documented by feminist scholars that self-harm is a neglected area by feminism (Kilby, 2001, Wilton, 1995). This is confirmed by searches yielding no results on the website *Grassroots Feminism* [11] and just one result in the journal Hypatia (which I refer to below). To conduct lengthy manual searches of feminist archives seems unlikely to produce results contrary to the observations already made. Secondly I believe that the use of the medical or more 'mainstream' databases will be to provide a more relevant comparison with the medical literature already discussed, especially in relation to effecting change in practice. Whilst important feminist explorations of self-harm exist, these individual understandings (e.g. Kilby's (2001) discussion of McLane's and Pembroke's works) do not appear to go on to effect praxis. Whilst understanding the individual is essential for effective care, the focus of this thesis is precisely upon transformative change and not solely increasing understanding. I assert that for change to be systematic it has to become a part of the mainstream discourse, just as the use of language is highlighted in the NICE guidelines. Therefore the extent to which emancipatory, feminist or service user works have influenced clinical practice is best answered through

exploration of the clinical literature which still, perhaps unfortunately, represents the mainstream discourse.

The search terms used were multiple combinations of feminis*, survivor, psychiatric survivor, self-harm*, self-injur*, deliberate self-harm*, parasuic*, self-mutilation. In all 15 searches were completed returning a total of 299 articles. A rigid inclusion criterion was not required although literature was restricted to psychiatric survivor and therefore did not include articles solely relating survivors of abuse or violence unless self-harm was specifically discussed.

Despite such a wide inclusion criteria just 25 articles were identified as feminist pieces and/or articles written by someone with first-hand experience of self-harm. Although inclusion was not based upon gender it is worth noting that none of the survivor literature was written by a male. Wilton (1995) commented that feminism had missed mental health and self-harm as a result of being anti-therapy and through accusations of "mind rape" (Daly, 1979 in Wilton) by separating the individual pathology from the causal political oppression of women. Kilby (2001) notes surprise at the lack of feminist readings of self-harm despite the issue sharing similar concerns as other areas of feminist critique such as language, power and subjectivity (p.129). Given the dearth of feminist literature it would appear that feminism may still be a part of the *"conspiracy of silence surrounding self-injury"* (Wilton, 1995, p.36). The wealth of feminist literature surrounding factors that may underlie the use of self-harm, such as surviving abuse, suggests that feminist studies may be more concerned with underlying causal factors of self-harm rather than the behaviour itself. However, as Wilton highlights, this position does not immediately benefit those women who are unable to engage in dissent against a political system that does not adequately acknowledge the abuse of woman (Westmarland, 2008) due to pressure of class or their mental wellbeing. Whilst consciousness raising activism will ultimately benefit all women, overlooking the immediate needs of those who receive inadequate or damaging care does little for the individual's immediate circumstances and arguably perpetuates the abuse inflicted by some clinicians. The identified feminist literature regarding self-harm can be broadly

differentiated into two categories: i) theoretical constructs of self-harm and ii) discussions around treatment and care for self-harm.

Despite feminism not being a unified discipline (Jones, 2000), and even medical models (unified by positivism) not consistently accounting for self-harm, feminist theories are surprisingly, though not entirely, consistent in their construction of self-harm. Most of the feminist literature works towards normalising the behaviour (as opposed to pathologising) in the context of its use as a response to abnormal situations such as abuse and violence (e.g. Crowe, 1996; McLane, 1996; Reece, 1998). McLane suggests that despite abuse compelling communication, the experience also nullifies the person's ability to communicate their experiences. This can be as a result of lack of self-worth, fear of repercussions or the failure of language as a proper medium of expression (Crowe, ibid). Self-harm, and in the majority of literature this means cutting, therefore becomes the medium for expression or "*the creation of a voice on the skin"* (McLane, 1996, p.115). Self-harm as a method of communication or expression is also borne out in the testimonies (Cresswell, 2005) of survivors. However it should be emphasised that the need to communicate is not always a result of sexual abuse (Reece, 1998) and of course the circumstances that lead to self-harm are often complex and multifaceted as described by Pembroke (2007). Harrison (1997) describes her use of self-harm as, amongst other meanings, a way to *"scream at my perpetrators"* (p.439) or as a way of telling abusive medical staff to "*fuck off"* (p.438). Similarly Elliott (2001) describes her own self-inflicted violence[12] as an expression of the justifiable rage she experiences and that she has to inwardly direct. It is this emphasis upon communication that particularly differentiates the feminist theories from the majority of the medical literature. Shaw (2002) reports that *"current treatment is characterised by disengagement with women who self-injure"* (p.199), and Johnstone (1997) considers this a result of the distance created by the medicalization of self-harm. A dialectic is thus created in which self-harm is used as a means of communication however the 'treatment' for the behaviour does not allow for the service user to communicate openly. This can be seen in medical treatments that do not necessarily promote open communication or allow the woman to set the agenda for the discussion;

particularly skills based interventions such as CBT & DBT and especially where these are self-administered from manuals sent in the post (Tyrer *et al.,* 2004). Interventions have also been bastardised from initiatives of the survivor movement and appear to have lost the personal approach in the process. Evans *et al's.,* (1999) administration of a 'green card' with a telephone helpline for example bears striking similarity to the crisis cards launched by Survivors Speak Out (Pembroke, in Spandler, 2007) which support advocacy in emergencies. It is perhaps unsurprising however that whilst Pembroke reports the crisis card, having been developed from the grassroots and indicating the bearer's choices of care and advocacy, is a useful tool for communication, the evaluation of the green card, an opportunity to talk to an on-call psychiatrist, was hampered by lack of use. Continuing the emphasis upon communication and expression, discussion around care has focused upon the need for therapeutic relationships (Harker-Longton and Fish, 2002) that promote openness, genuine empathy and are non-judgemental. Shaw (2002) criticises clinical approaches for having forgotten that self-harm is meaningful and a survival strategy instead viewing the behaviour as emotional blackmail. Johnstone (1997) suggests that the individualisation of the medical model neglects the relational and social factors that may also underlie self-harm. Attending to relational and social factors would allow for a more productive collaboration through consideration of personally relevant holistic or 'good life' aims (Adame and Knudson, 2008). For example planning for the person's future (Liebling and Chipchase, 1996) and not just planning for their abstinence from self-harm. This approach again mirrors service user's experience of useful care (Tate, 2010; Pembroke, 1994, 2007) and is distinctly different from the majority of the mainstream medical discourse, with some notable exceptions such as Kool, van Meijel and Bosman, (2009).

Feminism further contextualises self-harm within patriarchal hegemony, highlighting harmful yet culturally sanctioned cosmetic procedures ranging from hair removal and piercing to cosmetic surgery and dieting (Johnstone, 1997; Shaw, 2002). Self-harm which results in medical attention does not comply with cultural norms for femininity resulting in the stigma so often described by those attending for treatment. This context places self-harm within the politics of

gender and thus, for some, frames self-harm as a 'women's issue'. This is clearly seen in Brickman's (2004) rebuttal of self-harm and especially 'delicate cutters[13]' as pathologising female bodies and Shaw's (2002) assertion that *"self-injury reflects girls' and women's experiences of relational and cultural violations"* (p.192). In this context self-harm becomes a product of patriarchal hegemony that is unique to women. Marzano (2007) however describes this gendering of self-harm as regrettable recognising that of course *"men are also – at times – 'other' to women and, more often, to other men"* (p.298). It would of course be expected that feminism examines self-harm within the politics of gender. However the narrow focus upon cutting (as seen in Kilby's (2001) feminist reading) as *the* method is likely to be the cause of the disciplines erroneous claim of self-harm as a women's issue. Doyal (1995) highlights, the disparity in access to wealth between men and women often means men can manage their mental health through the use of expensive resources such as alcohol whereas women are perhaps more likely to access cheaper medical alternatives. The same could be true for self-harm, thus men who are 'other' may self-harm in ways that are different or more hidden (such as abuse of alcohol) than women who access methods such as cutting which are not as financially dependent. The implications of defining self-harm as a women's issue are likely to further confound stereotypes of self-harm whilst also potentially hampering the identification and subsequent treatment of self-harm by males.

Survivors attest to power differentials and the lack of control that this produces as being instrumental in self-harm. More commonly however, this is situated specifically within psychiatry and medicine rather than the overarching patriarchal society. Johnstone (1997) asserts that the professionalization of self-harm removes power from service users and places it within the patriarchal institutions of health and medicine. Harrison's (1997) expression of *"fuck off"* (through cutting her face) was in relation to being told to by a male nurse she would look prettier with makeup on. Elliott (2001) regained control over her fear through self-harm taking it from those who instilled fear in her. In this respect useful interventions/care are those that promote choice and further empower. For Pembroke (2007) it was information about harm minimisation that allowed

her to self-harm in a safer, more controlled way. For Tate (2010) it was being able to exert choice in whether she saw a psychiatrist or not. In Ashworth high secure hospital Liebling and Chipchase (1996) through 'feminist therapy' empowered women to choose not only the content of the sessions but also the staff facilitators and the way in which the group's progress would be monitored. Reece (1998), herself a nurse, identified that issues of power in the medical model needed to be addressed and professionals should recognise that self-harm does not necessarily indicate of a lack of control (but possibly the opposite). The implication of which is that control does not necessarily need to be imposed by removing choice from the person. This again contrasts with the medical model of treatment which often removes control through use of treatment goals such as cessation of self-harm, seeing continued self-harm as treatment interfering behaviour (Crowe, 1996) or through the application of punitive labels such as attention seeking (Johnstone, 1997).

The existence of these differences is not surprising given the differing approaches of the two paradigms. These differences are perhaps best summarised as the difference between treatment (medical model) and care (survivor/feminist models). Figure 2 briefly illustrates some of these differences.

Figure 2 - Consideration of the Difference Between 'Treatment' and 'Care' as Proposed by the Medical and Feminist/Survivor Paradigms Respectively

Characteristics of Treatment	Characteristics of Care
Goals of cessation of self-harm	Acceptance of self-harm
Treatment of the behaviour	Appreciation of social and relational factors
Delivered by a medical professional	Can be delivered by anyone with the appropriate personal qualities/values
Use of stigmatizing and reductionist labels	Holistic and person centred
Evidenced through quantitative analysis preferably RCTs	Evidenced through what is individually useful for the person
No discussion around harm minimisation	Tools for harm minimisation provided

It would appear from the discussion so far that there is little to distinguish the feminist and service user/survivor literature. The two however are not the same and this is most starkly illustrated by the involvement of service users and the

nature of the literature produced. The lack of involvement of service users is a criticism that can also be levelled at the feminist body of work. The majority of feminist works in this area are commentaries or theoretical pieces that do not relate or include individuals in any way (e.g. Johnstone, Shaw, Crowe). Where service users narratives are included the impression that these are just that 'used' in order to evidence the theory of the author with no discussion of how the narratives were obtained or a sense of who the person behind the narratives is (e.g. McLane, 1996). The academic distance that this creates is evidenced by the labelling language, such as *"cutters"* and *"burners",* (Brickman, 2004) that survivors have sought to change (e.g. LeFevre, 1996). It is also clear that, for some, the failure to involve service users leads to poor recommendations such as no-self-harm contracts (Crowe, 1996).

Another significant omission from the majority of feminist literature is specific research about self-harm. Whilst McAndrew and Warne (2005) used feminist informed psychoanalytic interviews to explore three women's self-harm, the authors claim to using a feminist praxis appears to fall short of Lather's (1991) definition of the term as it is unclear how the women who took part benefitted directly or otherwise from their participation. This gap in politically motivated research has been filled by service user organisations, most notably the Bristol Crisis Service for Women (BCSW)[14] which have explored the links between self-harm and abuse, hostile family communication styles and women's self-esteem (Wilton, 1994a; 1994b). Importantly, and proving that the BCSW was focussed upon praxis, this research also explored women's experiences of services and was published in an accessible way with the aim of increasing awareness and understanding of self-harm amongst service users, professionals and carers. The recommendations for care from the women who participated in the research included information, improved professional attitudes, counselling and therapy, peer support groups, specific support for times of crisis and practical help (p.27-28). These recommendations were delivered and expanded upon by Lois Arnold and Anne Magill (2000) in the production of information booklets and a guide to support organisations in the development of a self-harm policy (Arnold & Magill, 2001). Similarly, other service user led organisations such as Survivors Speak Out (SSO) and the

National Self-Harm Network (NSHN) were more informally involved in research, usually through canvassing opinions of survivors at conferences and meetings (NSHN, 1998). This resulted in the publication and promotion of a number of initiatives[15] including Crisis Cards (SSO, 1989) The 'Hurt Yourself Less Workbook' (NSHN, 1998) and 'Cutting the Risk' (NSHN, 2000). The accessible and inclusive style of this work as well as its focus upon harm minimisation sets it apart from the feminist literature. It could of course be argued that the academic feminist literature and the survivor research and publications are merely different sides of the same coin especially if, as Jones (2000) asserts, there is no discrete feminist academic field, merely a collection of feminist works. As such feminist scholars may have avoided research and user involvement because this is so ably done by survivors. As highlighted above however Wilton, (one of the few people to (openly) straddle both the academic and survivor fields), does not believe this to be the case, instead viewing self-harm research as being as marginalised as the behaviour itself.

Emancipatory Research in Prison

Sudbury (2005) described the *"global lockdown"* (p.xvii) of women through various means of incarceration including immigration detention centres, forensic psychiatric units, juvenile centres and prisons. Whilst all these institutions share similarities in their use of physical and procedural security to detain women and prevent escape it is only the prison system that is immediately relevant to this thesis. Richie (2004) wrote of the US prison system:

> *"There, behind the razor wire fences, concrete barricades, steel doors, metal bars and thick plexiglass [sic] windows, nearly all of the manifestations of gender domination that feminist scholars and activists have traditionally concerned themselves with, exploited labour, inadequate healthcare, dangerous living conditions, physical violence and sexual-assault are revealed at once"* (p.438)

Given that, according to Richie, prison represents a microcosm of feminist concerns a rich and extensive feminist literature about female prisons may be expected to exist. However Marcus-Mendoza (2011) highlighted that this is not the case as *"major feminist inroads have yet to be made into corrections"* (p.77). This is borne out by the literature search. Using the same databases and time

scales as above just 14 articles were included from the search terms feminis* and prison* service user* and prison and survivor* and prison*. Articles that related to alternative sentences for women and gender specific pathways to offending were excluded in order to focus upon women's experience of prison and literature relating to practical change through feminist or service user action. Themes commonly arising from the searches were issues of gender sensitivity, emancipatory practices within education, the educator's reflections upon this experience, and feminist therapies in prisons all of which originated from North America.

Labelle and Kubiak (2004) assert that a policy of gender blindness, treating male and female prisoners identically, within US correctional policy resulted in conditions that were more punitive for women than for men. This was also recognised in the English and Welsh prison system by Corston (2007) who recommended changes to procedures including ending the routine strip searching of women. The failure to consider women's life contexts and circumstances can also be seen in many of the interventions or therapies that are delivered within prisons. The cognitive behavioural basis of these presume that offending behaviour is a product of deficits in problem solving or emotional management and thus fail to address economic, relational or health circumstances that may also contribute to women's offending behaviour[16] (Maidment, 2006). One alternative to the CBT, approach often cited in the feminist literature, is feminist therapy. Brown (1994) describes this as therapy informed by the political and scholarship of feminism and which promotes resistance and change in relational and political aspects of life. Marcus-Mendoza (2011) claims this approach is essential for the wellbeing of marginalised women. Feminist therapy in prisons is described as subversive (Marcus-Mendoza, ibid; Bruns & Lesko, 1999) and yet the difficulties of working as a 'feminist' and a 'member of staff' is discussed and acknowledged. One aim of feminist therapy is to focus upon issues of power and to assist women in developing agency through making choices and appreciating the patriarchal system in which they are being forced to conform. These aims mirror those of educational programmes such as mentoring women through Women's and Gender studies programmes (Lempert *et al.,* 2012*)* or wider ranging educational

programmes (Fine *et al.,* 2004). The extent to which women were able to exercise choice in feminist group therapy in Ashworth hospital has already been described (Liebling and Chipchase, 1996). The tone of the North American literature in comparison to Liebling and Chipchase sets it apart. As well as claiming subversion Lempert *et al.,* illustrate staff abuses of power and its arbitrary use without any account of care or even handedness. The explicit abuse of power, or a conservatism preventing teaching of subjects such as racism or sexism for being deemed too controversial (Parotta & Thompson, 2011) will be regrettably real in all prisons, including those in the UK. However such an 'us and them' positioning does not allow room for consideration of ways in which staff themselves may be marginalised (Liebling, 2004) or arguably establish a sound working relationship with which to build lasting change. Similarly the analytical skills that Lempert *et al.,* wish to teach in order to challenge the patriarchal prison discourse should be caveated with realistic expectations. Although women in prison will benefit from education in identifying imbalances and abuses of power, challenging a system which compels conformity could be damaging for the individual or group of women who attempt to make the challenge. To this extent, Bruns and Lesko (1999) also conceptualize feminist therapists as being advocates for their clients through staff education and promotion of non-oppressive policies. To date however there is no evidence of this happening in a systematic way with the exception of the consciousness raising work of Carlen (Carlen, 1983, Carlen *et al.,* 1985) and the organisation Women in Prison (see chapter 3)[17]. This failure may be a result of therapists themselves not being in positions to inform prison policy or due to a confrontational stance not being productive in effecting changes. This later point is evidenced by Corston's successes in attuning the English and Welsh prison system to gender based practises. Although arguably Baroness Corston's position within Government places her as an instrument of patriarchy it was only through an engagement with authorities that beneficial change was achieved. The utility of this approach is also demonstrated by Fine *et al.,* (2004) who provided the only account of an emancipatory approach that involved women in prison through a Participatory Action Research (PAR) approach. Fine *et al.,* reported a supportive relationship with prison staff as a result of continuous dialogue resulting in involvement to an extent that has not

been reported elsewhere. Women in prison were recruited as researchers to examine the impact of education for women in prison. This involved women prisoners collecting, analysing and writing up the research under the facilitation of academics. As a result the essay produced went beyond the reflections of the academic authors as are included in the majority of the feminist literature but instead included the reflections of the women in prison, whether they were 'insider' researchers or the women enrolled on the courses. As well as the knowledge that this teaches women in prison it is evident that for the 'insider' researchers this also builds self-esteem and is beneficial for the research itself:

> *"Just because I am in prison does not negate the fact that I am a competent researcher. Using prisoners as researchers is a valuable experience that is beneficial to both the participants in the study and the readers of the results."* (Fine et al., 2004, p.188)

I would argue that such an active and empowering involvement of women in prison is more subversive (although subversion is never claimed by the authors) and challenging to the established patriarchy of the prison than education in feminist theory alone. The prospect of women occupying the position usually held by outside researchers or prison staff challenges both the positions of power that these roles usually bring and the status quo.

In relation to self-harm the emancipatory literature is non-existent within the prison context. Whilst some women have been consulted through interviews about self-harm (Borrill, *et al.,* 2005) or service users views have been sought of prison health services (Condon *et al.,* 2007) there has been no active engagement or involvement such as that achieved by Fine *et al.*, (2004). Thelmi (2006) goes further than most in politicising women's imprisonment by considering the life experiences of women in prison and how these relate to self-harm. Thelmi further reflects how women's rights in the criminal justice system are often marginalised by a system designed for men. As with feminist perspectives on mental health this therefore removes the emphasis upon the individual (the 'poor coper') and politicises the person's position. Thelmi concluded that the prison system reflects the dominant social norms, resulting in a *"system that crushes women mentally, leading them to enact suicide and other self-harm"* (p.193). Similarly Potier (1993b) reflected that a 'power game'

in secure hospitals suppressed women and resulted in self-harm as a way of attempting to regain control. Where feminism failed or overlooked women in the community who self-harmed, a politically similar survivor movement was able to fill this void, the seeds of which were sown by three women in a locked ward (Wilton, 1995). This, to date, has not been achieved in the prison setting and nor have feminist activists or survivor groups sought to take action to improve the immediate circumstance of women who self-harm in prison. Whilst Borrill (2002) reported that an adapted version of the 'Hurt Yourself Less' workbook was used in HMP Leeds, it was not clear what the adaptation was. Given the prison service's position on harm minimisation (see chapter 5) it was likely to be these aspects which are arguably the crux of the workbook. Whilst issues of gender in relation to self-harm in prison have been previously considered this has not been extensive and falls short of the politically motivated activism that is usually associated with feminist research. However there is recent evidence that service user involvement is increasingly gaining prominence in the NOMS agenda (Clinks, 2011). The publication of *Release* (Thorn, 2010), a collection of creative writing about self-harm by women in prison, was distributed around the female estate illustrating that the National Offender Management System (NOMS) has taken up the long history of publishing the creative writing of survivors. The compilation aims to be an educational tool for staff and women in prison about self-harm, its function for women, and the promotion of creative writing as a possible other outlet and method of communication. There are similarities between this and the suggestion of alternatives to self-harm in the Hurt Yourself Less Workbook and suggesting a more holistic approach in which women's voices are given prominence is starting to be adopted by prisons.

Summary of the Literature

This review of the literature, by necessity, does not consider all of the factors that relate to women, their pathways into offending and their experience of the criminal justice system as called for by feminist criminology (e.g. Love, 2008). Nor does it consider the retraumatization of women by prison as a result of its power imbalances, despite these being important political issues (Moloney, van den Bergh, & Moller, 2009). Instead I have focussed upon the empowerment of women whilst in prison through their active involvement with the aim of

improving women's immediate situations instead of the longer term political goals.

It is clear from the review that self-harm has been extensively researched by medicine. The positivist approach remains the dominant discourse despite its failure to definitively evidence effective interventions for self-harm. This failure may well be a result of its epistemology which overlooks the experience of service users and the importance of relational aspects of care in favour of treatment goals focussed upon cessation. This is challenged by the feminist discourse which stresses patriarchal oppression as responsible for the prevalence of women's use of self-harm. As such, feminist reflections on self-harm move the search for effective interventions away from the individual and their behaviour towards intervention in the political system as a whole through challenging patriarchal hegemony. However, there is little feminist informed research and feminist scholars are, in many respects, equally as guilty of overlooking the individual women as the medical model. This void of active involvement of service users has been filled by a functional and political service user/survivor movement which has advocated for people who self-harm and informed practice & clinical attitudes. The NICE guidelines (2004) recommendation that the use of the phrase Deliberate Self-Harm be discontinued as well as the functional publications of Arnold, Magill, Pembroke and Wilton are just some examples of the movement's success. However this has not been realised in the prison environment where service user engagement has been limited to occasional consultancy (Rose, 2003) with prisoners. Potier (1993a) states *"Women's voices must be included"* (p.3) in the development of gender sensitive services and despite a recent recognition of the need for this, driven by the Corston Review (2007), there is no evidence that women's voices are being systematically included or heard. Whilst there is evidence that SUI is becoming increasingly important within NOMS whether this will equate to emancipatory practices relating to self-harm is not yet known.

Chapter 3

Theoretical Framework

De Beauvoir (1949) stated the belief that women are limited in society due to their biology and especially their reproductive biology. If this is true then it could be argued that the health system, a political institution for which biology has the greatest relevance would also serve to limit women. There would be no reason to assume that the health system would be alone in rejecting patriarchy, as reflected by Zola's (1975) assertion that medicine serves as a form of social control. One example of this is seen in the medicalisation of pregnancy, a biological phenomenon that is no longer controlled by women with experience but by medical professionals who are predominantly male (Miles, 1991). If these assertions hold true then it would also be logical to assume that such oppression would be magnified in systems which serve the function of social control such as the prison service and healthcare in prisons.

Where reproductive health does not allow for meaningful comparison between males and females, mental health does. Whilst the generally held stereotypes and assumptions about women experiencing generally poorer health have been challenged (Macintyre et al, 1996) women are more frequently labelled as suffering from mental or psychosocial ill health than men (Annandale and Hunt, 2000). The existing debates around whether such discrepancies in mental health diagnoses are due to women's social positions (Brown and Harris, 1978) or a bias in the medicine that reflects an institutional sexism (Nettleton, 1995) are important; but they are beyond the scope of this chapter.

Instead the chapter will examine how well the feminist research methodologies account for women's experiences, if the medicalisation of women's experiences results in contact with the health and/or criminal justice systems and how, once in these systems, their experiences are accounted for. The feminist methods will be compared to the similar approach of service user involvement and consideration given as to the reasons for the successes and failures of these differing principles in the health and prison establishments.

Defining Feminism

Reinhartz (1992) highlights that "Feminism is a perspective not a method" (p.240) and had previously characterised the perspective as being contextual, inclusive, experiential, relevant, multi-methodological and mindful of the individual's experience of events and related emotions (Reinhartz, 1983). Such a vast variety of characteristics makes defining feminism difficult and a conclusive all-encompassing definition that satisfies all those involved in the perspective is unlikely (Ramazanoglu, 1992). For brevity and clarity this section will define feminism in relation to three aspects i) the epistemology of feminism or the methods by which feminist knowledge is acquired; ii) the relationship between researcher and the researched and iii) the purpose and utility of feminist knowledge.

i) The epistemology of feminism.

All of the characteristics set out by Reinhartz (1983) distinguish the feminist method (or perspective) from the traditional positivistic values of objectivity[18], replicability, and generalisability[19]. Hammersley (1992) critically describes this as valuing experience over method, suggesting that what is lost by the feminist rejection of empiricism is the objectivity of the scientific method to uncover a global or decontextualised truth. It is with intent however that feminists have taken an anti-positivism stance. This would suggest that the positivist approach is characterised by patriarchy and sexism (Seidler, 1989) and which excludes women and other marginalised groups (Collins, 1998). Feminism is therefore a set of methods to acquire a perspective of an individuals' constructs and interpretations of the world and their personal truths. Whilst Hammersley's point that women will not have *"uniquely valid insights"* (p.193) [in to all areas of interest to the researcher] seems common sense, so too is the notion that the research participant (whatever gender they may be) will surely have uniquely valid insight in to their own circumstances, situations and perceptions of what is true. This mirroring of Gramsci's (1982) proposition that everyone is an intellectual [it is just that not all have the social function to utilise this] lies at the heart of the relationship between participants and feminist researchers.

ii) The nature of researcher-participant relationships

As well as rejecting the patriarchy of positivism, feminism also rejects the traditional power relationship of the researcher and the researched. Stanley and Wise (1983) claim that conventional research relationships involve objectifying participants and maintaining a hierarchy in which the researcher assumes a position of power or specialised knowledge and insight over those researched.

The feminist methods are marked by a collaborative and equal researcher-participant relationship often involving participants in research and data collection and design (Gatenby and Humphries, 2000) and in the discussion of the information collected (Wardhaugh, 1989). Whether truely equal collaboration is achievable has been debated (see Hammersley, 1992) and will be considered in relation to this research in detail in chapter 6. The intent of non-hierarchical relationships often results in feminist researchers taking a more socially active role whether this be in forming lasting friendships with participants (Oakley, 1981), the emancipation of participants (discussed below) or through the extension of the research project due to a reluctance to disengage (Gatenby and Humphries, 2000).

Fine (1994) suggests that those who participate in feminist research are often labelled as "other", a classification that is often borne from gender, class, ethnicity or in the case of this research being a "prisoner". As such participants may be disenfranchised or marginalised and it is for these reasons that feminist research is often driven by an agenda and a specific objective.

iii) The purpose of feminist research

As previously noted feminist methods diverge from the empirical in the specific objective of acquiring knowledge for the purpose of change and reform rather than for solely acquiring information or seeking a truth. This is highlighted by the use of feminist knowledge for political ends (Eisenstein, 1979) and by Cook and Farrow (1990) who highlight that *"the transformative nature of knowledge is emphasised in the feminist methodology*[sic]*…attention is paid to generating information that create alternatives to oppression"* (In Nielsen, p.89). Reinhartz (1992) makes the purpose of feminist research clear *"to create new relationships, better laws and improved institutions"* (p.175).

Yet despite the political intentions of feminist research the perspective is not always directly or inextricably linked with action or emancipation. This is exemplified by no index reference to action or emancipation in the book '*Doing Feminist Research'* (Roberts, 1981) and possibly the amount of literature defining the feminist methodologies and critiquing the empirical position without actually affecting change. This would therefore appear to create a distinction between feminist research as a means to gather knowledge (which ultimately may or may not be used to create change) and a feminist action methodology which specifically sets out to emancipate and create change, whether within the participants or on a more macro scale[20].

As has been implied, but not been made explicit, feminism's primary concern is with the issue of gender and how this is used to oppress women. Ramazanoglu (1992) succinctly describes the marrying of research and political agenda through the statement:

> *"feminist methodologies are then new ways of knowing and seeking 'truths', but they are also forms of political commitment to the empowerment of women"* (p.210).

As such, power relations and issues of patriarchy[21] are key issues in feminist research. It may therefore be assumed that institutions of patriarchal social control (such as the prison service and mental health hospitals), combined with the previously discussed gender discrepancies in the diagnosis rates of women's mental health, means that the area of women in secure settings is a well-studied area by feminist researchers. The literature review has already established this is not the case however.

Feminism and Women's Imprisonment

McKeown *et al.,* 2003) commented that "*It has long since been recognized that in forensic services women are a minority group cared for in services that cater primarily for men."* (p.585) This was also reflected by Baroness Corston's report of 2007 (see Chapter 4). It is further evidenced by practice throughout the female prison estate including the 'adaptation' of offending behaviour

programmes, which essentially attempt to modify interventions written for men to suit women, the gender neutrality of the ACCT process and until 2008 the use of routine strip searching for men and women. The use of near identical physical security conditions and regimes for men and women has also been reported to exacerbate coping strategies such as self-harm which emerge from feelings of powerlessness, low self-esteem and even the recreation of early childhood experiences (Carlen, 1983). The use of such coping strategies further serves to undermine the woman through often being labelled difficult to manage or manipulative (McKeown *et al.,* 2003). This use of equivalent treatment is a result of a historical minimisation of gender differences in criminal justice policy (Labelle, 2004).

The minimisation of differences is in contrast to another commonly held feminist theory that gender differences are exaggerated to position women as "other" in a society characterised by the male norm. Such exaggeration can be observed in the 'double deviancy' (Allen, 1987) of women who offend. This phenomenon sees women who commit crime facing civil judgement for breaking the law and often societal judgement for breaking the archetype of femininity. Such 'double deviance' may be particularly acute in condemning women whose offences include masculine traits such as aggression or offences against children and thus the notion of the woman's role as nurturing and motherly.

It would appear therefore that women who come in to contact with the criminal justice system are subject to two processes in which their gender plays a detrimental role. She may be viewed and judged more harshly for transgressing gender stereotypes only to find that her differing needs as a woman are overlooked at the second (punishment and rehabilitation) stage. Such observations and theories about gender differences are commonly borne from the observations of academics who may identify themselves as feminist criminologists. The custodial setting would therefore seem to embody many of the struggles and oppressions that feminists have descried (see Ritchie, 2004)

Given that prisons are a microcosm of feminist concerns it is curious that, as Mary Bosworth noted, *"women have been noticeably absent from most studies*

of incarceration" (Bosworth, 2000). Four years later Martel (2004) described feminist scholarship of women in prison as being in its infancy and lacking coherency. This absence is particularly manifest in the study of women who have not received a mental health disposal, i.e. those not in secure forensic hospitals. What feminist critiques of women's imprisonment there are mostly stem from the criminology of Pat Carlen. Carlen situates female offending in relation to class and race conflicts and, as such, a rational response to powerlessness (Carlen & Worrall, 1987). Of more relevance to this thesis is Carlen's work which provides women's narratives and experiences of imprisonment (Carlen, 1983, Carlen *et al.,* 1985) and her co-founding the Women in Prison campaign and support group. These, in many ways, are comparable to the survivor literature around self-harm in that they achieve two objectives. Firstly, they raise the public consciousness and give a voice to women. Just as *Self-harm: Perspectives from personal experience* (Pembroke (ed.) 1994) delivered the first-hand experience of self-harm; *Criminal Women* (Carlen *et al.,* 1985) is a collection of essays of the experiences of women in prison. Secondly, just as the *Hurt Yourself Less Workbook* (Dace *et al.,* 1998) and the National Self-Harm Network provide practical support, guidance and assistance, so too does *Women in Prison*. It is within these similarities however that the differences become apparent. Just as the survivor literature does not address self-harm in prisons, Carlen does not tackle the issue either. Whilst it may be unsurprising that self-harm does not feature in her book *Women's Imprisonment: A Study of Social Control*, given her role as a criminologist, it is perhaps quite surprising given the prevalence and importance of self-harm for women in prison.

Outside of Carlen's predominately UK based feminist criminology, feminist critiques of women's imprisonment mostly stem from examinations of the Canadian prison system. This is seemingly universal and is most starkly illustrated by a report for the Canadian Solicitor General which identified women in Canadian prisons as *"correctional after thoughts"* (Fabiano and Ross, 1989), written a full 18 years before the Corston Report highlighted exactly the same issue in English prisons. This omission is not negated by the relatively small numbers of women in prison (compared to males) as it would be expected that

feminism would highlight the situation of women in prison. There does exist a North-American body of work detailing women's ethnographic accounts of pathways into offending, and subsequently prison (see Owen, 1998; Girshick, 1999). Such works call for wide sweeping cultural and political reform and stand alongside critical feminist criminology describing the *"global lockdown"* (Sudbury, 2005, p.xvii) of women due to political and economic inequalities in societies that see the global rates of women in prison increase significantly (Martel, 2004). However research with more modest (and perhaps more easily achieved) objectives of improving and empowering those who participate, or enabling small changes within individual establishments are unprecedented.

Such a dearth of feminist action research methodologies may result from the prison setting not lending itself to the use of such methods. Women are a small minority in the prison system and as such demand for research amongst a small population is high. Martel (2004) highlights how, in her experience, criminological knowledge is 'policed' by criminal justice and academic institutions[22] to ensure they fit more accepted or valued epistemologies. If this were true one could speculate that overtly feminist research proposal to these bodies may be rejected on methodological or (prison) operational grounds.

It may also be that feminist researchers, whether action researchers or otherwise, are hesitant to enter the prison field. The inherent power-relationships of the prison and the multiple disadvantages of the women in prison perhaps makes successful feminist research (if success is defined similarly to Rienharz's (1992) purpose of creating new relationships and improved institutions) seem unlikely or too large a challenge to take on. True empowerment may simply not be achievable in the prison setting. This last point is illustrated through Moffat's (2000) description of the *"neo liberal"* (p.510) policy of the Correctional Services of Canada (CSC) in which she described the aims of providing 'empowering' prisons. The use of the term empowering for the CSC was however condemned as being a sham in which empowerment became a responsibility to make decisions based upon predetermined criteria of the authorities rather than the ability to choose freely outside the confines of gender roles or power-relationships. Free choice is rarely available to someone

in prison as a consequence of the system, and this significantly impacts upon the ability to empower and so perhaps upon the researcher's attempts to empower.

Feminism and Mental Health

Just as biology has been used to limit women's power in society, it has also historically been used to explain women's mental health as seen in the administration of hysterectomies to cure insanity (Geller and Harris, 1994). This in turn has been hypothesised as a form of social control by patriarchal institutions such as medicine in order to maintain the existing social order (Daly, 1991; Zola, 1975). Such a focus upon biology has resulted in the relevant life experiences, social positions and social roles that may impact upon mental health being overlooked by psychiatry (Holmshaw and Hillier, 2000; Ashurst and Hall, 1989). Wright and Owen (2001) summarise this succinctly in their literature review of feminist concepts of women's mental ill health

> *"Two key themes that encapsulate women's experience of mental illness are identified, namely psychiatry as a method of socially controlling women and the medicalisation of unhappiness"* (p. 144)

If feminist action research is not able to fully account for women in secure settings it may be able to engage in those sets of circumstances that may, for some women, result in incarceration and/or the use of self-harm. It is known that 80% of women in prison have a diagnosable mental health condition(s) and that 15% have previous experience of psychiatric admission (Stewart, 2008). Similarly the experience of psychological trauma (Briere & Scott, 2006) most commonly in the forms of sexual abuse, violence or neglect is also over represented in women in prison (Prison Reform Trust, 2010). These experiences are further linked with post-traumatic stress disorder (PTSD, American Psychiatric Association, 2000), personality disorder (Livesley, 2003), self-harm (Briere & Scott, 2006) and offending behaviour in women (Gelsthorpe, Sharpe & Roberts, 2007). The diagnosis of borderline personality disorder is particularly linked with experience of sexual abuse (Byrne, *et al.,* 1990; Herman and van der Kolk, 1987) with 25% of women diagnosed as having a personality

disorder in prison meeting the criteria for borderline personality disorder (Stewart, 2008).

What is very often of concern for feminist observers is the ease with which women, who have been victims of violence and abuse, are able to attract such diagnoses and that this in itself is seen as an example of patriarchal medical power. The use of labels to blame or further control women in psychiatry has historically been seen to justify (Majid, 2006) or socialise (McAndrew and Warne, 2005) women in to traditional gender roles and is often linked back to the psychodynamic theories of hysteria (Freud, 1895). Herman (1992) argues that diagnoses such as borderline personality disorder and somatization disorder represent a *"diagnostic mislabelling"* (p.116) as they fail to take in to account the woman's experiences and how fear and terror inform their current perspectives on the world. Such diagnoses, in other words, medicalise the woman's unhappiness. The use of these labels therefore act, at best, to distract from the common causes of the woman's distress (i.e. the victimisation of women by men, (Astbury, 1996)) or at worst to place blame and further stigma upon victims of trauma (Herman, 1992). In the case of self-harm this results in the behaviour attracting negative judgements (Cresswell and Karimova, 2010) from healthcare practitioners with the utility of the behaviour being overlooked (Orbach, 1986). Furthermore, self-harm as a result of women's position of powerlessness maybe ignored (McAndrew and Warne, 2005; Potier, 1993b). Such ignorance as to the causes of self-harm is often reportedly due to clinicians treating the behaviour of self-harm rather than the underlying issues of distress and trauma (Liebling, Chipchase & Velangi, 1996).

As a result of these concerns and oversights feminist research and activism in the field of mental health has sought to rectify the issues in a number of ways. Potier (1993a) argues that:

> *"Women's voice must be included and any research should be needs based and gender sensitive. Purely scientific dispassionate research is not appropriate at the time of great need for women in specials [hospitals] and research must aim to create change"* (p.3)

This reflects the already discussed feminist aims of promoting women's voices and collaborative involvement in research. Research completed around self-harm has reported that responses from healthcare providers reinforced power imbalances between clinicians and patients. As such patient-clinician interactions were often unhelpful or punitive and did not provide opportunities to discuss the underlying distress or allow for their patient to be involved in planning their own care (Liebling *et al.,* 1996).

Unsurprisingly change is called for in a variety of forms. Herman (1992) advocates moving away from diagnoses such as borderline personality disorder to a concept of complex post-traumatic stress. More radical commentators such as Burstow (2003) call for *the "rigorous demedicaliz[ation]"* (p.1301) of symptoms of trauma asserting that the psychiatric system is a further source of traumatic experience for those who enter it. In both cases the emphasis on the experience of the individual is fundamental to the feminist framework of examining mental health systems and this is exemplified in the use of feminist therapy with survivors of trauma (Brown and Bryan, 2007).

Although the above is just a short summary of feminist involvement in the mental health system it is clear that feminism's three defining features outlined in section one of this chapter have been rigorously and systematically applied to women's mental health. It is a seemingly obvious oversight that such an approach has not been taken with women in prison with only a small amount of feminist research examining the situations of women who find themselves incarcerated. This oversight is compounded by the clear overlaps in need between women who access mental health services in the community and those who are in prison. Wright and Owen (2001) emphasise three aspects of women's lives that lead to unhappiness (or depression) these being: loss, helplessness and trauma. If these are common features of women's lives in the community, they are everyday occurrences for those who have to live in prison.

If feminism then cannot provide an existing theoretical framework for conducting research with women in prison, it is necessary to examine other methodologies that also lay claim to working collaboratively with and for the empowering of

research participants. Service User Involvement (SUI) is a significant movement with similar aims and objectives to that of feminism and may be better able to account for women in prison.

Defining Service User Involvement

SUI, like feminism, is a broad concept that employs a variety of methodologies and entails a variety of agendas for the involvement of 'service users'. Perhaps unlike feminism the movement has recently enjoyed increased popularity that has seen progress from being described in 2003 as marginalised to the 'grey' literature (Rose, 2003) to being depicted as a new characteristic of society (Kemp, 2010). This has been a result of changes to the concepts of citizenship and participation, and from developments in government policy relating to social inclusion (Smith & Bailey, 2010). The term 'service user' is also equally broad and it would be difficult to find a person who did not access some kind of service. In general the literature defines service users as those who enter the health system in some capacity with other labels generally being used for different group memberships (for example community involvement in the case of urban politics see Smith and Beazley, 2000). The acquisition of the term service user by health researchers may be a reflection of the Department of Health policies under the New Labour administration (Bailey, 2011; see chapter 4 for discussion around policy) and is exemplified by the funding of the organisation Involve through the NHS Research and Development group. The fact that people often use different services and will receive different labels over time is reflected in the varying use of the term 'service user' throughout this thesis. For the sake of this work the labels 'service user', 'expert by experience' (Branfield *et al.,* 2006) 'prisoner', 'woman' and 'participant' will all be used interchangeably depending upon the context of the discussion. The need to label people at all is purely pragmatic and is done so in recognition of the criticism, concern and reductionism that this can create through terms such as 'service user' can create as highlighted by the Shaping Our Lives Network:

> *"The term 'service user' can be used to restrict your identity as if all you are is a passive recipient of health and welfare services…this makes it seem as though the most important thing about you is that you use or have used services. It*

> *ignores all the other things you do and which make up you as a person."* (Shaping Our Lives Network, 2003)

SUI has often been placed on a continuum of involvement from simply giving information to service users at one end, through to total user control on the other end of the continuum. Rose (ibid) identifies three significant levels of SUI on this continuum, i) consultative research, ii) collaborative research and iii) user led research. With the differentiation of levels of user involvement, (depicted as a ladder by Arnstein (1969)), a lot of the SUI literature implicitly passes judgement about the value of the research with those involving consultation or limited collaboration being criticised for tokenism (Jayne, 2006) or merely attempts to secure funding or credibility. Such lip service may be a result of regional requirements of having to be demonstrating SUI in order to secure research funding or approval from NHS Research and Development (NHSE, 2001). Like feminist methodologies SUI commonly uses the language of empowerment, emancipation and participation and recognises the value of experience and the lay perspective either above or in addition to the professional perspective (Beresford & Evans, 1999). Where feminism places gender at the centre of enquiry to explore inequities in power, SUI has a wider remit of *"mak[ing] specific provision to engage and include all groups facing particular oppression, disempowerment and exclusion"* (Beresford, 2007, p.310). As such SUI commonly involves people with disabilities and learning difficulties, from minority ethnic groups, and includes a focus upon sexuality and gender. Given this there appears to be little to differentiate feminism from SUI other than the former having a narrower focus (specifically inequalities resulting from the false dichotomy of gender) upon a large group (all women) whilst the later has a wider focus (the imbalance of power between professionals and 'patients') through a number of much smaller groups (the particular services accessed). Such similarities are acknowledged with Beresford and Evans (1999) tracing the roots of SUI back to feminism and Black people's movements of the 1970's and 1980's.

SUI and Women's Imprisonment

Whilst feminist research into women's imprisonment is rare SUI does not specifically address women in prison at all. This omission may be due to a number of reasons. A 2007 review of research priorities for service user mental health services specifically identified women as one of a number of marginalised groups (Sainsbury Centre for Mental Health, 2007). The report did not identify those in the criminal justice system as marginalised but[23] did recommend that one research priority should include assessment of the *"effectiveness of user-led training for police and prison staff regarding mental health, substance abuse and cultural sensitivity"* (p.9). Researching the effectiveness of such user-led programmes implies that they exist, which, for prison staff at least, does not appear to be the case. Such premature recommendations may disguise the lack of SUI in these settings and therefore distract from the urgency of need for establishing such schemes, or even just exploring whether they are a viable proposition.

Where SUI does include prisoners it is gender neutral in that no existing literature differentiates between men and women in prison[24]. Steel (2005) explicitly calls for the inclusion of prisoners as a group to be engaged through participatory research. Whilst there has been some SUI in the prison setting (e.g. Jayne, 2006) and organisations have formed specifically to promote service user involvement (e.g. User Voice and the Prison Reform Trust) participatory research is rare and what service user involvement there is in prisons is generally considered to be consultative or information sharing (Sainsbury Centre for Mental Health, 2008). As such it is not particularly empowering for those involved. This is particularly exemplified by schemes such as The Listeners, mentors, diversity representatives and wing representatives all of which employ prisoners to support and assist other prisoners, to help the establishment address problem areas such as discrimination or act as a liaison between prisoners and prison management. However none of these schemes empower those involved to change systems of working or to establish evaluations of service efficacy. At best the wing representatives (which make up prison councils) mostly communicate that specific policies or rules are causing upset amongst the prisoners and help

avoid conflict or disruption (ibid). Solomon and Edgar (2004) recommend that such prisoner councils should be given power to initiate and inform change and be able to argue in favour of change with prison management. In the language of SUI to be empowered is to be part of the process of transformational change.

A review of SUI in prison mental health research[25] (Sainsbury Centre for Mental Health, 2008) concluded that *"the dearth of research literature on SUI in prison mental health research reflects its relative infancy"* (p.14). I would suggest that the use of language and the lack of a neutral label or identity for those who access services whilst in prison is also an indicator of a lack of a framework for SUI in the prison setting. The label 'prisoner' is used throughout the reviews discussed above but is defined as

> *"A person who is kept in prison or in custody; spec. one who is legally committed to prison as the result of a legal process, either as punishment for a crime committed, or while awaiting trial for an offence"* (Oxford English Dictionary, online version March 2011).

Whilst this label is accurate it is also potentially pejorative and serves to focus upon the individual's offending behaviour when, in the context of mental health or the level of service they receive, this may not be immediately relevant. Just as for those who attend healthcare services after a self-inflicted injury find the label 'self-harmer' unhelpful and possibly instrumental in them receiving lesser care (Pembroke, 1994). This may surely be the case for someone given the identity of a 'prisoner'. Those for whom it is made immediately apparent that they have committed a crime may also receive lower levels of care or indeed not receive recommended interventions (such as NICE guidelines around harm minimisation) due to their given identity. Other groups have appropriated less pejorative identities such 'service user' or 'consumer' (Boote, Telford and Cooper, 2002) for healthcare recipients and 'survivors' for some of those accessing mental health services. This moves away from labels that have negative connotations or disempower those who receive them such as 'patient' (Telford *et al.,* 2002). There is no equivalent noun for those in prison. Nor would some of the existing labels be of use to those in prison. The identity of 'consumer' would not be appropriate as those in prison do not necessarily

receive the choice that the marketisation of healthcare has aimed to provide those in the community. The identity of 'citizen' (Arnstein, 1969; Bastian, 1998) is clearly inappropriate given the sanctions imposed upon those in prison and whilst 'service user' may be the most appropriate the continuous distinction between prisoners and service users in the literature suggests that this is not widely recognised. A more neutral label may emerge if SUI in prisons becomes established enough to develop a shared identity. It is clear that, as with feminism, SUI in the prison service is far from established and there is no clear framework for the engagement of those in prison in participatory research. However, as with feminism, this is not the case in the field of mental health.

SUI and Mental Health – The Survivor Movement

SUI in the mental healthcare system is established, recognised and valued to a much greater extent than in prison. The volume of policies and the number of recommendations around SUI in the mental health field is testament to user involvement being mainstream and widely accepted by policy makers and mental health practitioners. It is possibly the incorporation in to the mainstream that has been instrumental in the development of the 'Psychiatric Survivor' or 'Survivor' movement (although these in themselves may not be mainstream). Beresford and Wallcraft (1997) describe the Survivor movement as sharing some of the values of the Service User movement, namely those of treating service users with respect and allowing those who access services a voice in the services they access. Where Peter Beresford uses the terms 'Survivors'and 'Service Users' interchangeably (Beresford and Wallcraft, 1997; Beresford, 2000; Beresford, 2002) it is clear that in some respects the agendas are different. The description of someone as a 'Psychiatric Survivor' is to imply a negative experience of psychiatric care and thus an unwillingness to accept the medical model of mental health. This is reflected in rejection of mental pathology which Survivors claim is *"preoccupied with analysis, eradication, physicality and mechanical and chemical constraint"* (Beresford and Wallcraft, 1997, p.69) at the cost of the acknowledgement of human diversity and empathic understanding by those practicing in the medical model. To confound the description of service users with that of survivors is therefore to overlook

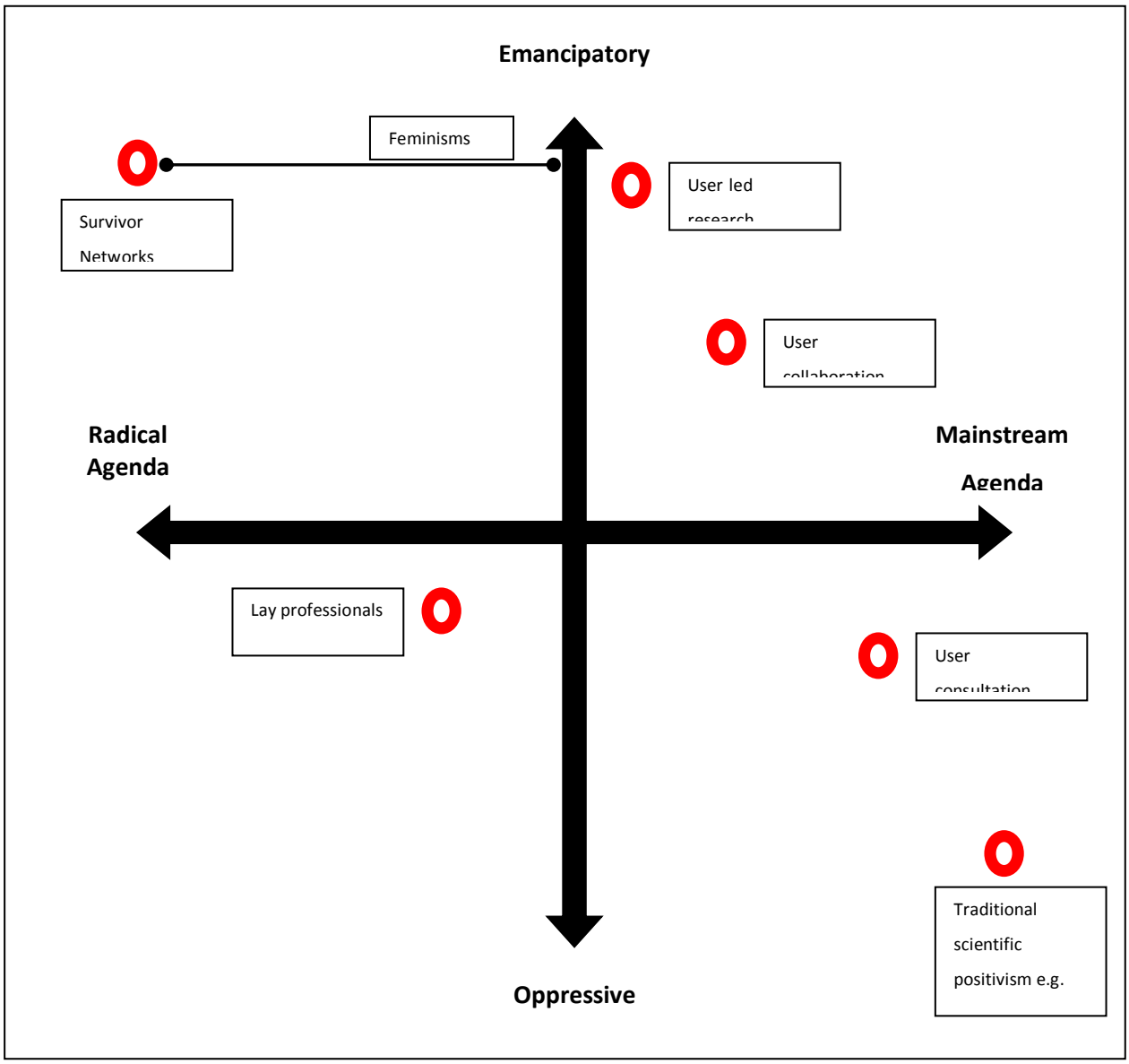
those who have positive, or even neutral, experiences of accessing mental health services.

It may be clearer therefore to acknowledge that, just as there is not just one form of feminism, SUI exists in many forms. Some forms are incorporated in to the mainstream such as service user groups in forums such as the NICE guidelines or representatives on recruitment panels for NHS Trusts. Other forms however have more radical objectives such as significantly changing mainstream working practices. I would argue that the survivor movement's dissatisfaction with the way service user involvement is used by the mainstream, places it on a more radical footing than SUI. In this respect the term radical is used to convey aims such as the rejection of established 'norms' such as the medical model and by the use of direct action (Beresford, 2000). The concepts of respect, empathy and inclusion of and for service users, which are also aims of the survivor movement, should not be seen as radical even if they are not widely practised. Beresford would probably disagree with this radical-mainstream dichotomy arguing that many survivors work from within the system through developing patient councils and advocacy groups. Instead he distinguishes between survivor movements and mainstream use of SUI by defining the former as *"explicitly political"* (Beresford, 2002, p.101) whereas mainstream SUI is not. This confounds meanings as mainstream SUI can be politically motivated (as Beresford (ibid) also highlights) through the use of SUI as a consumerist approach to healthcare by new right politics. A conceptualisation of the political agendas (radical to mainstream) and degrees of empowerment (emancipatory to oppressive) incorporated by each of the paradigms discussed so far can be seen in figure 3.

A survivor movement further exists amongst those who use self-harm. The dissatisfaction of some who have accessed services after self-harm (Pembroke, 1994) necessitated the call for humane and empathic treatment, especially by Accident and Emergency (A&E) staff. This reflects similar concerns expressed in other areas of mental health and feminism about the traumatising experiences of psychiatry (Burstow, 2003). The evident reluctance to provide people who use self-harm with information to minimise risk has led survivor

groups including the National Self Harm Network (NSHN) to develop tools to empower those who come in to contact with health services. Examples include check lists to assist people in A&E (NSHN, 2008) and the provision of guidance for harm-minimisation (Dace *et al.,* 1998).

Figure 3 A Conceptualisation of the Agenda of Varying Research Paradigms



Finally, as may be expected in such a strong and well represented movement, there also exists a specific paradigm of survivor research. Lindow (2001) described this as research to discover acceptable alternatives for those who are dissatisfied with the current care they receive. This shifts the emphasis of research away from the professional establishments to the individuals and

recipients of services. Beresford described this as a political activity (Beresford, 2002) with the epistemology of such research focussing upon the validity of the experience of the individual as opposed to the representativeness of a 'sample' with an objective of change rather than knowledge generation. In this, and many other respects, the distinctions between service user involvement and feminism are small and possibly more due to semantic differences than true methodological disparities. Figure 4 illustrates the similarities and marginal differences between the two.

Figure 4 A Comparison of the Approaches of Lather and Beresford

Feminist Emancipatory Research (Lather)	**Service user involvement (Beresford)**
• Political: i) Unjust androcentric hegemony ii) Gender at the centre of enquiry to correct distortions to and the invisibility of women's experience • "Empower" the researched AND contribute to the generation of change enhancing social theory. • Dialogic, dialectically educative encounter between researcher and researched…a two way process (c/f Oakley, 1981) • Notion of praxis (e.g. Mies (1984) development of a women's house) • Researched involvement in developing research tools • Multi-methodological • Reflexivity/self-critique of researcher to guard against imposition of values and to understand one's own frameworks…biases become part of the argument to lend greater legitimacy. • Permanently partial, post-modern, no absolute truths.	• Political: i) Shift from increasing professional power and knowledge to liberation and emancipation of service users ii) Sensitive to all considerations of diversity and how these create disadvantage. • Change in line with service users rights and wants, not just a generation of knowledge. • Equalised relationships between researcher and research subject • Makes specific provision to engage groups facing particular oppression (e.g. Steel (2005) prisoners). • Service user involvement in research design, commissioning, managing, funding and dissemination. • Emphasis on lived knowledge and experience to effect political change. • Ethically principled (Faulker, 2004), particular emphasis in informed consent.

The Third Way? Qualitative Research in Prisons

There is undeniably a wealth of research that emerges from prison populations; however none of this emerges from the theoretical/political standpoints of feminism or SUI. This would imply that prison research is essentially positivistic and without regard for empowerment of its participants or affecting change. Of course this is not the case and most notably the works of Alison Liebling (1994, 1995) who's work on suicide and self-harm in prisons takes an ethnographic approach and pays much more attention to the lived experiences of its participants than any similar research in the prison environment. This work has undoubtedly had an impact upon prison culture and challenged the use of labels such as 'poor copers' to describe those who self-harm in prison. Liebling is concerned about power imbalances in respect to staff as well as people in prison. This is seen in her conjecture that sociological research's focus upon the prisoner has, historically, had *"intellectual hegemony"* (Liebling 2001, p476) to the detriment of studying the way power is used by those managing the prison system. If the same were true it begs the question in which ways have the prisoners benefited or been empowered by the sympathies of the researchers and have any benefits been realised through the empowering of participants through action research? Liebling and Hall (1993) highlighted the use of punitive practises for those who use self-harm in prison in the article entitled *'Seclusion in prison strip cells: A practice to be ashamed of'*. Strip cells are no longer used in the prison service in England and it is unclear what impact Liebling's work had on this change of policy. Where Liebling has achieved clear and definite change is through her work is the Measuring Quality of Prison Life (MQPL). The survey developed through this has become one indicator of prison performance and is measured through listening to the experiences of the prisoners in relation to attributes such as decency and safety (see Liebling, 2004).

Liebling's (2001) argument that sympathy should not always be reserved for the subordinate prisoners but that managers and governors are also be in some way subordinate, and therefore equally deserving of a sympathetic approach, certainly counters the 'them and us' positioning of much feminist and survivor research. She also argues that it is possible to *"take more than one side*

seriously" (Liebling, 2001, p.473) whilst acknowledging that being entirely neutral is impossible to achieve. It is perhaps Liebling's affinity with neutrality, or the suspension of personal beliefs about the way things should be, that leads her to conclude that *"Whose side are we on? The side of prudent, perhaps reserved engagement."* (ibid, p. 483). This conclusion certainly differentiates Liebling's qualitative approach from that of feminism and SUI whose objectives of systematic change and political agendas are contrary to prudence and reserve. Liebling certainly isn't the only researcher to compromise (see Martel, 2004) and it can be argued that sensitivity and respect for prison governance is essential in order to inform productive working relationships. However such an approach is unlikely to produce any substantial or comprehensive change that may be required. Such a conservative approach is, at best, more likely to result in evolution of existing processes (akin to consultative service user engagement) rather than true empowerment of those involved or the introduction of new methods of work.

Conclusions

There is, perhaps, little to distinguish the feminist and service user movements other than those with whom they engage. It is clear that neither adequately accounts for the lived experiences of women in prison and previous prison based research that has attempted to do so has been conservative in its approaches (although some of its success may be due to such an approach). Whether this is due to people in prison being categorized as 'less deserving' (Beresford, 2000), the prospect of affecting political change in prisons is seemingly too unachievable, or whether access for such projects has been denied by the prison authorities is unclear. This does mean however that a specific theoretical framework cannot be straightforwardly applied to this research. What this research aimed to do was to use the common values and methods expounded by both feminist and service user ideologies empowering the women who become involved through an action research approach that utilises their knowledge and expertise. This thesis will demonstrate how women's life and prison experiences were valued and validated and those that become involved were supported in producing recommendations and action for

change. This approach was also adopted with prison staff for without their experience the full picture of prison could not be appreciated.

Recommendations and change however were not always delivered through prudent engagement with the prison authorities but through pragmatic assertion and the development of a productive working relationship with prison staff and women in prison alike. This pragmatic assertion, a new concept which I expand upon (see p.201), necessitated flexibility and compromise for existing prison practices but also pushed boundaries that could be pushed and raised questions about current practices. Whether this resulted in a feminist, service user, survivor, prudent, or other framework will be discussed and if necessary an alternative theoretical framework will be proposed for emancipatory, inclusive and involving research in the prison environment.

Chapter 4

Policy Frameworks in Health and Prison Services

Given the prevalence of self-injury[26], it is not surprising that the management and intervention for self-harm has been a priority for the Department of Health (DH) since 1992 (Hughes and Kosky, 2007) and that there exists a plethora of policy, guidelines and instructions around the issue. This 'grey literature' is broadly broken down into policies for the 'general', 'mental health' and 'criminal justice' populations. It is immediately apparent however, that to make such clear delineations between groups of individuals is to falsely dichotomise services which are likely to attend to the same people at different or even the same time. This differentiation is particularly meaningless given the common occurrence of mental health needs of those who come in to contact with the criminal justice system (Stewart 2008). Joined up and coherent policy with regards to self-injury is therefore essential in order to ensure equity of care and integrated services (DH, 2009). Also given the differing mental health needs of women (Williams, 1984) and the incumbency upon authorities to ensure gender equality of services (Gender Equality Duty, 2007) one would also expect gender sensitive guidance for the management of self-injury. To date however it would appear that none of these requirements have been achieved and coherent, gender sensitive policies relating to self-harm are still needed.

National Health Policy

The contemporary agenda, at least since the New Labour administration, for improving mental health arguably originated with the publication of the Saving Lives white paper (DH, 1999). This set four priority areas for health strategy, one of which was mental health. That self-harm has been a priority for the DH is reflected in the number of policies and guidelines which either specifically relate to self-harm or issue guidance on the 'management' of self-harm. These include Mainstreaming Gender and Mental Health (DH, 2003); the National Institute for Clinical Excellence[27] guidelines (NICE, 2004); National Suicide Prevention Strategy for England (DH, 2006) and Improving Health Supporting Justice (DH, 2009). Such national policy can be seen to be the forerunners of

institution specific policies such as those that exist within the prison service and which are discussed later in the chapter.

These policies need to be considered with other contemporary strategies including the 2003 Mainstreaming Gender (ibid) report which aimed to deliver the government's gender equality policy and address the acknowledged health and welfare inequalities within society that continue to have a greater impact upon women than men (Delivering on Gender Equality, 2003). Addressing self-harm is a consistent theme throughout the implementation guide including recommendations in the development of policy and primary care services. Mainstreaming Gender also dedicates an entire section to the use of self-harm by women, whilst acknowledging the (then) forthcoming guidelines from the NICE. The report acknowledged that the use of self-harm is often a coping mechanism for surviving trauma and that the focus of existing services is on the prevention of self-harm rather than support for the underlying causes. To address these issues the report recommends considering the use of 'harm-minimisation', which it carefully defines, as well as staff training and support and continuing service user involvement in the development of all practices. Overall the Mainstreaming Gender implementation guidelines in relation to self-harm were brief in anticipation of the NICE guidelines yet arguably progressive in the recommendations relating to harm minimisation and service user involvement.

Within a year of Mainstreaming Gender the NICE (ibid) published guidance for the physical and mental health care for, and prevention of, self-harm: 'Clinical Guideline 16'. This was reportedly developed through consultation with numerous establishments for physical and mental health alongside service users. The guidelines took both a broad definition of self-harm *'self-poisoning or self-injury, irrespective of the apparent purpose of the act'* (p.16) and applied itself to a wide intended audience, explicitly including healthcare professionals working in prisons.

The NICE guidelines continue to provide comprehensive (too comprehensive to adequately summarise here) and seemingly service user focussed guidance for the treatment of patients who use self-harm. The guidelines (like Mainstreaming Gender before it) highlight the use of the pejorative language of deliberate self-harm and acknowledge the often negative

experience described by service users coming into contact with health care services after self-harming including the inadequate use of anaesthetic (c/f Pembroke, 1994). Amongst the many recommendations and instructions around the use of triage, physical and psychological assessment and intervention for patients I would argue there are six key recommendations that stand out as involving and acting upon service users wishes as highlighted by the literature. These include:

1. The involvement of people who self-harm in the planning, commissioning and evaluation of services by Strategic Health Authorities and Primary Care Trusts (PCTs).
2. The involvement of service users in the development and delivery of training for staff.
3. The provision of advice for wound care of injuries and the provision of means to do so.
4. The discussion of harm minimisation techniques.
5. The acknowledgement of the role of gender and guidance on offering the choice of either male or female staff to attend.
6. The recommendation that all services should be provided in an atmosphere of respect and understanding for the service user's mental and emotional wellbeing.

Many other recommendations, although sensitive to the need of the patient, mirror the expected standard of all healthcare services, such as patient choice and autonomy in choice of treatment.

The NICE built upon the Mainstreaming Gender report through the recognition that many users of self-harm are also survivors of other experiences whether these are traumatic life events, mental ill health or poor services in response to self-harm. This is seen in the recommendations around choice of staff gender where possible and for sensitivity when treating self-harm inflicted to the genitals. The recognition that self-harm is often symptomatic of other distress, and thus will continue to be used whilst the individual struggles to survive, find other ways of coping with it, or are offered better alternatives (Thomas, 1998)

are reflected in the recommendations advising harm-minimisation rather than an insistence on cessation by healthcare professionals. These are again reflections of much earlier work of self-harm survivors through publications such as Cutting the Risk (National Self-Harm Network, 2000) and The Hurt Yourself Less Workbook (Dace, et al., 1998).

Although the guidelines are not without its detractors in the professional fields, for example Owens (2006) who it is clear believes the NICE guidelines represents a missed opportunity at substantial change settling instead for *"simple alterations"* (p.271), it could be argued that the NICE guidelines attempt to address many of the concerns and criticisms voiced by service user and women's groups around the labelling, treatment and through care of people who use self-harm. Thirteen years before the NICE guidelines, Louise Pembroke wrote of the inappropriate and unnecessary use of the phrase deliberate self-harm (Pembroke, 1994) as well as the *"Health Fascism"* (p.6) of unequal services based upon perceived worthiness rather than need. It is clear that the guidelines specific recommendations around use of language and adequate anaesthetic are designed to address such points.

In the same publication Pembroke wrote of the need for service user involvement in services accessed by people who self-harm:

> *"The only way forward is to end the silence. For people with direct experience to share their experiences, and for a dialogue to start between self-harmers and service agencies. Then there is a need for greater mutual understanding and professional assumptions must be surrendered if the current figure of 100,000 people being treated annually for self-inflicted is to be reduced."* (ibid. p.7).

Pembroke herself however would be unlikely to argue that the NICE guidelines fulfil this need for service user involvement given that the guideline development group – tasked by NICE to evaluate the 'evidence-base' - consisted of just two service users (of which Pembroke was one) both of whom resigned within six months and who both went on to heavily criticise the process (see Cresswell, 2004, James, 2005). One major criticism levelled at the NICE was its failure to put in to practice its own recommendations. For although the guidelines recommended as 'good practice points' the involvement of service users the

users voice or the voice of 'experts by experience' is paradoxically dismissed in the guidelines own hierarchy of evidence (ibid). This was precisely one of Pembroke's own criticisms. The 'clinical experience of the guideline development group' (having delivered or received a service) therefore comes at the bottom of the list just below the 'clinical experience of respected authorities' and much further down the list than empirical studies, of which the randomised control trial (RCT) is held in highest esteem. Whilst it is not clear what a 'respected authority' is, it would seem logical that these are most likely to be those clinicians who are delivering the existing practice that the guidelines aim to change. Service users' experiences of damaging care are therefore given less credence than the judgements of those delivering it. The NICE guidelines therefore seemingly perpetuate the problem that service users had been highlighting, that at best their voices were not being heard, or at worst being dismissed (or devalued in terms of the 'evidence' in the case of clinical guideline 16). It is surely the case that healthcare professionals may use the hierarchical grading system developed by the NICE in a similar fashion to the way prospective employers' sieve job applicants based upon qualification grading, to make quick and pragmatic judgements about value and worth. This would be likely to negatively impact upon the uptake of good practice points, such as the inclusion of service users. If this were the case it would surely make a mockery of the guidelines given that the vast majority of recommendations are good practice points based upon the individual experiences of the guidance delivery group, which it is again worth emphasising, almost solely comprised of healthcare professionals. Nevertheless, despite these criticisms the guidelines do represent the first, albeit late and limited, official attempts at the inclusion of people who have received services as a result of using self-harm.

Regardless of how progressive the guidelines may or may not be in terms of the development of service user and survivor agendas, the acceptance of the recommendations and their implementation is surely a key measure of the policy's success. Criticism exists about the lack of systematic implementation of procedures recommended by the NICE (Hughes & Kosky, 2007) and that the guidelines do not go far enough to tackle the problems in care for people who use self-harm (Simpson, 2006). However the NICE guidelines attempt to effect

a greater change than just methods and practice of working but also the way healthcare providers perceive, think about, and respond to self-harm down to the language professionals use. Schien (2004) defines these values as the organisational culture:

> *"A pattern of shared basic assumptions … as the correct way to perceive, think, and feel in relation to problems.*" (p.12)

The NICE and Mainstreaming Gender recommendations arguably attempt to impact upon the culture of the organisations which fall under their scope, through recommendations for training and service user involvement. This is consistent with the DHs aims of instilling a patient-led culture in the NHS (DH, 2005). Such organisational change however is notoriously difficult to effect (Schein, 2004) with the existing culture often being a barrier to change (Newman, 1995) and with the gap between policy formation and policy implementation being subject to a number of obstacles such as 'street-level' or 'soft' bureaucracies (see Lipsky, 2010; also Courpasson, 2000) – in other words, the 'values' and 'priorities of the workers 'on the ground' may just not be the same as the bureaucracies of 'clinical governance' (NICE). Other vested interests such as the trade unions may also interfere.

The main way both policies recommend effecting cultural change is through the use of training and the involvement of service users in this. The need for this is supported by evidence that healthcare professional's attitudes towards self-harm can often be negative (Cresswell & Karimova, 2010; McAllister et al, 2002; Sbaih 1993) or tinged with ignorance (Jeffrey & Warm, 2002) as well as the experience of service users discussed above. Two years after the issuance of the NICE guidelines Friedman *et al*, (2006) reported that only 6% of Accident and Emergency staff had received specific training on self-harm whilst McHale and Felton (2010) concluded that although negative staff attitudes and service user dissatisfaction were directly linked to lack of training, NHS budget cuts meant it was unlikely training in self-harm would take place. The lack of implementation is also reflected in the recommendation of the national enquiry in to self-harm in young people ('Truth Hurts'[28]) which reports that many young people's experience of asking for help in relation to self-harm is met with ridicule

or hostility which only serves to exacerbate their problems. This prompted a recommendation in the report:

> *"There is an urgent need for many professionals…to reflect on, and update, their practice in relation to young people who self-harm. To do this they need to re-connect to their core professional skills and values: empathy, understanding, non-judgemental listening, and respect for individuals. Professional training…needs to reinforce the fact that young people who self-harm are entitled to a response based on practice of the core skills and values of the caring professions".* (Mental Health Foundation, 2006, p.14)

This is damning, suggesting two years after the publication of the NICE guidelines that staff not only still required further training but also needed to reflect upon the core values of healthcare principles as these are not generally applied to service users attending for matters relating to self-harm. Simpson (2006) suggests that implementation of the NICE guidelines is hampered by an institutional prejudice towards self-harm, as possibly demonstrated by a failure to adhere to even the basic values of delivering healthcare without causing harm and thus a resistance to change or undertake training by healthcare professionals.

It is therefore unclear what impact the NICE guidelines have had on wider, community based, clinical practice and to what extent recommendations have, indeed, been implemented. More recent reports of service users, especially those highlighted in the 'Truth Hurts' enquiry suggest that there has been no improvement in healthcare professional's attitudes or the pervasive culture of hostility towards people who use self-harm. This reported failure to effect change may be a reflection of the guidelines own failures in the adoption of service user involvement. They may also be a reflection of the general lack of effectiveness of NICE as a form of 'clinical governance' caught as it sometimes is between the 'rock' of central government directives – which seeks in NICE guidelines a 'techno-political fix' to matters of public concern (see Syrett, 2003) – and the 'hard place' of organisational vested interests ('street level' and 'soft' bureaucracies, trade union resistance etc).

National Offender Health Policy

Given the wide remit of the NICE guidelines it may be expected that there has been a positive influence in other areas of service provision, so attention will now turn to healthcare policy in the criminal justice system.

A month prior to the implementation of the statutory Gender Equality Duty in April 2007, Baroness Corston published her report reviewing the services available to women who come in to contact with the criminal justice system (CJS)[29]. The report highlighted what Corston terms an *"institutional misunderstanding"* (p.8) of women's needs in the CJS, an organisation that she described as designed by men for men. The Corston Report made 43 recommendations spanning the breadth of the CJS from point of arrest to pathways away from offending. In relation to self-harm the report went to lengths to highlight that self-harm was (and still is) particularly and disproportionately a feature of life in women's prisons, and provided vignettes exemplifying women's use of self-harm in the prison system. Yet despite the prominence self-harm is given only one recommendation is made: that the management and care of self-harm is led by the NHS, either solely by an NHS resource or as a part of a multi-disciplinary team. Although specific advice about intervention and management of self-harm is probably beyond the remit of Corston's commission the recommendation made remains vague. What constitutes an 'NHS resource' is unclear. Since 2003 when the Department of Health took responsibility for prison healthcare all prisons have been equipped with an NHS resource but it is not feasible that all prisoners who self-harm could be located in the prisons' healthcare centres. The Corston recommendation was partially accepted by the government with the caveat that although they recognised that a more consistent approach to managing high levels of self-harm was needed, neither an NHS nor a HMPS led service could address this suggesting that an interdepartmental approach was required (MOJ, 2007). The Government response also argued that the prison service, through its Safer Custody and Women and Young People's groups[30] offered *"well developed gender specific approaches to care"* (p. 29). Whether this last assertion holds up to scrutiny at a local level is discussed below. The government did, however, undertake a commitment to improve services for women who self-harm in

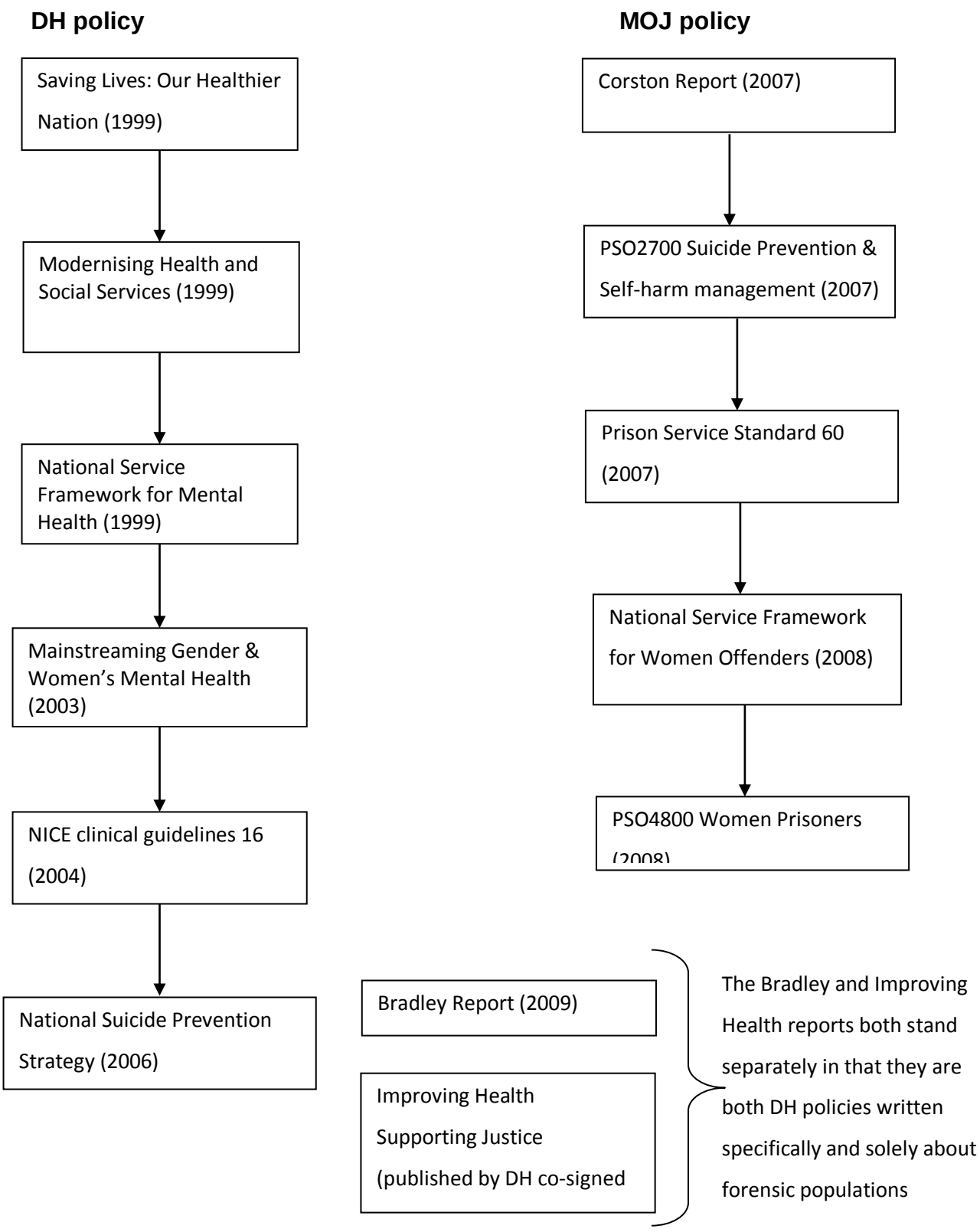
custody. This was reflected in the National Service Framework for Improving Services to Women Offenders (MOJ, 2008) which outlines just four departmental objectives for the MOJ, one of which was the *"Improved well-being and a reduction in self-harm for women in contact with the criminal justice system"* (p. 6).

Where the agenda of tackling self-harm is well served by the MOJ, especially for women, the service user involvement agenda is neglected. Neither the Corston Report nor the National Service Framework makes reference to the inclusion of service users in meeting the recommendations. Conversely, the offender health policy produced by the Department of Health addresses service user involvement but not the issue of self-harm in any depth. This is exemplified by both the Bradley (DH, 2009) and the Improving Health Supporting Justice (DH, 2009) reports which scarcely touched upon self-harm, despite a focus on improving mental health and access to services. Both do, however, make recommendations for the inclusion of service users in the development and delivery of mental health awareness training for healthcare professionals and the way in which information is delivered to offender groups. This is perhaps a reflection of the differing cultures between the Department of Health and the Ministry of Justice or of the differing histories of service user involvement in the health and criminal justice institutions. What emerges therefore are health and criminal justice policies developing in parallel and with similar objectives, such as improved mental health, addressing gender inequity and reducing incidents of self-harm. The policies also propose similar systems of delivery through interdepartmental co-operation or joined-up government (Powell *et al.,* 2001). What differs however is the recommended method of local implementation, i.e. the explicit advocacy of service user involvement. This is illustrated in figure 6. Such differences combined with the sheer volume of policy and grey literature around offender health and mental health may be expected to negatively impact upon frontline or local policy.

Figure 5 below illustrates the parallel development of policy around mental health and self-harm. The linear lines of development represent chronology

and not necessarily a causal link. The list is not exhaustive and reflects key relevant policy.

Figure 5 The Parallel Development of DH and MOJ Policy



Prison Specific Policy

From the National Health and NOMS policy it could be anticipated that the prison service would draw upon the existing 'grey' literature to produce comprehensive and effective procedures for the management of self-harm. However this does not necessarily appear to be the case.

Prison service procedures are governed by Prison Service Orders (PSO), written mandatory instructions to staff on how to manage situations and incidents. Written by the prison service's relevant headquarter team, adherence to these is audited and contributes to a specific prison's performance rating and should ensure that each prison manages self-harm in a similar fashion. PSO2700 entitled Suicide Prevention and Self-Harm Management was first published in 2007 and stated its objectives as being:

1. A reduction in distress for all those who live and work in prison
2. A reduction in incidents of self-harm and suicide
3. The provision of positive care and support for vulnerable individuals including the provision of alternative methods of coping.

PSO2700 also introduced and instructed staff on the use of the Assessment Care in Custody and Teamwork (ACCT) approach. The aim of ACCT is to provide individualised and multi-disciplinary care planning for those at risk of self-harm and/or suicide.[31]

The ACCT process was developed by the HMPS Safer Custody Group and The London Development Centre, an organisation that also worked to implement NICE guidelines in three London mental health trusts (DH, 2006). PSO2700 does not reference the NICE guidelines yet a number of NICE recommendations bear similarities with the PSO's instructions. These include the use of psycho-social assessments, guidelines on staff-service user relationships and collaborative decision making when formulating care plans. The PSO also specifically addresses the differing needs of women in relation to increased risk through substance withdrawal and separation from children and family. This gender specific guidance however is in the form of information only

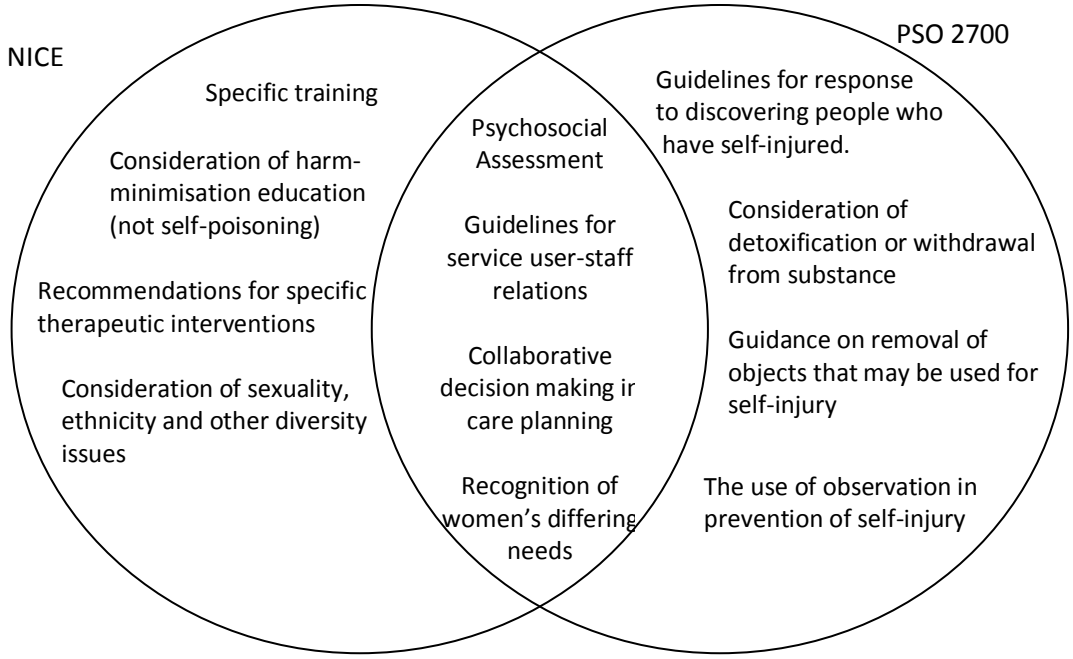
and perhaps crucially despite acknowledging that *"uniformity does not necessarily amount to equality"* (PSO2700, chapter 12) the ACCT process remains identical for men and women in prison. It is surely the case that staff working in a women's prison will already be very aware of the information given such as the higher percentages of foreign national women, or the effect of family separation. What the PSO2700 and the ACCT approach do not provide staff with are a different set of procedures or systems of work with which to manage the increased rates of mental health problems, victimisation and greater educational needs that women in prison experience (Corston, 2007; Stewart, 2008).

Whilst the PSO does not reference the NICE it does make reference to the Mainstreaming Gender report highlighting that women's prisons must also account for gender differences. Whilst this clearly reflects the gender equality duty incumbent upon the prison service the guidance to account for gender differences is so vague as to be worthless. The PSO does not include a number of Mainstreaming Gender recommendations, such as the choice of female caseworkers. It also specifically opposes others such as the use of harm minimisation, relying solely on prevention, thus raising the question as to what should and should not be 'accounted' for when developing a gendered approach.

The involvement of service users in PSO2700 is limited to directing prison staff to use The Listener[32] and other peer support schemes available in the prison to support those at risk of self-harm or suicide. This, as would appear to be the case with criminal justice policy, falls short of the recommendations made in many health policies, including Mainstreaming Gender, and the NICE around the inclusion of service users in the design and evaluation of the services they receive. PSO2700 and the ACCT process, the lynchpin of the prison services management of self-harm, therefore appear to exist independently of healthcare policy, albeit with a number of similarities. Most significant is the detachment of prison policy from the NICE guidelines, despite being co-authored by an organisation that was involved in the implementation of these

and specific reference to prison healthcare workers by the NICE. Figure 6 illustrates the commonalities and differences in the two policies.

Figure 6 Commonalities and Differences between NICE and PSO2700 Guidelines



Alongside PSO2700 and the ACCT process is a published prison service standard that *"care and support is provided to all prisoners to reduce the likelihood of suicide or self-harm, and staff identify those prisoners at current risk of suicide or self-harm and implement plans to keep them safe and address the cause of the problem(s)."* (Prison Standard 60, 2007, p. 1). The standard outlines 46 actions individual establishments must undertake when delivering the ACCT system of management providing a level of detail not included in the PSO. As such this does not add anything new to the prison service policies but does add another document whilst directing staff to a further 6 prison service documents including guides for managers and staff on the ACCT approach and a handbook introducing the suicide and self-harm warning form.

A second relevant prison service policy is the PSO4800 titled Women Prisoners. Released a year after PSO2700 this aimed to provide conditions that meet women prisoners' specific gender needs as required by the Gender Equality Duty. The policy also introduced a number of the accepted recommendations from the Corston Report, including the support of women

who have experienced abuse or violence and reforming security procedures to stop the routine strip searching of women. As the PSO4800 relates to such wide needs it is by nature much more generic than the PSO2700. Yet despite a much wider remit PSO4800 managed to incorporate health as well as criminal justice policy and recommendations made by third sector organisations such as the Fawcett Society[33]. This resulted in a rounded and holistic policy that sets audit baselines from access to mental health support for victims of abuse and mental health training for all staff, to the provision of advice on dangerous clients in the locale for those who will continue to engage in sex work after release. The PSO dedicates a chapter and contributes two audit baselines to the management of self-harm by women, making reference to service user literature including *'The Pain Inside'* by the Bristol Crisis Service for Women. Instructions to staff revolve around the encouragement of using alternative coping strategies other than self-harm and providing a regime that women find occupying and useful. In doing so the policy acknowledges the need of many to use self-harm (highlighted by the advice to give information around harm-minimisation – see Chapter 5) and the impact this may have on staff.

In many ways, therefore, PSO4800 is arguably a progressive and responsive policy that bridges some of the discussed gaps between health and criminal justice policy as well as incorporating other perspectives such as those of third sector and service user groups. It is, however limited in its ability to do this. That the policy has to refer and subsume to the PSO2700 in the management of self-harm limits its ability to be truly gender responsive. There is also no provision for the evaluation or development of the guidance, whether this involves service users or not. That the PSO4800 is a set and indefinite instruction only to be reviewed by the prison service through audit again limits the policies ability to respond to the changing needs of service users.

It is unsurprising that in many ways prison specific policy reflects policy development at a national level not only in volume but in that it is mostly also isolated from other organisations. What is perhaps unique to the prison specific policy is the timeframe in which this has happened. The policies described above were all introduced over a two year period between 2007 and 2008

despite numerous recommendations in health literature emerging from 2003 onwards. To what extent the amount and speed of change impacts upon local implementation may be found in the results of this study. What is apparent, however, is that the criminal justice policy, and consequently prison service policy, has not embraced the involvement of service users in the design and evaluation of services as fully as its health service counterparts. Whilst gender sensitivity has been introduced in many aspects of prison life through PSO4800 this has not resulted in a fully woman focussed approach to the management of self-harm.

Conclusion

What conclusions, then, may we draw from this plethora of policy and guidelines? There seem to be three:

The number, breadth and multiple authorships of policies relating to self-harm reflect the 'holistic' and 'culture changing' approach that the New Labour government was aiming to achieve (Perri 6, 1997). These policies are not without progressiveness whether in terms of their attempt to address the needs of women who self-harm, or the acknowledgement of discriminatory treatment of self-harmers. The policies also gesture, at least, in the direction of flexible approaches to care such as 'harm-minimisation'. Such 'progressiveness' is especially located within Mainstreaming Gender, NICE's clinical guideline 16, and PSO4800. Considerable problems, however, remain.

The approach adopted by New Labour sought to solve problems such as the prevalence of self-harm through central administration which spans departments and agencies thus, in the language of the National Offender Management Service (NOMS), preventing 'silo' working. This is evident in the use of interdepartmental recommendations. However it would be too quick to conclude from this that with respect to the implementation of health policy 'on the ground' (whether in terms of treatment, anti-discriminatory practice or service user involvement) huge gains have been made. Worryingly, evidence post-NICE suggests that discriminatory staff attitudes to self-harming behaviours persist notwithstanding NICE's guidance. This may be due to the

sheer pervasiveness of negative moral attitudes surrounding deliberately inflicted self-injury held by health care professionals. It may also be due to the notorious difficulty in actually delivering organisational and value-based change 'on the ground' where various powerful interests and bureaucracies tend to possess a 'life of their own' and the where the power and influence of centralised governance may not reach (Rhodes, 2000). Resistance to implementing change may also be a product of a lack of collaboration with the implementing agencies in the development of policy (Rhodes, 1997) which is consequential of this style of centralised government.

Finally difficulties in effecting change may also be due to certain 'paradoxes' which surround NICE's own commitment to user involvement. A lack of genuine service user involvement in treatment and policy formation by both health and criminal justice policy makers is markedly the case in the context of the prison service. Prison service policy is characterised by a complete lack of discourse as to the involvement of service users in the formulation of policy or services. This may be a result of the time-lapse of (approximately) five years between the formulation of health policy and the formulation of similar prison policy or a result of the differing cultural values of the differing organisations.

Chapter 5

Harm Minimisation

Harm minimisation reflects the meeting of the theoretical and policy frameworks already described in chapters 3 and 4. This chapter will therefore seek to explore the current health policy and practises around harm minimisation for self-harm and how these have been shaped and influenced by SUI. These will then be compared to prison policies which, as has already been established, are often not always informed by current health policy and have been little influenced by service user or feminist movements. The reasoning behind the prison services' policy and its 'duty of care', which precludes harm minimisation relating to self-harm but promotes education around safe substance use and safe sex, will be explored.

Harm minimisation refers to practises aimed at reducing the likelihood of causing harm to the self or others through high risk behaviour. Given the variety and different natures of 'risk', harm minimisation can therefore legitimately include initiatives as wide ranging as the provision of safer means to practice high risk behaviours (for example needle exchanges for people who use substances) to the education of both healthcare professionals and service users. The practice of harm minimisation has a long history in relation to substance misuse (Berridge, 1992) but is held to have commonly come in to the public awareness due to the HIV and AIDS crisis in the 1980's (DesJarlias & Friedman, 1993). This resulted in large public campaigns promoting safe sexual practices and safer drug use (Marlatt, 1998; Chalmers, 2008). Harm minimisation interventions for alcohol and substance misuse are held to be *"demonstrably effective"* (Logan & Marlatt, 2010, p.208) and set a low threshold for service engagement, thus ensuring they meet a large proportion of those accessing services (Marlatt, 1998). However such an evidence base does not exist for harm minimisation in regard to self-harm (Benbow & Deacon, 2011) its practice is not mainstream (Inckle, 2010) and, where used, it is often controversial. This chapter holds harm minimisation for substance use as an example of success[34] given its widespread use and the almost unanimous acceptance of initiatives such as needle exchanges in the UK (McDermott,

1997). As such it is used to contrast similar practices for self-harm, which for the sake of brevity, will be termed self-harm minimisation.

Harm Minimisation and Self-Harm

Despite the mainstream adoption of harm minimisation strategies for behaviours such as substance misuse and sexual practices, self-harm minimisation remains a controversial and stereotyped field.

Marlatt (1998) identified the five key principles of harm minimisation for substance misuse as:

1. Harm minimisation as an alternative to the prevailing criminal, moral and disease models of substance use
2. Accepting outcomes other than total abstinence
3. Developed bottom up through service user involvement rather than a top down policy approach
4. Low threshold access to services and a person centred approach
5. Based upon *"compassionate pragmatism"* rather than *"moralistic idealism"* (p.56)

I would suggest that there is significant overlap between these five principles, for example both principles 1 and 5 relate to an alternative conceptual model for high risk behaviour. Similarly a person centred approach that allows low threshold access necessarily requires acceptance of outcomes other than total abstinence. As such I shall examine self-harm minimisation using an adaptation of Marlatt's principles which I shall condense to just three principles. These are:

1. Harm minimisation offers an alternative model to the moralistic, disease and criminal models.
2. Harm minimisation offers person centred, holistic approaches that, through accepting that the client may continue to use risky behaviour sets a low threshold for service access.
3. Harm minimisation approaches are developed through service user activism.

In doing so this chapter will consider whether self-harm can be compared with other risky behaviours such as substance misuse and the extent to which harm minimisation principles for other behaviours can or cannot be considered for self-harm.

Harm Minimisation as an Alternative Model

That drug use is held to be both simultaneously a criminal act and a disease is highlighted by its position both in legal policy (e.g. the Misuse of Drugs Act, 1971) and as a mental health diagnosis (e.g. Substance dependence and abuse disorders DSM IV-TR, APA, 2000). Marlatt (1998) highlights the contradictory nature of this and suggests that such a twofold approach doubles the effort upon the 'war on drugs' which results from the moralistic view that drug use is wrong. In contrast the harm minimisation model seeks to shift the focus from the risky behaviour and the moralistic judgements this elicits to the consequences of the behaviour, whilst seeking ways of reducing the harm that comes from it.

How then does self-harm minimisation offer an alternative model? Self-harm is not illegal, however whether a person is entitled to self-harm is debated and supporting an individual to self-harm is considered to be a legal issue, inseparable from professional ethics and professional codes of conduct (Warner & Feery, 2007). One consideration in legal arguments is the extent to which self-harm is truly voluntary.

Self-harm is commonly linked with suicide either through ignorance of the often differing motivations between the two acts (Pembroke, 1994) or through predictive risk assessment. A personal history of self-harm has been reported to significantly increase the risk of suicide (Appleby *et al.,* 1999; Royal College of Psychiatry, 2003). Suicide rates amongst those with a history of self-harm are reportedly to be 3-5% over 5-10 years (Hawton, 1988) and particularly higher with repetition of self-harm by women (Zahl & Hawton, 2004). In comparison, the Office for National Statistics (ONS, 2011) reports the UK suicide rates as being 16.8 per 100,000 men (0.0168%) and 5.0 per 100,000

women (0.005%) in 2007. The risk of suicide by people who self-harm is also much higher than reported drug related deaths. There are reportedly 34 per 1,000,000 (0.0034%) in the general population or around 0.5% of the estimated population of problematic substance users (1,644 deaths from an estimated population of 327,000 substance users in the UK (Reuter & Stevens, 2007). The figures quoted will invariably overlap and include or not include deaths that have been incorrectly recorded[35]. Regardless, the figures do illustrate that the risk of self-inflicted death, whether intentional or not, is clearly much higher by those who self-harm than amongst the general and drug using populations. As Hewitt (2004) highlights, under the Suicide Act (1971) it is an offence *to "aid, abet, counsel or procure someone else's suicide"* (p.162). This opens the possibility of prosecution and even manslaughter charges for practitioners delivering self-harm minimisation to a client who subsequently completes suicide. Even in cases where there is no intention to cause death as Hewitt (2004) *states "it is only necessary that she or he intends to provide the relevant assistance, and is 'reckless' as to whether the patient dies"* (p.162). Such 'relevant assistance' is invariably the provision of resources to self-harm, such as sterilised blades to someone who cuts and who then uses these to complete suicide. Given the increased risk of death and subsequent threat of prosecution it may be understandable that healthcare providers would be reluctant, or even consider themselves negligent, to practice self-harm minimisation. Whilst this does not place self-harm or the person who self-harms in a legal model per se it does put the potential consequences of the behaviour in a legal context for the practitioner.

Gutridge (2010) argues that a *"desire"*[36] (p. 86) to self-harm, especially as a result of abuse, often co-exists with a wish to be able to resist this desire. She argues that because of this ambivalence, self-harm is neither entirely voluntary nor the sole responsibility of the individual who inflicts the harm upon themselves. This conflict has been acknowledged by survivors of self-harm for example Pembroke (1994) who writes of self-harm as being *"in control and out of control simultaneously"* and describes her need to self-harm as *"an intense, unseen war in myself where there is no winning move."* (p. 32) Therefore, Gutridge argues, under such conditions self-harm minimisation is analogous to

aiding physical injury given that there is some part of the person that doesn't want to self-harm. This then creates a situation in which the medical practitioner who provides self-harm minimisation can be seen to cause harm that is not entirely consensual and that is therefore in conflict with medical codes of practice if short of legal frameworks for bodily harm. Of course the same could be equally true of anyone who self-harms through using substances for similar reasons and raises the question of whether providing methadone or clean paraphernalia to anyone with an ambition to stop using opiates also creates harm. Gutridge's concept of the non-voluntary nature of self-harm therefore appears to confuse future aims (possibly to stop self-harming) with current necessity (i.e. in order to survive) totally disregarding the dialect of ambivalence that people encounter not just in relation to self-harm but also in day-to-day life. Nor does Gutridge account for those whose self-harm may be used to reassert control over their body or explain why harm minimisation for substance misuse might flourish whereas self-harm minimisation hasn't. It does, however, raise the consideration that self-harm minimisation may not be permissible in either law or professional ethics if considered to be aiding injury.

It is beyond the scope of this chapter, or my expertise, to debate the legal intricacies of self-harm minimisation. What stands out, however, is that such a case has not been heard by the courts and that whilst such conjecture is expert and well informed it is just that, conjecture. Those that write about the legalities do so in the abstract and with reference to the Bolam test[37] which to-date has not been tested by legal action. Whilst the court has ruled that those in custody do not have a right to self-harm (Warner & Feery, 2007) this is not the same as being found guilty of assault or manslaughter for practicing self-harm minimisation. It is under the auspices of the Bolam test that self-harm minimisation, including care planning allowing patients to retain (but not providing) material for cutting, is practiced in St George's Hospital[38]. This practice appears to date to have gone unchallenged and has reportedly resulted in reduction of admission times and incidents of self-harm whilst increasing staff's confidence in dealing with clients (National Self-Harm Minimisation Group, 2010). It could then be that the legal concerns prove unfounded upon testing and that the courts may not find the clinician negligent or to have acted

illegally. This would require the practitioner or healthcare provider to take the calculated risk that they could sufficiently satisfy the court that self-harm minimisation was in the best interest of the client. Given the suicide rates of people who self-harm and that self-harm minimisation has not been empirically evidenced (Benbow & Deacon, 2011) this may seem to be too great a risk. However, what is unclear in the figures quoted is the number of those who complete suicide who are practising self-harm minimisation. Given that the practice appears to be a rarity the numbers are surely small and this remains an area requiring further research which may or may not strengthen the legal argument.

If the legal basis of self-harm minimisation is untested then do the professional standards and ethics of those who would practice it prevent them from doing so? Whilst the Nursing and Midwifery Council (NMC) code of conduct includes the standard that practitioners should work with others to protect the health and wellbeing of those in their care, neither health nor wellbeing are defined. This may suggest that self-harm minimisation strategies are not in conflict with guidelines when they promote the individuals safety in using self-harm and psychological wellbeing when managing their distress. This is particularly relevant when distinguishing between psychological harm and physical harm as Edwards & Hewitt (2011) do. Both the Good Medical Practice Guide for Doctors (General Medical Council (GMC) 2006) and the Nursing Standards (NMC Council, 2008) are silent on the specific practice of harm minimisation. However they are equally tacit, as are the Royal College of Nursing, and the British Medical Association, on the topic of protecting clients from harm. One theme that does exist across the codes of practice is the importance of a person centred approach that is supportive of the individual's choices and promotes self-care, for example, *"Support patients in caring for themselves to improve and maintain their health"* (GMC, 2006, p.2) and *"You must support people in caring for themselves to improve and maintain their health"* (NMC, 2008, p.3). These principles are also specifically supported in relation to mental health "*People with mental health problems can expect services that…offer choices and promote independence and safety"* (NHS, 1999, p.14). Such principles are arguably supportive of approaches i) that promote choice and methods that

reduce risk of harm as well as self-care (Inckle, 2010) and ii) that acknowledge the individual's choice in using self-harm as a mechanism for survival. As with the legal position however and as acknowledged in guidance received from the NMC by Pengelly *et al.,* (2008) there are no precedents for practitioners to base their judgement upon. This again gives the impression that progressing self-harm minimisation is reliant upon practitioners taking a calculated risk. This is despite support for self-harm minimisation in the NICE (2004) guidelines:

> *"Advice regarding self-management of superficial injuries, harm minimisation techniques, alternative coping strategies and how best to deal with scarring should be considered for people who repeatedly self-injure."* (NICE, 2004, p.64).

The impact of the NICE guidelines has been questioned (see chapter 4) though and its recommendations around harm minimisation overlooked in reviews of impact (for example Kapur, 2005). Furthermore the guidelines do not define what is meant by harm minimisation techniques and it is possible that, for this reason, the practice has not become more commonplace. The arguments around self-harm minimisation are often polarised and stereotypes of the facilitation of self-injury through provision of sterile blades and 'cutting rooms' seems to be the default point of reference. This has been the basis of the discussion about the legal and ethical frameworks discussed above and is acutely demonstrated by the Royal College of Psychiatry's (RCPs) report (2010) which in its brief reference to self-harm minimisation states:

> *"Harm minimisation is a strategy, recommended by NICE, only to be used in specialist and dedicated services that allow people to harm themselves in a controlled environment and with sterile instruments in order to ensure that any harm done is as clean and well managed as possible."* (RCP report CR158, p.40)

The fundamental flaw in this aspect of the RCP report, and the arguments around harm minimisation so far presented, is to define harm minimisation as the facilitation of self-harm. Such a definition overlooks the many aspects of harm minimisation that exist, instead reducing self-harm to cutting and harm minimisation to the facilitation of cutting. The impact of such a statement by the RCP is not known, however one could hypothesise that such reductionism not

only reinforces negative stereotypes but also dissuades healthcare providers from considering harm minimisation as an approach.

Whilst self-harm does not exist in a legal framework and the practice of self-harm minimisation is a legal grey area, self-harm is definitely held in a moralistic model just as much as substance misuse. The existing moralistic idealism surrounding self-harm is clearly the view that people shouldn't self-harm and this is reflected in professional attitudes and approaches to treating self-harm. Schramme (2008) described a *"common discomfort regarding non-therapeutic mutilation"*[39] (p.9) whilst Cresswell and Karimova (2010) specifically identified medicines moral code against self-harm. Others have also identified institutionalised prejudices (Simpson, 2006) or pervasive negative attitudes that impact upon care (Huband 2000; McAllister *et al.,* 2005; Kenning *et al.,* 2010). Such stigma has been described in the first hand accounts of treatment that depict substandard care (Pembroke, 1994; Le Fevre, 1996; Dace & Smith, 1998) which can result in the reinforcement of the negative emotions which initially caused the self-harm (Jeffrey & Warm, 2002). Such attitudes are also acknowledged in the NICE guidelines which contain similar accounts of service users receiving treatment without appropriate analgesia, and recommends additional training for staff who come in to contact with people who have self-harmed to address such deficits in care.

Such moralistic idealism or moral codes are, inevitably, harmful. Pembroke (1994)[40] compares this to iatrogenic harm, a well-researched phenomenon in the area of psychotherapy (Dimidjian & Hollon, 2010) and community health provision (Koekkoek *et al.* 2010) to name a few. Iatrogenic harm has been described as resulting from stigma and labelling (Sartorius, 2002) or from treatments and decisions made about treatments (Dimidjian & Hollon, 2010). However the phenomenon has not been investigated in the area of self-harm despite the wealth of personal accounts and research regarding the impact of moralistic codes. Iatrogenic harm caused can conceivably range from causing upset and distress (RCP, 2008b) to preventing the person seeking medical help in the future (NICE, 2004), delaying treatment (Taylor, *et al.,* 2009) or even traumatising the individual to an extent where self-harm may be exacerbated.

In these contexts therefore, self-harm minimisation can relate to the education and training of healthcare providers regarding self-harm's purposes and the importance the person may place upon it for their survival (McHale & Fenton, 2010; Patterson, *et al.,* 2007; Pembroke, 2007). Self-harm minimisation may also extend to the education of therapists about appropriate goals for intervention (Kelly, *et al.,* 2008) or the provision of clinical supervision and support to help staff manage feelings of helplessness and frustration (Pengelly *et al.,* 2008; Patterson *et al.,* 2007; Cooke & James, 2009). Moving away from a moralistic perspective that one should not self-harm also opens up the area of self-harm minimisation moving it away from simply the facilitation of self-harm to much broader practices which can reduce harm inflicted either by the client or the service provider.

Are such negative moral ideals of self-harm the reason why harm minimisation approaches are not more broadly adopted? This would suggest that forms of care would be purposively withheld due to individual and institutional prejudices. This may be a possibility and mean that personal discomfort, unease or even revulsion at self-harm could prevent the practising of care that accepts the continuation of the behaviour and provides the means to do so in a safer fashion. Whilst Schramme (2008) compares this with Kant's (1797) duty to oneself[41] which, failure to fulfil, results in a 'debasement of humanity'. Schramme eloquently argues against this in relation to ethics and, I would argue, in a simpler fashion. A duty to oneself implies a value placed upon oneself. If self-worth hasn't been taught or demonstrated or has been fundamentally undermined (e.g. as a result of abuse, neglect or violence) how could the individual possess enough self-worth to justify fulfilling that 'duty'? It could then be that local practices and policy that don't reflect a harm-minimisation approach are based upon values of the importance of demonstrating self-worth without fully acknowledging the extent and prevalence with which individuals (and especially women) are devalued by others. It might be surprising that healthcare providers could be blind to such victimisation, given that they will commonly be dealing with the aftermath of abuses. However Herman (1992) catalogues a history of *"episodic amnesia"* (p.7) in relation to psychological trauma and describes the temptation to side with the

perpetrator given the emotional burden that the victim brings. A failure to recognise the importance of self-harm minimisation may therefore reflect either an inability or refusal to recognise the importance of self-harm to the survival of the person, based upon commonly held assumptions about self-worth and its demonstration.

To summarise, whilst self-harm does not exist in a legal framework (i.e. there are no sanctions by law for the act of self-harm). Whilst the practice of self-harm minimisation potentially does carry sanctions this is untested and so the actual consequences for the practitioner remain unclear. In a culture averse to risk, that fears litigation and is presented with the worst case scenarios of suicide and prosecution, it may be understandable why healthcare practitioners are reluctant to provide self-harm minimisation. Reluctance may also be a result of the moral position many hold against self-harm and the belief that to harm oneself is wrong, amounts to attention seeking or is symptomatic of mental illness. However, such reluctance only serves the healthcare provider and not necessarily the service user. The refusal to practice self-harm minimisation due to focussing upon the *possible* negative consequences, denies the service user the possibilities of positive consequences such as education about wound care and discussing safer methods of causing injury. Blanket refusal may also hamper the relationship between the client, who can't currently see an alternative to self-harm, and a clinician who can only deliver services based upon abstinence. Such an all-encompassing position as a blanket refusal fails to account for the individual's needs, despite these being a consistent focus in clinical practice guidelines. Self-harm minimisation however provides an alternative conceptual model which places the individual client ahead of concerns of litigation. The model also accepts the person's use of self-harm whilst they seek to find alternative coping strategies; this leads to the second pertinent principle of self-harm minimisation, that of a person centred approach.

Harm minimisation and Person Centred Approaches

Accounting for the individual and their personal rights and needs is at the heart of a harm minimisation approach and moves the discourse away from models of

pathology, criminality or morality to focus on the individual. Stimson (2007) describes one basis of harm minimisation for substance misuse being that of the individual's human rights to life, health and security. Similarly Tammi and Hurme (2007) discuss the importance of inclusion, emancipation and individualism to the harm reduction movement for substance misuse. In relation to self-harm minimisation Inckle (2010) writes:

> *"Harm reduction entails a more nuanced interrelationship between the individual who hurts themselves, their immediate and long-term needs and their support person than is the norm within conventional approaches…only by paying careful attention to the individual and their experience can an accurate picture of the specific risks they face and the means of reducing them be established"* (p.186-187)

As highlighted above, person centred approaches which promote self-care and independence are also required by medical guidelines. Despite these, people who self-harm often report not being involved in decisions about their care (Taylor *et al.,* 2009) and being subjected to the moral judgements of healthcare providers. This poses the question if people who self-harm require a more individual approach than the 'norm' why is this not being provided?

One argument against the use of self-harm minimisation strategies (which accept the continued use of self-harm) is the impact it will have upon existing, already stretched resources. Provision of "nuanced" or tailored approaches are inevitably more time consuming than what is currently the "norm" (ibid). Given that even lower-end estimates suggest that as many as 2.4 million people in the UK may self-harm[42] (Briere & Gill, 1998), over seven times the number that are estimated to misuse illicit substances, self-harm presents a greater public health problem than that of drug use. Such numbers alone may be prohibitive of introducing the effective and individualised self-harm minimisation that is required to avoid potential litigation. Whilst alternatives to one-to-one approaches are available, for example self-harm minimisation literature, these may not represent a viable first option. Given the importance of therapeutic and collaborative relationships in interventions for self-harm (Kool, van Meijel & Bosman, 2009; Brown & Bryant, 2007) the provision of reading material, no matter how useful, may be counterproductive and promote the message that

those who self-harm are not deserving of the time and care they receive. This is made more likely by the pervasive moral judgements that exist and is potentially seen in services which attempt to offer distant interventions such as telephone help lines and 'green card' access but which report little service uptake and no treatment effect (Evans *et al.,* 2005). It may be then that primary care services may not have the resources nor the culture to deliver self-harm minimisation.

Self-harm survivors however, are not solely demanding harm minimisation from primary care but also the respect and options in treatment that other patients receive. With regards to practising self-harm minimisation in secondary or tertiary care services the argument of numbers and resources could be reversed to ask the question, can healthcare providers afford not to take such an approach? It is apparent that interventions that prohibit self-harm are not only ineffective but often punitive. This approach therefore may reduce rates of re-attendance at primary care settings such as A&E but do not reduce actual rates of self-harm. Such approaches also treat self-harm as the primary focus and not as a potential symptom of underlying causes, commonly distress. Failing to properly provide for needs, such as the treatment of post-traumatic stress, is to overlook a major public health concern which often manifests in the form of self-harm. This opens the potential for self-harm minimisation to also include interventions to assist those who suffer with symptoms of traumatic experiences, which in turn may impact upon their self-harm.

Although many argue against the pathologising of self-harm, particularly in relation to the diagnosis of Borderline Personality Disorder, it may because the behaviour is not a diagnosis in itself, that it is not represented by guidelines for self-care. This is highlighted by the Royal College of Psychiatrists offering information and self-care advice for conditions such as 'bipolar disorder' and 'schizophrenia' but not for self-harm. It may be that common misconceptions about self-harm (for example that it is something done by adolescent girls and is just a 'phase') or that the behaviour is not a diagnostic label, results in it not being treated as a long-term condition (unlike illnesses such as bipolar disorder). That is not to argue that diagnoses such as 'self-harm disorder' be

invented but to recognise the behaviour as a possible long-term and enduring characteristic of the individual, just as illnesses may also be. With such recognition may come clinically sanctioned strategies for self-care and management that are not solely focussed upon abstinence, but also upon acceptance and choice in change.

Harm Minimisation and Service User Involvement

Marlatt (1998) described harm minimisation practices such as needle exchanges and methadone maintenance as first developing in the Netherlands through a *"bottom up"* (p.52) approach. This involved service users coming together to form a politically active organisation the Junkiebond, translated as the 'Junkie League' (ibid). The Junkiebond was established in 1981 in protest at planned legislation allowing the forcible detoxification of drug addicts (Friedman *et al.,* 2007). Through activities such as organising mass protests, the publication of literature critical of current practices and starting underground needle exchanges (ibid) the Junkiebond was able to gain the support of the National Health Ministry and shape Dutch policy. Wijngaart (1991) described the purpose of the league as *"The most important thing…to improve housing and the general situation of the addict"* (p.39) and examples of success included the first legalised needle exchange programmes being introduced in 1984.

The self-harm minimisation approach can be similarly seen to have developed from such grass roots. Emerging from the wider psychiatric survivor movement and radical feminism, Cresswell (2005a) describes a specific self-harm survivor movement developing to challenge psychiatric and medical conceptions of self-harm or what Cresswell describes as attempts to *"displace psychiatry's hegemonic truth"* (p.275). The *"first phase* [1988-1996]*"* (ibid, p.260) began just six years after the Junkiebond and similarly published literature that was critical of current policy and treatment of service users (Pembroke, 1994). Protests, commonly in the form of conferences, were also held and the Survivor movement was further willing to provide what the healthcare providers were not, in the form of information about safer ways to self-injure, basic first aid and wound care techniques (National Self-Harm Network, 2000) and care planning activities to promote self-care and self-worth (Dace *et al.,* 1998).

It may be, however, in the overall aims of the two organisations that difference is found. Where the Junkiebond sought to achieve practical and tangible outcomes, for example improved housing, the self-harm survivor movement sought to challenge the culture and prejudices (or the moralistic ideals) that surrounded the behaviour and the pathologising of women's experience. In reality this meant attempting to redefine self-harm away from being seen as a symptom of mental ill health (psychiatry's perception) towards recognition as an expression of distress that often resulted from women's position in society (women's lived experience). Creswell (2005b) describes the objectives of Survivors Speak Out as a:

> *"Step backwards away from the mandating platforms of action in the direction of buttressing the basic right of the 'mentally ill' to 'speak their minds'"* (p.1669).

Arguably the self-harm survivor movement was not as broad in its approach focussing upon the rights for women's voices in the mental health system to be heard. This could be argued given the movement's roots in feminism and that all the prominent activists in the self-harm movement, with the exception of Andy Smith, were women. Whilst the need for women's voices to be heard by the patriarchal institutions of medicine and psychiatry is undoubtedly vital whether such a close alignment with feminism made the debate more about gender than about self-harm, at least for those in the field of psychiatry, is unknown. If this were the case then it would appear that the survivor movement is left with two difficult changes to promote, namely the challenge to the existing patriarchy AND the principles respect and individualism that underlie self-harm minimisation. This contrasts with the Junkiebond's focus upon practical change. This is perhaps most easily identified in the nature of the early aims of the two organisations. Junkiebond sought needle exchanges and improved housing whilst the survivor movement sought to address the moral judgements around self-harm. Where members of the Junkiebond even used the derogatory labels they must have endured when naming their league the survivor movement sought to challenge the culture behind the labelling of people. Where it took the Junkiebond three years to achieve state sanctioned

needle exchanges it took the survivor movement 12 years for the publication of the NICE (2004) guidelines to recommend that the label 'deliberate' not be used because of its negative connotations. The value of the differing goals, or the form of protest, of each movement is not in question however the challenges of changing a culture as opposed to policy may be evidenced in the differing timescales between the two. It could be argued that Survivors sought to properly prepare the cultural foundations of care services for a self-harm minimisation approach where the Junkiebond took immediate action. The clearest evidence of the mainstream success of the survivor movement is perhaps that of the NICE guidelines which recommend not only self-harm minimisation but also the involvement of service users in the commissioning and evaluation of services and the training of healthcare staff. The guidelines also emphasise the need for services to be conducted with respect and understanding for the individual's mental wellbeing and thus appears to fulfil the three principles of self-harm minimisation outlined here[43].

To conclude this discussion of the principles of self-harm minimisation it is apparent that the practice can include a large spectrum of interventions from the often thought of provision of sterile equipment, to wound care and anatomical information to staff supervision and training. This therefore encompasses providing service users both the means and information by which to reduce the risk to themselves but also methods of reducing risk to staff (e.g. stress) and thus reducing the possible iatrogenic harm sometimes inflicted upon those accessing care. Self-harm minimisation is underpinned by the principles of accepting, person centred approaches that involve users in service design and choice. What is apparent is that self-harm minimisation is beset by moralistic and cultural prejudices towards and misunderstanding of self-harm as well as legal concerns about the practice. That the behaviour is often pathologised as a characteristic of an untreatable disorder and over looked as a chronic symptom of distress, and that those who self-harm commonly present to under resourced staff who feel threatened by the nature of their presentation, appears to prevent the individualised care planning that is required for the effective delivery of self-harm minimisation. I shall now go on to examine whether any of these principles are delivered within the prison environment.

Harm Minimisation in Prison

Given the complexities of the arguments for and against harm minimisation and the prison service's unique position in its role of providing care, punishment and rehabilitation, it is unsurprising that the service's policy and practice around harm minimisation is convoluted.

The prison service's approach to harm minimisation in relation to substance misuse is consistent with, if not equivalent to, that of community health and drug services. This is reflected in a number of performance targets that prisons are set. For example the education of harm minimisation strategies for prisoners who misuse substances is a clear audit baseline in the prison services drug strategy (HMPS, 2006): "*the provision of treatment, counselling and support, health promotion and harm minimisation".* (Baseline 2.6, p.1). The inclusion of this requirement results in an individual prison's performance being, at least in part, measured by its promotion of safer substance use. The delivery of this requirement is usually done through the Counselling, Assessment, Referral, Advice and Throughcare Service (CARATS) but is also a feature of drug related offending behaviour programmes.

Harm-minimisation is not limited to education; Prison Service Instruction (PSI) 34/2007 (HMPS, 2007) reintroduces the provision of sterilising tablets for the purpose of properly cleaning materials used for injecting drugs[44]. The clear aim of the scheme is to prevent the spread of communicable blood borne diseases, despite "*the possession of injecting equipment* [being] *strictly prohibited in prisons".* (p. 2, PSI 53/2003) and is, arguably, just one step short of needle exchanges. It would appear therefore that harm minimisation in relation to substance misuse is well established and its guidelines are clear and unmuddied by (at least published) concerns about the service being seen to condone a behaviour that is not only dangerous but also illegal. As such substance harm minimisation in the prison can be seen to exercise Marlatt's (1998) principle of compassionate pragmatism, moving substance misuse away from a purely legal framework to one in which there is a degree of acceptance of drug use. The practice is also varied to include provision of equipment to

education and through care. This is not the case for self-harm minimisation in the prison.

As discussed in chapter 4 the prison service's ACCT procedure for the management of prisoners at risk of self-harm and suicide is laid out in PSO2700. The only reference to harm minimisation in the policy is in relation to substance misuse services; however its intentions are clear in the statement

> *"Establishments must <u>not</u> provide self-harming prisoners with materials to harm themselves more 'safely'* (e.g. sterilised blades), *<u>nor</u> provide encouragement to 'safer' self-harm"* (para 8.4.5)

This clearly rules out the RCPs vision of harm minimisation as well as the provision of anatomical information to reduce risk and also encouraging the person to consider less dangerous ways of harming themselves. PSO2700 does concede to the use of activities which mimic self-harm such as the use of elastic bands, red pens and ice cubes, for suitably assessed prisoners. Such mimicking behaviours could be considered harm minimisation but the reason for the service's reluctance to engage in the education of 'safer self-harm' becomes clear from an ACCT training hand-out outlining the prison services 'Duty of Care'. This duty of care is reportedly

> *"We have a legal duty of care towards all prisoners: we are required to take all positive steps to protect a prisoner. The duty of care within a custodial setting is higher than in the community…In presenting safer self-harm strategies we may be at risk of being seen as 'encouraging' self-harm* [which opens up the possibility of a legal challenge]*"* (hand-out 3.3 p.1)

In contrast to substance misuse this then places prison based self-harm minimisation in a purely legal model, which again presents the worst case scenario of legal challenge for 'encouraging' self-harm. Encouraging is defined by the Oxford English Dictionary as to urge or advise, to promote or assist. As previously discussed urging, promoting or assisting someone to self-harm could be legally indefensible. However, as already highlighted, these are not practices associated with self-harm minimisation. As with self-harm

minimisation in the community, it appears that the fear of litigation stifles the development of new practices at the expense of individualised care and removes choice of safer self-harm options from those who may need them.

With regards to the provision of individualised care, PSO4800, which was established in response to The Corston Report (2007), gives gender specific guidance on the needs of women in prison. As such an entire section of the PSO is in relation to self-harm with guidance including:

> *"Women who self-harm should be offered interventions that are responsive to their individual needs, and that form part of a realistic, multi-disciplinary care plan. Interventions should include advice on harm-minimisation."* (PSO4800, p.15)

This would therefore suggest a person centred and holistic approach the concords with the principles of harm minimisation. As with the NICE guidance harm minimisation is not specifically defined. This however is the exact opposite to the stated objectives of PSO2700 and the published duty of care. A further contradiction arises when considering prison health policy. Prison standard 22 'Health Services for Prisoners' (2004) states that local healthcare policies and practices should be in line with the NHS standards. NHS standards, guided by the NICE, recommend the teaching of harm minimisation strategies. As with the policy development outlined in chapter 4, prison health policies are not consistent with community health settings. Arguably prison staff are governed by policy that is contradictory and unclear.

The impact of such a policy framework is surely significant for day-to-day working practices. In addition, prison staff attitudes, regardless of discipline or area of work, reflect those of the wider population. This results in self-harm often being perceived to be attempts at 'manipulation' or 'attention seeking' behaviour. Such attitudes, as in the community, negatively impact upon service delivery and care (Kenning *et al.,* 2010). The inability to offer self-harm minimisation also restricts those who deliver care and prison staff find themselves in a position in which they are neither able to encourage cessation through reward or contract (PSO2700) nor accept self-harm as a viable strategy for the individual. This surely contributes to the frustration and helplessness

that those who work with people who self-harm often report (Cooke & James, 2009).

Finally, it is worth re-iterating the point made in chapter 3, that whilst survivors borne from feminist roots have sought to address the negative perceptions and attitudes that surround self-harm, neither of these movements have adequately accounted for people in prison. This has resulted in the biggest advance in the area of self-harm developing not from the grassroots, as in the community, but from the government commissioned Corston report.

Conclusions

Harm minimisation, whether for self-harm or substance misuse, share the principles of healthcare providers being non-judgemental and accepting, of using person centred and holistic approaches and of development through the direct action of service users. Self-harm minimisation encompasses a wide variety of care options that can sometimes involve sanctioned use of self-harm, but more commonly encompasses patient education and information giving, staff training/supervision and perhaps most importantly the use of non-judgemental and empathic approaches by healthcare providers. However the practice has faced, and continues to face, a number of obstacles in its delivery. These include common misconceptions about what the practice entails, negative moral judgements against people who self-harm and a misunderstanding of the meaning and significance of the behaviour. These misconceptions continue to be pervasive, despite being the main focus of an active survivor movement for nearly thirty years, and continue to make self-harm minimisation an area of controversy. It would appear that at the heart of the controversy is the fear of the unknown. Despite self-harm minimisation being practiced in individual areas such as St. George's hospital, receiving favourable review from professional standards bodies, and even forming a recommendation by the NICE the practice is uncommon and remains legally untested. This legal uncertainty combined with the possibility of legal action for; (in the worst case scenarios) assisting suicide prevents practitioners from delivering self-harm minimisation. This is often under the guise of a professional duty of care. This duty however overlooks the need of the

individual and fails to recognise that, for some, self-harm is an attempt to survive until other forms of coping can be found. This also leads to missed opportunities to educate people in self-care, empower them to improve their own wellbeing and make positive choice (Spandler & Warner, 2007) as well as protect them from harm should they continue to self-harm. These are principles which do not conflict with current codes of conduct but instead lie at the heart of the practitioner guidelines. Harm minimisation approaches also encourage the practitioner to view their client in a more holistic way, thus treating the person and their situation and seeing self-harm as a symptom of underlying distress rather than an aberrant behaviour. In short, it would appear that until the debate on self-harm minimisation can move away from the stereotypes of cutting rooms and the provision of sterilised equipment towards encompassing the client centred approaches that move away from the moral condemnation of self-harm, the "risk" to the community healthcare provider will continue to be prioritised over the risk to the individual who continues to self-harm without the support of a harm minimisation approach.

The prison service reflects the general consensus of community policy and attitudes. In the custodial setting the prioritisation of legal concerns also overrides the potential needs of the client resulting in the prison service's 'higher duty of care' reportedly preventing the use of self-harm minimisation. Here the policy discussion is around the concern of appearing to encourage the use of self-harm. This though is contradicted by the service's position on harm minimisation for substance misuse, and other existing prison service policy. It also indicates a failure to implement the NICE guidelines in relation to self-harm. Similar to the community, attitudes and moral judgements about self-harm also exist within prisons. Unlike community based services, however, these are yet to be challenged by a cohesive movement representing service users in custody. Whilst prison policy does stress the importance of empathic and warm approaches between staff and prisoners in the management of self-harm, the inability of staff to deliver self-harm minimisation surely prevents a truly individualised care planning approach that is the intended basis of the ACCT process.

Chapter 6

Ethical Considerations

This research has been ethically complex with three aspects to consider: Firstly, obtaining ethical approval within health and criminal justice systems is notoriously difficult (Gill, 2009). The considerations of clinical and information governance when working with multiple stakeholders and ethical gatekeepers, such as the prison and the NHS, will be explored.

Secondly, there exist inherent ethical dilemmas and considerations when working with women in prison. Methods for obtaining and maintaining informed consent, limitations upon confidentiality and security implications, and the protection of participants will be discussed. These restrictions, along with others such as the lack of participant involvement in the research agenda, may, arguably, prevent the formation of the relationships of solidarity and personal investment that many feminist researchers see as critical to the emancipatory paradigm (Modleski, 1991). To this extent the ability to conduct feminist emancipatory research in a prison environment will be explored and the question considered as to whether the practicalities of such research necessitates a compromise for, or a re-orientation of, the original paradigm (Levinson, 1998).

A final ethical consideration is the issue of *gender* and *reflexivity* (see Gill & Maclean, 2002). To what extent can a *man* conduct explicitly *feminist* research with women as research subjects? Whether men can contribute to the feminist agenda is a matter of debate (Levinson, 1998). Through the use of auto-ethnography the chapter will personally reflect upon the experience of conducting feminist (or pro-feminist, Levinson, 1998) research and how this interacts with complex power relations which involve both gender (i.e. male researcher/female research subjects) and institutional role (i.e. staff/prisoner) divides.

Ethical Approval

Obtaining ethical approval for prison based research can be difficult and time consuming and levels of bureaucracy can prove to be insurmountable resulting in cancellation of studies before they have even begun (see Gill, 2009). Difficulty in obtaining ethical clearance to include prisoners in research may be a result of the abuse of prisoners in war time and post-war medical research (Hornblum, 1997).

Given the multidisciplinary nature of prison work it was inevitable that the research would involve multiple stakeholders. In all, the project required ethical approval from five organisations, with differing vested interests and ethical standards:

- The National Health Service Research Ethics Committee (NHS, REC)
- The Ministry of Justice (MoJ)
- The Primary Care Trust (PCT)
- The University
- The Prison.

Ethical clearance from the REC and MoJ was received via the completion of the Integrated Research Application System (IRAS, see Appendix A) and attending a REC board. Despite the IRAS's intended aim of providing a *"one time entry of information"* (IRAS user manual v.2.0, p.1) separate ethical applications were still required from the remaining three organisations.

Each organisation's agenda was evident through the requirements and evidence they requested in order to provide ethical clearance. Of particular concern to the REC were issues of informed consent and confidentiality and the possibility of harm to participants as a direct result of discussing self-harm. The focus of the prison ethics board, however, was more upon the risk to the institution as a whole, the possible impact upon the prison regime and any disruption this may cause. The PCT was concerned about information governance and access to patient[45] records requiring an honorary contract and assurances around data security. Finally the University's concern, as my employer, focussed more upon risk to me, requiring vaccinations I had not

previously had (despite working in prisons for 5 years previously) and occupational health assessments. Whilst in total these provide coverage of all ethical considerations to participants, the institutions and the researchers, the disjointed nature of the applications gave the impression that this coverage was more a result of good luck than good planning.

Given the levels of bureaucracy involved pertinent questions would be i) are these measures are essential in order to protect participants and researchers? and ii) does the emphasis on the protection of participant's result in missed opportunities, due to aversion to risk? Glasziou and Chalmers (2004) argue against the *"one size of ethics review fits all types of evaluation"* (p.122) approach that is taken by the REC. It is clear that the processes for obtaining ethical approval through the IRAS system are the same for clinical trials as they are for less risky types of research. Glasziou and Chalmers reported that this single approach can result in delays which in turn have negative consequences for participants, including in one case the unnecessary deaths of an estimated 10,000 people due to delays in a clinical trial. In all it took almost a year for this research to gain all the necessary ethical approvals. Although this delay wouldn't have had such dire consequences as the example above, given the limited three year time frame of the project it does pose the question what else may have been achievable had there been another six months in which to work with the women and staff in the prison? Glasziou and Chalmers concluded that REC's should consider the possible benefits more (which I shall explore further), as well as the risks of research for participants whilst considering applications for ethical approval.

There is of course a balance to be struck between expediency, pragmatism and protection of all who may become involved in research. This is particularly the case for those in prison who often have multifaceted needs[46] (Stewart, 2008) and whose access to resources and sources of support is limited due to the nature of their incarceration. A primary concern, for both the REC and the prison, was the possibility that the research process may cause those involved, and especially the women, to become distressed and self-harm as a result of participation. It was felt by both organisations that a woman's risk of harm to

herself would be increased through interviews inevitably touching upon upsetting issues, including trauma, due to women in prison's greater experience of victimisation (Sable *et al.,* 1999), loss of family contact and the impact of imprisonment. However Rivlin *et al.,* (2012) concluded that such a priori assumptions about the effects of research may be unfounded. In their study of the impact of interviews with people in prison about their recent near lethal suicide attempts, Rivlin *et al.,* concluded that for many the experience was beneficial and in some cases cathartic even when participants found the interview difficult. A minority of prisoners reported regretting taking part in the interview with the reasons given indicating an element of coercion to participate "*I don't really want to talk about it"* (p.59) or a lack of information about the subject of the interview. Both of these, however, are addressable through the use of feminist informed research practices, such as empowering choice in participation, as outlined below and in more detail in Chapter 3. Previous literature has also highlighted the potential benefits of asking about traumatic experiences such as sexual abuse (Edwards, *et al.*, 2007; Read, 2007) or the potential therapeutic benefits for people of becoming involved in such studies if done with sensitivity (Rossiter & Verdun-Jones, 2011). Becker-Blease & Freyd (2006) consider a number of ethical concerns around asking research participants about abuse concluding that not only is it ethically justifiable but required. This requirement to ask difficult questions around abuse, it is argued, is to ensure that the effects of abuse upon the person are neither under nor over estimated (Putnam, Liss & Landsverk, 1996). Given Herman's (1992) account of the systematic denial of abuses against women throughout history and Westmarland's (2008) observation that the welfare state is ill equipped to care for female victims, it is arguable that a feminist approach requires researchers to ask about abuse in order to fully appreciate the unfortunately commonplace occurrence of violence against women. The failure of ethics committees to adequately differentiate between distress and harm and the assumption of a causal relationship between the two (Edwards *et al.* 2007; Brabin & Berah, 1995) results in committees either overlooking the possible positive aspects of discussing abuse or trauma as a part of research, focusing solely upon the potential negative implications. Faulkner (2004) considered that

this resulted in ethics committees attempting to shield service users from upset to such a degree as to make them feel patronised.

Harm may not only be inflicted on participants however, and the risk of vicarious (Dunkley and Whelan, 2006) or secondary (Motta, 2008) trauma is a real ethical concern for those conducting prison based research. Vicarious trauma is often associated with therapists or mental health workers who are exposed to narratives of traumatic events (Sabin-Farrell & Turpin, 2003) and particularly associated with empathic engagement (Pearlman & MacIan, 1995). This can result in those listening to accounts of traumatic events experiencing similar feelings of distress, fear and other symptoms of post-traumatic stress to those recounting the experience. Figley (1995a) described such effects upon the listener as the "cost of caring" (p.1). This may be particularly the case if the methodology uses life history accounts or includes topics that are also likely to cause distress in the participant. Risk to the researcher may be increased when trying to build collaborative and meaningful working relationships with those participating in the research as required by feminist principles. Throughout the research I have had access to the same staff support schemes as prison service employees and the offer of additional monthly sessions with the CareFirst service provided by the Dangerous and Severe Personality Disorder (DSPD) team in the prison. Support from academic supervisors and the occupational health resources of the university have also been available throughout. Such concerns, however, appear to stem from the same a priori assumptions that research will be upsetting for the participants and so subsequently for the researchers. Again ethics committees require planning for 'worst case' scenarios. If, however, the experience is positive for the participants in the ways described above, it may prove to be equally positive for the researcher bringing the benefits that any collaborative and productive working relationship can produce.

Ethical Dilemmas

> *'The ethics framework that regulates Western research and guides the decision making of ethics committees is based on the concept of a universalized rational subject and an ethic of*

> *justice derived from Kantian moral theory'.* (Halse & Honey, 2005, p.2152)

Noddings (2003) argues that contemporary ethics are focussed upon universal concepts such as logic, justice, rights and other 'masculine' principles at the cost of 'female' moral reasoning which includes ideals of caring, relationships and responsibilities. Halse and Honey (ibid) described the relative ease with which they were able to satisfy the REC, but also the struggles they encountered with their own ethical dilemmas informed by their feminist principles. Yet prison research presents challenges to both the mainstream (or malestream) ethical paradigm as well as the feminist ethics of care (Jaggar, 1991). These dilemmas are considered from the perspectives of informed consent and confidentiality, principles required by RECs but are also fundamental to feminist values of developing relationships; and the feminist principle of representation (Preissle, 2007).

Informed consent and coercion

Informed consent is considered to be the central tenet of ethical research (DH, 2005) and, for non-feminist scholars, is key to the relationship between the researcher and the researched (Kimmel, 1988). It is defined by the Royal College of Nursing (2005) as '*an on-going agreement by a person to receive treatment, undergo procedures or participate in research, after risks, benefits and alternatives have been adequately explained to them'* (p.3). This definition, it seems, presents universal principles including the right to refuse or withdraw consent to participate, to fully understand the risks and benefits of participation and awareness of what will happen with the information gained from the research. These requirements are generally fulfilled through information sheets and written consent forms. However, coercion is a key consideration in prison based research. The prison environment is inherently coercive (Dubler, 1982) and coercion is institutionalised within prisons with the aim of maintaining discipline and order. This can be seen in adjudications[47] of sentenced prisoners refusing to work, and the progression of prisoners being dependent upon them conforming to their sentence plan[48]. Moser *et al.,* (2004) highlights that with such a marginalised population as those in prison, coercion can be very broadly defined to the extent of

> *"The fact that participation may enable the inmate [sic] to leave his or her cell more frequently and interact with people from outside the facility is a form of potential coercion"* (p.2).

Additionally, people in prison may become unaccustomed to being able to refuse to take part in activities with staff-prisoner relationships often being a directive *"instrument of power"* (Liebling, 2004). As a result they may be fearful of the consequences of refusing to participate, wanting to appear cooperative in the expectation of better treatment (Moser *et al.,* 2004). The pervasiveness of coercion is such in prison research that the National Commission for the Protection of Human Subjects of Biomedical and Behaviour Research concluded that informed consent could never be truly elicited in a prison environment (Byrne, 2005). Whilst Day, Tucker & Howells, (2004) suggested that coercion was not inherently unethical (citing having to pay taxes as an example), in relation to research, coercion is surely the antithesis of informed consent.

Coercion is also a form of the exploitation of people in research that feminist ethics has attempted to address. I tried as best as I could to address this through distancing myself from the prison service and stressing the independent nature of the research. **Previous to this however I had been employed by the prison service and had worked in the same prison for over five years as a Psychological Assistant, a Trainee Forensic Psychologist and latterly the Deputy Manager of Psychology. Inevitably a number of women who became involved in the research knew me already from working in the psychology department and in the case of two women I had written parole reports for/about them. Despite trying to develop collaborative working relationships in my previous roles in the prison such relationships were unavoidably based upon a power differential between me and the woman. I was involved in the delivery of offending behaviour work. Whilst women could seemingly 'choose' not to engage in these, such a choice would invariably negatively impact upon their dates for release from prison and, for those serving indeterminate sentences, their progress through the prison system. Those women that did engage the agenda of our work was very much dictated by me and my supervisor and inevitably focussed upon issues that many found difficult to discuss around their

offending behaviour. For the women I wrote parole reports for my opinions even contributed to decisions by the parole board as to whether they should be released from prison and what offending behaviour work they should complete next. Finally, and perhaps less obviously my position in these roles placed me in the position of authority and expert over the women who I worked with. The basis for the majority of psychological work undertaken assumes offending behaviour is a result of choice on the part of the offender and so focuses upon challenging the ways that offenders solve problems and make decisions. In these roles therefore, no matter how gently the process is conducted or how much time is spent developing rapport, I am positioned to have a greater insight in to the woman's offending behaviour that she has herself.

My role as researcher then required me to be, as far as possible, the antithesis of my role as 'psychologist'. Whilst there was a great deal of stress placed upon the fact that refusal to engage in the research would have no implications for the woman's sentence or status in the prison, suspicion as to whether this might be the case possibly still existed, especially during the early stages of the research. It would be impossible for me to conclude definitively that no woman chose to undertake the research in the hope that it might be beneficial for her in some way. Similarly I could not say for definite that all women were at ease in refusing to participate. Arguably, due to my gender and freedom of movement, regardless of how much I stressed I was 'independent' of the prison service I was more easily identifiable as a member of 'staff' than as a 'prisoner'. As such, elements of coercion could not, unfortunately, be ruled out. It is possible that a certain level of exploitation is unavoidable due to the inescapable inequalities between the researcher and the researched (Meyer, 1993; Patai, 1991) particularly in a prison environment. I do believe there was some mitigation against the power dynamics that may have arisen as a result of my previous job roles.

As discussed, ethical approval took nine months to achieve and during this time I was mostly absent from the prison. This provided a useful break in that a number of women who engaged in the research did not know me and those that did were aware of my leaving and returning. This I believe helped to accentuate

the difference in my two roles. This in addition to the stress of choice and time taken to develop working relationships, described throughout this chapter, I believe went some way to address the power imbalances.

Stacey (1991) insisted that feminists take responsibility for ethically imperfect research and whilst far from perfect I attempted to redress this power differential from the very first time I met with women to ask whether they would consider participating. I spent time, typically between 30 minutes to an hour, with every woman who I approached to discuss the aims of the research, the implications for her should she choose to take part and also stressing her choices in how, when and where she could contribute to the research. In accordance with REC guidelines all the women were asked to take time to think about participation, even when they were eager to take part, and left at least over night with information sheets (see appendices B and C). Also in accordance with the REC those who agreed to take part were asked to sign a consent form (see appendices D and E) to confirm that they were aware of the research process, had the opportunity to ask questions and understood their right to withdraw at any time. Arguably, this provided a difficult start to the development of a working collaborative relationship which aimed to embody the principles of trust and connection (Noddings, 2003). The act of 'signing up' for some women who's literacy made reading and writing difficult was off putting (often resulting in women just signing the forms once we had discussed the research for a second time). Having to sign also placed the onus upon the woman to withdraw from the research and would suggest that I was absolved from the responsibility of providing care throughout the process having explained what the research entailed. I attempted to redress this balance through ensuring scheduled meetings were mutually convenient, contrasting with the common experience for women in prison of being told where to be and when. That the appointment was still convenient and that the woman was happy to continue to participate was also established at the beginning of each meeting. This approach was particularly important given the nature of action research, often described as a journey (Hope, 1998) in which initial informed consent may not even be possible given it is not clear in which direction the journey will take. Some women were therefore happy to complete questionnaires but chose not to take part in

interviews; others became involved just in focus and working groups and vice versa.

The numbers of women who agreed to participate suggested that these approaches were largely successful but it was apparent that, for some, saying no was difficult. Two women agreed to take part yet repeatedly missed the appointments we made. When I followed up on these to check whether the woman was OK, whether she had changed her mind or if she had simply forgotten, both women apologised, gave reasons and re-scheduled appointments, none of which were kept. I was left with the dilemma of how long to continue to follow up with these women and reschedule without coercing them into participating. In both cases, after three missed meetings, I decided not to follow up believing that, for whatever reason, the women perhaps felt unable to say that they did not want to participate in the research. Given that no aspects of the project involved observation, an aspect that can be particularly difficult to opt out of (Williamson & Prosser, 2002); these women were able to effectively avoid the research process without having to explicitly say no.

The issue of payment was also an ethical dilemma that was considered. There are a number of guidelines, especially for those involving service users, that indicate payment should be offered to people who give their time to participate in research (Faulkner, 2004, INVOLVE, 2006). Some feminist researchers consider payment as compensation for the equal contribution participants are making to the co-production of knowledge (Landrine, Klonoff & Brown-Collins, 1995). This practice is not supported by the Prison Service however (Prison Service Instruction 41/2010) due to concern about the use of the money for illicit purposes (Seddon, 2005). The use of payment may also introduce a further element of coercion given that although most people in prison have the opportunity to earn wages through work, these are small sums of money that can be used for buying additional 'canteen'[49]. Compensating women for their time, therefore, could make it more difficult for women to refuse or withdraw from the research. After some reflection on the issue, paying women for their time was rejected for three reasons. Firstly, the financial incentive would be likely to add an element of coercion into taking part. Secondly, payment would

be unfair for those who were unable to take part due to being excluded by the prison authorities or due to not meeting the criteria for self-harm that was agreed for this research. Finally, there was an issue of resources and the unfortunate bottom line of money. Offering to pay women would require a matching offer to prison staff to ensure equity (in the research at least) across both groups of people. Paradis (2000) gave an example of participants receiving the same wage as researchers in order to ensure equality. Regardless of the likely objections that this would raise with the prison, ultimately this could not be sustained by the project budget. Payment was never requested by any of the women or member of staff who took part, and it did not appear to be a barrier to engaging with the project. Towards the end of the project, bonuses were added to wages for those women who had given significant amounts of time over the three years to the development and delivery of some of the project's initiatives. This was done as a small way of saying thank you for the effort, bravery and commitment these women had shown to the process without which it would not have been possible. Due to the practicalities of releasing staff from their duties, the amount of time they were able to give did not nearly amount to that given by women and as such no bonuses were given to staff.

Confidentiality and relationship building

DH guidance (ibid) requires particular attention to be paid to the security and confidentiality of information gathered through the research process. The freedom of participants to be able to disclose in confidence whatever they felt relevant is surely central to Gatenby and Humphries (2000) assertion that the development of relationships and friendships is integral in the feminist participatory action research process. Prison researchers, however, are unable to offer total confidentiality to those who participate and are required to report information which indicates a risk to the participant themselves, others or the general security of the prison. Bond (1990) promoted the discussion of the research relationship as crucial in empowering research and as such I reminded the women each time we met of the caveat that should she disclose an actual incident or an intention to self-harm or commit suicide I would have been required to 'open' an ACCT. Similarly she was reminded that any disclosure of

a risk to other women or staff in the prison, risk to any children, or possible breaches of prison security would be reported following the appropriate procedures. Whilst this reminder was given to ensure women understood what would and what would not be held in confidence, the potential implications for the researcher-researched relationship were clear, the result being a hierarchy that allows the prison to exploit research information from participants for intelligence purposes. This presented the dilemma of attempting to provide women with the opportunity to openly discuss anything they felt was relevant, whilst making clear the consequences of discussing matters involving 'risk'. These consequences could include the imposition of care in the form of the ACCT process (where risk is to self) or mandatory drug testing or searching of property (where there is risk to the prison security or others). This is not unique to the prison environment and Williamson and Prosser (2002) acknowledge that confidentiality cannot be guaranteed when engaging in close working relationships with participants in small organisational environments.

In relation to feminist ethics, Noddings' (2003) ethics of care rejects the absolutes of concepts such as justice; however prison rules and the requirement to conform to these rules are absolute in order to gain and maintain access for research. This is no different to the role prison staff are required to fulfil in developing rapport for the purpose of relational security (Fitzgerald & Sim, 1982) and again blurs the boundary between an independent researcher and prison staff. Arguably, this blurring impacts upon the ability to develop relationships with participants in prison to the extent that feminist ethics asserts is required in order for research to be truly liberating. However, although women in prison are inevitably oppressed, for the majority this is a result of committing offences, and a smaller number still pose a threat to others, resulting in their liberty being curtailed. Leaving aside arguments as to whether prison is a suitable sanction for women offenders and the implications of liberation of offenders for victims of crime, the degree to which liberation through research can be achieved may still be restricted due to the nature of the punishment. This overarching limitation on emancipation for women in prison means that the impact of not being able to secure truly equal and trusting relationships has less impact than were this not achieved in a community

setting. Ultimately it is impossible to achieve the same levels of empowerment in prisons as it is in the community or other settings. It is finally worth noting that despite the requirements of the prison throughout the research process, I was not required to open an ACCT management plan nor submit any security information reports. Whether this is a result of women not discussing issues that would be required to be reported or whether genuinely no such issues occurred is not known.

Representation

In addition to the research process potentially causing distress Preissle (2007) asserted that the ethics of representation may also harm the participants or those belonging to similar groups. Paradis (2000) highlighted how perpetuating negative stereotypes will cause harm as will participants being unhappy with their portrayal or the dissemination of the research. Similarly Jaggar (1991) cautioned against identifying *"women's issues"* (in Card (ed.), p.85) in case biological determinism is implied or gendered stereotypes reinforced. Self-harm has been represented in the research as a women's issue (e.g. Gratz *et al.,* 2002) with epidemiology studies suggesting that women more commonly self-harm than men (e.g. Hawton et al, 2000). The survivor literature, however, frames the prevalence of women's self-harm in the context of gender and power relations. Where Pembroke (1994) criticises society for the socialisation of women in a way that encourages self-harm, Harrison (1995 in Cresswell, 2006) describes women's bodies as a battlefield in western societies. These first hand experiences therefore move self-harm away from being a 'women's issue' and demonstrate that it is an issue for society as a whole. It is therefore important to acknowledge that self-harm is not a 'women's issue' only and that attention needs to be given to the impact of the gender and power relations that exist. Gender blindness has historically done little to progress care for those who self-harm and particularly women in custody. As Corston (2007) highlighted, equity in care does not necessarily result from providing women and men with the same systems of care. This gender blindness is demonstrated through the lack of gender sensitive guidance for the care of self-harm in PSO2700. Working with women in prison who self-harm is therefore an

attempt to address this deficit in care, but does not intend to locate self-harm as a women's issue only.

Whether self-harm represents a priority that women in prison would choose to address is unclear. This project was funded by the local offender health commissioners having identified that the rates of self-harm, and the subsequent resources for care, were problematic within the prison. This resulted in women not becoming involved in the research agenda until ethical clearance was received and access to the prison agreed. Ideally, in keeping with the principles of equality and ownership of the research process, women in prison and staff would have been involved in the development of the research questions and agenda. Whilst REC ethical approval is no longer needed to engage service users in the development of research agendas, whether access to the prison would have been granted for something as speculative as the development of a research question is unclear. Despite the research question not being agreed by all those involved this did not prevent, in my opinion, the process being informed by feminism or make the purpose less valid. Given the opportunity, women in prison may have identified a different research topic other than self-harm and a 'democratically' chosen topic may have been one that was more immediately relevant to larger proportions of the prison population. This, however, does not negate the fact that self-harm in women's prisons is disproportionate to that reported in men's. Throughout my experience of working in the prison, lots of women I have spoken with have talked about foregoing their own needs in an attempt to care or provide for others, whether children, partners or friends. This, I have been told, is often a contributory factor in mental health problems and stress, substance misuse and offending. These women's experience of care accords with the feminine caring ethic described by Jaggar (1991) in which women often subsume their own needs in the care of others. It may be, therefore, that by choosing a research agenda from an apparent, observable issue within the prison, this provided the women with an opportunity to contribute to something that was almost entirely focussed upon themselves rather than the needs of others. Once this agenda was established those who choose to become involved could then influence the direction and further formation of the agenda. It should also not be overlooked

that, although not in prison, women were integral in the development, commissioning and supervision of the research.

A final consideration of representation is the language used throughout the research. Labels are unavoidable for the pragmatics of writing and describing research and will never fully represent the diversity of those who participate. Throughout, however, I have tried to use the neutral labels of women and staff. Whilst this is a clumsy dichotomy as some members of staff are also women, these labels are used to reflect the general 'groups' that exist within the prison without limiting these people to aspects of their behaviour such as 'offenders', 'self-harmers', 'officers', etc. or their status such as 'prisoners' or 'governors'. Thus, I have tried to represent those who participated in such a way as to make clear their perspective when involved, either as a service user (a woman in prison) or a service provider (member of staff).

The language used to represent self-harm itself also requires consideration. Self-harm has previously been misrepresented and the language used to describe the behaviour has reflected the moral judgements of those who use terms such as deliberate self-harm (Cresswell & Karimova, 2010). This was a significant factor in the development of the research tools and advice was received from service users and service providers through the National Self-Harm Expert Reference Group. Given the nature of the research, I was keen to ensure that the research tools subtly challenged any negative culture or values about self-harm rather than reflect them. This is often reflected in the label 'self-harmers' commonly used by both women and staff to primarily identify a person based upon this single aspect of their behaviour. Women commonly identified themselves as self-harmers too, requiring me to subtly shift this in conversation to reflect them as being someone who self-harms thus moving the label from a primary identity to a smaller aspect of the overall person. This consideration of language led to me asking those women who self-harm, at our first meeting, how she referred to the behaviour and what language she would want to use. All women used the term self-harm with just one exception, a woman who felt that self-harm did not adequately reflect the injury she caused herself and instead preferred the term self-mutilation.

The application of feminist ethics to prison based research is clearly a challenge. Whether the compromises that were made in the light of these challenges resulted in research that was not essentially feminist, I shall consider towards the end of this chapter. Before this, however, another significant aspect that requires consideration relates to my own values and my approach to the research process as a man attempting to do feminist research with women. I will attempt to explore this through a number of autoethnographical accounts.

Issues of Gender

Whether a man can be a 'feminist' is a well contested issue. Card (1991) indicated that, in her opinion, sexual politics and commitments to feminism are sufficiently different between men and women as to warrant different identities. Thus Card indicated that the term 'feminist' could only be applicable to women, and men should therefore be considered 'pro-feminist'[50]. Jaggar (1991) however highlighted that just as not all women are 'feminists', some men can be. For Jaggar and others (e.g. Ruddick, 1989) a 'feminist' is, therefore, not biologically determined but a product of characteristics, ethics and moral sensibilities (such as those described above) that are as accessible to and demonstrable by men as they are by women.

What labels should or could be attached to me as the primary investigator (PI), I do not see as relevant to this thesis and the arguments do not need to be revisited here. I am, however, concerned about the impact that my work may have, whether intentionally or inadvertently, upon those people I have worked with over the duration of the project, and that it adheres to feminist ethical principles. By being a man, however, have I perpetuated a male hegemony against the women that became involved in the research, especially given my position of power in comparison to women in prison? Imbalances in power between me and the women who became involved would invariably result in distortions or suppression of women's accounts. However were these distortions likely to be a result of intimidation, fear, anger, or shame (Rollins, *et al.,* 2009). Whilst it is hoped that through triangulation of methods the fullest possible accounts of self-harm in the prison were obtained the impact upon the

women giving their accounts was of greater concern than the 'validity' of the information.

Safeguards in order to help women manage any negative consequences were built into each stage of the research process. However in the prison the imbalances of power that may cause such consequences were unavoidable. Fear or intimidation due to such imbalances may be due to the fact that I am not imprisoned and was free to leave (identifying me closer to staff than women in prison) in which case this has little to do with my gender. Some disparities in power were accepted, such as not offering total confidentiality, in order to ensure that the research could take place and continue. My acceptance of these regulations, I feel, reflects my own relationship with the prison service over the last eight years and my subsequent values. Whilst I could have refused to accept such limitations on confidentiality and left the research to someone else to do, I can appreciate the regulations intentions even if I do not always agree with the results of them. Having started in the prison service in 2004 I, in hindsight, was overwhelmed by the environment and the preparation for the worst case scenarios that were as much a feature of security protocol as they were of ethics. This resulted in a strict adherence to the rules, often to the cost of developing useful relationships with the women in prison I worked with, and I am in no doubt this was to the detriment of my work with the women in prison.

Over the last eight years however, and particularly in the last three years of this research I have been able to relax more and allow myself to critically think about my relationships with women in prison and the role of women's prisons more generally. Thus, the values with which I accepted prison regulations are similar to those which enable me to work in a prison altogether. I accept that the regulations are far from perfect, sometimes being inappropriate and sometimes altogether damaging. I have also learnt that the prison service reflects the patriarchy of the wider criminal justice system; however I believe that only by working within the system can changes be made for the better and that such improvement will be most effectively driven by those with first-hand experience of the systems deficits. Thus I was willing to compromise, to an

extent, the feminist ethic of equal power relations with the aim of achieving positive change towards empowerment. Of course, it is much easier to make such compromises when you are the one who retains the power. In many ways though, the research processes described above and in chapter 7 were more empowering than much of the research that takes place in prisons in which questionnaires are often put under cell doors during times when women are confined to their rooms. This is reflected by the commitments to the project that the women gave.

Levinson (1998) asserted that gender privilege should be guarded against in any feminist work by a male through *"continuous reflexivity"* (p.359). Whilst this may be true, I suggest that in feminist prison research the privilege of freedom possibly outweighs the freedom of gender. I believe that the ethics of care in prison research is not predominately an issue of me being a man but of not being a prisoner. Options for women to join the research team, conduct interviews, distribute questionnaires and analyse results could have been further explored and whilst this would have, to some extent, addressed the power imbalance, concerns about anonymity and participant safety would have increased. From my previous experience in the prison I was perhaps better positioned to address these inevitable differences in power. I had the knowledge of both the prison systems and the resources that were available to the women. As such, I was able to offer advice about how to put in complaints about a range of issues from waiting too long to see a doctor to issues with personal property. I was able to suggest how women could confidentially go about reporting bullying behaviour on the wing to the appropriate members of staff, how to get information about sentence plans and in one case suggested a woman take legal advice about her ability to be seen to be actively reducing her risk of re-offending. On several occasions, having discussed options with particular women, I also made referrals to appropriate services and used my working relationships with members of staff to expedite them (where I genuinely felt there was a need for expediency). I was able to empathise with women when they discussed members of staff who they thought were particularly good or bad at their jobs. I was also able to offer perspectives from the experience of working within the prison regulations and the frustrations this can cause.

Through being able to do these things I feel I was able to demonstrate that whilst I couldn't be 100% 'on women's side' I was neither 100% 'on the side of the prison', instead I was trying to balance the needs of both for productive change. I was also trying to balance the shifting social locations of being an insider and and outsider (Naples, 1996). Using my insider knowledge I was able to make referrals or tentatively offer advice where it was sought. Of course this does not make me an 'insider' by virtue of the fact that I am neither a woman nor a prisoner. However I was not perhaps an 'outsider' to the extent that prison service employees are. This resulted in relationships that could never be classed as friendships or even based on unconditional trust but were pragmatically formed in the work towards a joint goal and in which the boundaries were clearly delineated.

Whilst I consider my freedom to be the greater obstacle in equal relationships with the women who I have worked with, it would be wrong to totally discount or ignore the issue of gender and my masculinity. Seidler (1991) asserts that men are socialised to be estranged from their emotions and I cannot discount this for myself. Does this however mean that I am unable to connect and empathise with women in prison in the way that feminist research demands? Maybe, there are times when I have felt hypocritical for suggesting to women that talking about how they feel may be positive for them when I myself find it difficult to discuss my emotions. My divorce from my emotions is likely to be a result of my indoctrination to masculinity as well as my experience of working in prisons. Prison is a hyper-masculine environment in which both staff and prisoners are encouraged to disconnect from their emotions in order to either fulfil their job role or survive the prison experience. The extent to which this is true will be explored through the narratives of women and staff in relation to self-harm later in the thesis. Due to the masculine environment and the limited means available to staff and women with which to address their distress I would suggest that an emotional connection is not necessary in order to effect change, at least not initially. Women's experiences need to be validated, heard and respected however a sharing of grief or anger or any other strong negative emotion may not be productive and more importantly may not be safe to do so.

Gender undoubtedly impacted upon my research practices in other ways and has likely resulted in methods of working that may differ had a woman conducted the enquiry. Most notably was the use of spaces in the prison in which to interview and talk to women and my personal preference not to meet women in their cells. Cells are simultaneously private and public spaces and I was keen to not impose myself upon a private space for fear of appearing threatening but also to ensure appropriateness (there are also a myriad of security considerations around hostage taking etc.). Would a female researcher have been at such pains to avoid meeting in a woman's cell and would the information shared by women have been different in the relative security of their own space? Very possibly, yet I return again to the consideration that even the most empathic feminist scholars are unlikely to be able to inhabit the same emotional space as women in prison, unless they too have shared experiences regardless of the physical space in which the discussions take place.

A final consideration around gender needs to be the consideration of patriarchy. Modleski (1991) argues that when male hegemony faces crisis through the challenges of feminism it seeks to incorporate female power in to its own structures of patriarchy through a process of "male feminization" (Newfield, 1989). Have I been a part of this process? In many ways it could be argued that I have. One example of this was my position as a go between, between the women with whom I worked and the prison's Senior Management Team (SMT)[51] when proposing initiatives identified through the research process. This generally resulted in me presenting the findings of the research and making suggestions for development that had been discussed and agreed with working groups of women. Sometimes these suggestions were rejected by the SMT. Others, such as suggestions to purchase Rubik's cubes to occupy women when confined to their cells, I rejected (through discussion) without taking it to the management board as I knew similar requests had been denied on security grounds. In this instance I realised I was reflecting the standpoint of the dominant group (prison managers) over those of the women. At other times however this role was reversed and suggestions for development that were important to the women but resisted by the prison authorities (both locally and nationally) were doggedly pursued. One example included a proposal to allow

women means to dress their own wounds following self-injury. In this instance my position as 'go between' resulted in me representing both the dominant culture of the prison and clinical authorities but also the women in prison as well as my own position in ensuring the sustainability of the research to produce some form of positive lasting change. Rather than weakening my position (or the research) through misrepresentation of those I worked with, arguably this straddling of the various positions has provided a 'strong objectivity' that feminist research requires (Harding, 1991).

Levinson (1998) believed that every time he recontextualised women's narratives he was being symbolically violent towards them. In relation to Standpoint Theory (Harding,1991, 2009) this would particularly be the case given my very different positions of gender, and typically economic status and social location (Dugger, 1988) compared to many of the women in prison. My representation of women's contributions to the research, therefore, could never truly reflect their reality and this may be the reason why my negotiations were not always successful. Again, I would argue that pragmatism is, in some way, mitigation for this. Having women present their suggestions for service development would have required negotiation with the prison management in addition to that described above. Whilst this may have been possible it would have been more time consuming. Given that a number of prison Governors reacted with suspicion to the proposal that women train staff around care for self-harm, I suspect having women presenting suggestions for service development may have been deemed to upset the balance of power too much. Women in prison, too, were hesitant about training staff and only one woman volunteered to deliver the package. Whether women would have felt comfortable entering into negotiation with senior managers may have been questionable and a lot to ask given their relative positions within the prison hierarchy. As Chataway (2001) observed, not all those who are oppressed and participate in research will necessarily want to be publicly involved but may instead choose to engage privately. Had women, given the choice, chosen to meet with prison senior managers this could equally be criticised for creating a false, bourgeois version of democracy (Fraser, 1990). Fraser argues that in stratified societies characterised by dominant and subordinate relations, debate

and negotiation is not possible. In some respects negotiation was beyond my reach, I was unable to secure compromise on issues such as staff support or changes in the ACCT procedure. Whilst disempowered by the prison managers through my position as an external researcher, I was still more protected than had a woman in prison also entered into negotiation. Ethically it may be questionable to allow someone to enter such a stressful situation if, as Fraser asserts, success or even true negotiation is not possible. On reflection however, this is certainly an aspect of the project that I would change if I were to do it again by exploring options for dialogue between the women and the prison senior management.

Other discrepancies as a result of gender and position required balance and judgement in particular aspects of the ethics of care that are built upon shared experiences. I am rarely able to share personal experiences that mirror women in prison's own in order to offer empathy or draw advice from as Oakley (1981) did to develop rapport and friendships with the women she interviewed[52]. I am aware consideration was given when recruiting for the PI position as to whether a woman would be more appropriate. Would a female PI be able to draw upon more similar life experiences, perhaps from the result of being oppressed by patriarchy? Very possibly. From a white middleclass background I am fortunate enough to be in a privileged position in relation to the vast majority of women in prison. Yet Piacentini (2007) found there was very little common ground between her and women in a Russian prison and suggested that being female was occasionally a hindrance to the development of relationships. It may be that gender privileges me in a way that makes it easier to develop relationships with women in prison. This seems counter intuitive given the undoubtedly large proportion of the abuses women in prison have experienced are likely to have been perpetrated by men. However, given that women in prison live in a hostile, female dominated environment and whilst I am in a position of relative power (but not necessarily authority compared with other male staff), it may be that gender, in this instance, worked in my favour to some extent.

Is Ethically Sound Emancipatory Research Possible in Prison?

In their consideration of moral dilemmas in research ethics Halse and Honey (2005) found that

> *"Our experiences suggest that research ethics policy and processes provide guidance but not definitive solutions to questions about ethical research and moral behaviour"* (p.2157)

This is equally true of feminist ethical values and is particularly the case in prison based research in which the environment presents a unique set of challenges. No research will be ethically perfect yet some will be better than others. Due to the constraints on confidentiality, the coercive environment and the social position of people in prison, action research projects in custodial environments are perhaps more likely to be imperfect. This, however, does not mean action research endeavours should not be undertaken. As discussed, the very process of participation can be mutually beneficial for those involved before change is even produced. Solid working relationships can be formed, even if these do not meet the high bar that Oakley set in her work, especially when the principles of transparency and honesty are applied. Participants can also exercise choice if given the proper options and tools with which to do so. A lack of involvement in the research agenda, in this case at least, did not appear to have lessened women's personal investment in the research. With regards to my gender, this would inevitably have had an impact in both positive and negative ways. However I believe that the relative position of power that all external researchers will find themselves in is possibly a greater obstacle to emancipatory research than issues of gender. Does this mean that different criteria or values should be applied to emancipatory research or feminist ethics should be re-orientated for the prison environment? Possibly not. Emancipatory research in prisons can still aspire to such principles; however the likelihood of them ever being fully achieved is diminished by the unequal and hierarchical prison structure. This inevitably results in compromises in the process (such as adherence to prison regulations), in order to make gains in the outcomes, for example women delivering training to staff. Whilst the principles of feminist research may therefore be aspired to, the endemic challenges the environment presents need to be considered in the critical review of such research.

Levinson (1998), in his consideration of a man doing feminist ethnography raised two points. Firstly whether research not designed to immediately benefit women who participated should be conducted at all. I hope this research, as will become more apparent as the thesis progresses, was immediately relevant to the women involved. Secondly Levinson suggested that he, as a man, could not judge whether his contribution to feminism was important. I would argue that those who it should be most important to are those who gave their time to be involved. In Chapter 9 I have asked two women to give reflections upon their experience of being involved in the project which I believe may answer this question.

Chapter 7

Methodology

As highlighted in chapter 2, research into self-harm is most usually empirically based examining the treatment effects of various psycho-social interventions. There also exists a body of literature of qualitative enquiry, a small amount of which is feminist, exploring either the utility of self-harm for the individual or the impact and experience of treatment. Few studies combine these methods and fewer still use the research process for constructive change at grass root level.

This chapter describes the use of a mixed methodology with the aim of providing insight into the use of self-harm by women in prison and the care given for self-harm by prison staff. This is then utilised in constructive action for change. The overall approach of the methodology is one of emancipation based upon the principles of feminist research and praxis for change. I start with the rationale for both the mixed methodology and the overarching emancipatory approach with which it was carried out.

The Rationale for a Mixed Methodology

Jick (1979) described a *"tradition"* (p.602) in social sciences of using multiple methods in research, arguing that such an approach is desirable given the strengths and limitations of each individual method design. The arguments for and against mixed methodologies (Onwuegbuzie & Leech, 2005; Olsen, 2004) and the advantages and disadvantages of singular methods are well rehearsed and so do not need to be repeated here. Carter and New (2003), however, described mixed methodologies as useful in researching aspects of life that have both personal/private and public aspects. Self-harm can, for some, be intensely private and thus arguably best understood from the perspective of the individual through qualitative enquiry. For others (or for the same people at different times), self-harm is socially mediated (Tantam & Huband, 2009) or an attempt to influence social interactions. As such, it is entirely relevant that the discourse around self-harm between staff and prisoners be examined through the inclusion of staff in the research process. Self-harm as a behaviour, however, also exists within a context. Sayer (1992) suggested that single

pieces of research should choose either in-depth qualitative or extensive quantitative enquiry. I would argue that within such a small environment as a prison, a happy compromise can be reached between the two. Quantitative information through the extraction of existing records around the rates and methods of self-harm as well as quantified survey information from women and staff in the prison can therefore be used to contextualise self-harm within the prison. I would, therefore, argue that mixed methodologies are the most appropriate techniques for examining a multifaceted phenomenon such as self-harm. It is also in keeping with social scientific theories and methods which stress the "complexity" of the social world (e.g. Byrne, 1998).

Denzin (1970) described the process of combining methods in the study of the same phenomenon as triangulation. This is used as a tool in order to assimilate and examine the different sources and types of information that mixed methods produce. Two forms of triangulation were employed in this research. Firstly, methodological triangulation such as that advocated by Denzin (1970) aimed to enhance the 'validity' of the results through seeking similarities or differences in the information obtained by different methods (Bouchard, 1976). Validity in this context therefore is the opportunity to understand meaning and individual reality (Harding, 1987a), differing from the positivistic definition of validity which relates to replication of findings. As Olsen (2004) highlighted, however, methodological triangulation is *"not merely aimed at validation but at deepening and widening one's understanding"* (p.1) - thus the author sought to learn from the 'lived experiences' of those involved in the research process with the aim of acquiring a broader and more detailed understanding of self-harm in the prison environment.

Secondly, a process of data triangulation was used (Guion, Diehl & McDonald, 2011) through the collection of different sources of information relating to self-harm. This was achieved by asking the same questions of both prison staff and women in prison, again with the aim of increasing validity and to garner more insight in to the experience of self-harm in prison from a number of perspectives. Olsen (2004) describes such techniques as producing a "*dialectic of learning"* (p.4) as a result of comparing different perspectives. In social

theory, a “dialectic” refers to an oscillation between opposite positions or forces which sometimes results in their unity (see Bhaskar, 2008) so that, in the context of the prison environment, the “dialectic of learning” refers to the way in which this research “oscillates” between, on the one hand, the perspectives of women who self-harm and, on the other hand, the prison staff. Olsen highlighted that differences between official and unofficial accounts of events or dynamics that underlie interview and survey information can be dialectically different. A dialectic between the experiences of prison staff and women in prison may be expected to exist, especially given the dualism of the prison’s approach to managing self-harm (i.e. prevention) and the need to self-harm reported by some women. It may also account for the reported attitudes of some prison staff (Kenning *et al.,* 2010*)* and the subsequent impact this may have upon treatment given, as discussed in previous chapters. The triangulation of both method and data allows for the exploration of such dialectics.

Triangulation has been used in prison research previously, most notably in the UK by Liebling and Arnold (2004) in their study of the moral performance of prisons. This resulted in the development of the Measuring Quality of Prison Life (MQPL) tool which itself employs methodological and data triangulation. These techniques are also employed in prison inspections by Her Majesty’s Inspector of Prisons[53] (HMIP) which gathers evidence from staff and prisoners from five key sources of evidence: observation; prisoner surveys; discussions with prisoners; discussions with staff and relevant third parties; and documentation. This is carried out in an attempt to capture a more holistic understanding of the performance of the prison. A holistic perspective is particularly relevant given Liebling and Arnold’s observation that *“the search for ‘what matters’ in prison has been overshadowed by a narrower focus on what can be easily measured”* (2004, p.132). Liebling and Arnold were critical of the focus upon outcome measures, such as performance indicators regarding rates of assault or positive drug tests, which resulted in overlooking significant aspects of culture or individual experience of services within prisons. With this in mind this study aimed to use mixed methods, not in order to find an objective ‘truth’ or to solely focus upon outcomes, but to better understand self-harm in

the prison in question with the purpose of translating the knowledge generated into action for change.

Finally, on a practical level, the use of mixed methods allowed greater flexibility and choice in the way women and staff could engage with the research process. Furthermore the use of a variety of tools including questionnaires, interviews, focus groups, creative writing or art can ensure that the needs of the individual are better met in order to participate. This is particularly relevant given the learning needs of many people in prison (Stewart, 2008), and the principles of emancipatory research discussed below.

Triangulated mixed methods are therefore the most appropriate form of investigating self-harm in a prison context for four reasons:

1. Self-harm is both a private and public act requiring different methods of research.

2. Mixed methods not only increase 'validity' but also result in an increased depth of understanding.

3. The impact of imprisonment, and the effect this has upon relationships and care for self-harm can only be known through the inclusion of different sources of information (i.e. prison staff and women in prison). This may uncover dialectical differences in the viewpoints gathered.

4. Mixed methods offer greater flexibility and choice in the way people can engage with the research process.

The Rationale for a Feminist Participatory Action Research Approach

The theoretical framework is outlined in chapter 3 and, whilst this does not need repeating at length, it is worth re-iterating and rationalising the approach taken in this thesis. This approach is that of feminist action research involving service users and staff.

Feminist approaches have given a voice to the unique experiences of those women who participated in the research process with the aim of emancipation. The subsequent rejection of the quantitative methods by some feminist researchers has been on the grounds that empiricism had been used as a tool of power by men against women, to the extent of equating the process of research to metaphorical rape (Reinharz, 1983) or highlighting failures to address the social problems it describes (Jayaratne & Stewart, 1991). The total rejection of quantitative methods by some, however, has been criticised as being misguided and a failure to distinguish between statistics and empiricism (Olsen, 2004). Others consider such a stance as being unhelpful in terms of the feminist objective of achieving *"an emancipatory social science* (which) *requires a range of methods within which 'quantitative' methods would have an accepted and respected place"* (Oakley, 1998, p.723). The use of mixed methods therefore is wholly compatible with feminist research. This is even truer when considering Reinharz's (1992) description of feminism as a perspective rather than a specific method suggesting that feminist research is not characterised by methodology but by the principles with which they are applied. These principles are described in chapter 3 but can be summarised as:

- **Non-hierarchical –** The relationship between the 'researcher' and the 'researched' does not reflect the traditional power relationship between expert and subject but is a collaborative approach to understanding the participants experiences.

- **Accepting -** Positivism is rejected and rather than looking for knowable facts the research is interested in the individual and her 'lived experience'.

- **Emancipatory –** It should follow from the previous two points that the process of involvement in research should be liberating for the individual and that the knowledge generated be used for change of social problems or inequalities.

These principles are not to ignore the political aims of feminism, but to expand upon what Oakley (1998) succinctly described as the moral obligation to treat others as you would wish to be treated. Arguably, such an approach is vital when engaging women whose self-harm maybe linked with stigma, possibly compounded by their status as a prisoner (Allen, 1987), mediated through social rejection or an attempt to control threats to self-identity (Balsam *et al.,* 2005). For similar reasons, a feminist approach can be used to justify the inclusion of prison staff (regardless of gender) as well as women in prison. Liebling (2001) described an *"intellectual hegemony"* (p.476) of research focussing upon prisoners to the detriment of prison staff. Her argument that sympathy should not always solely be reserved for the subordinate prisoners but that managers and governors can also be in some way subordinate and thus make them equally deserving of an approach informed by feminist principles. Similarly, the gender neutrality of many prison service orders and instructions is arguably an example of hegemonic masculinity (see Connell, 1987, 2005) in which the services aimed at meeting the needs of women in prison are forced to shape themselves towards the male majority. Staff are required to try to make these regulations fit as a part of their job role and therefore need to be included in an acknowledgement that they are not only instruments of power but also influenced by relationships of power and control. The inclusion of male members of staff may not always be expected in feminist research, however, excluding men would be to ignore a substantial part of the workforce who care for and interact with women in prison and for whom an understanding of gender may be significant. In this way, Connell's theory of 'hegemonic masculinity' (e.g. Connell and Messerschmidt, 2005), in which the focus is not only upon the exercise of patriarchal power over women but also upon power differentials between men, may be seen as a useful adjunct to a feminist approach.

Another ambition of this research was to affect change through an action research approach. The goal of producing change is particularly relevant given previous criticisms that knowledge generated from prison research is seldom of benefit to prisoners or prison staff (Crighton, 2002) and the review recommendations highlighting the need for gender sensitive approaches to the

management of self-harm (e.g. Corston, 2007). Feminist research lends itself to effecting change as it is fundamentally linked to the notion of feminist praxis (Lather, 1991), and seen as a natural process from the emancipatory approach (although, as already argued, this is not always realised). Watts and Jones (2002) described four characteristics of action research: i) a focus on problem solving; ii) promoting partnership and collaboration; iii) creating change in practice; and iv) developing theory. Watts and Jones' characteristics are just that, '*characteristics'*, defined as *"indicat[ing] the essential quality or nature of persons or things"* (Oxford English Dictionary (OED), 2011). This is distinct from the *'principles'* of feminism which represent *"moral codes or obligations"* (OED, 2011). Action research per se, however, is gender neutral and whilst it shares the goals of action for change with feminism, it does not intrinsically aim to emancipate women or explore issues of gender and power. Participatory Action Research (PAR) is perhaps more closely linked with feminism than action research.

Reason (1994) defined the essence of PAR as being liberationist, grounded in the individual and committed to collaboration. However PAR has been criticised by feminists for continuing to marginalise women (Maguire, 1987) and for being ahistorical and apolitical in its approach (Lather, 1991). Whilst the characteristics of action research and PAR are highly compatible with feminism they could feasibly involve all male groups or deliver change in a process without giving consideration to oppression or power dynamics (Cook & Farrow, 1990). Action research therefore brings a specific focus to problem solving and practice whilst the application of feminist principles attunes it to power imbalances and considerations of gender.

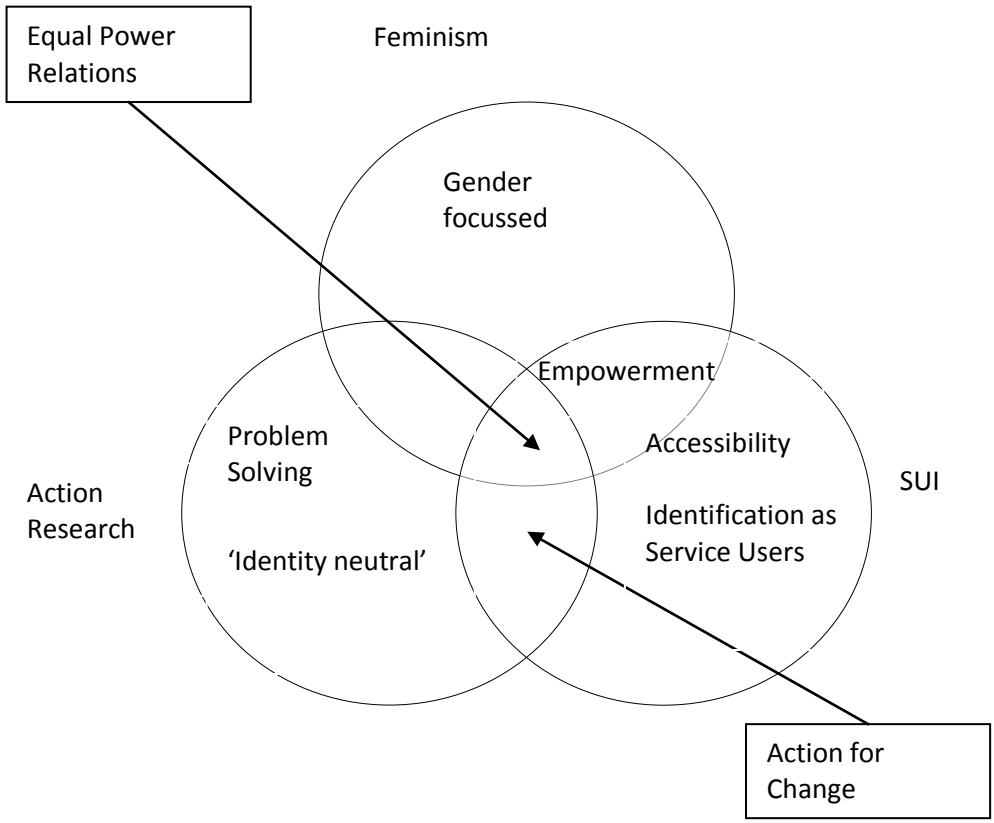
The final approach incorporated into this research is that of service user involvement (SUI). This is particularly relevant given the importance of SUI and survivor activism in the field of mental health services. Where feminism broadly addresses all areas where women are constructed as 'other' (Fine, 1994) and action research commonly focuses upon marginalised communities, one specialism of SUI is arguably the area of mental health. Utilising the experiential expertise of 'service users' in the process of change is clearly

desirable (Beresford, 2000). This can result not only in services being better equipped to meet the needs of its users but also increased service uptake due to greater ownership (Foster et al., 2005). Furthermore, in the case of women in prison it may also result in secondary gains such as increased self-esteem in those who may feel stigmatised and/or socially excluded (Blakemore, 2003). Guidelines by the Service User Research Group England (SURGE[54], 2005) again describe *principles* [emphasis added] for the involvement of service users in research. This similarity is unsurprising given that Faulkner describes SUI as evolving *"in the wake of…feminist research"* (In Wallcraft, Schrank & Amering (2009) p.15). The principles include the need for respect and equality in the relationship between researchers and the researched, clarity, transparency and flexibility. Faulkner added to this list a commitment to change, empowerment and application of theory.

Perhaps the key features that distinguish the principles of SUI from those of feminism and the characteristics of action research is the attention given to accessibility. Accessibility relates to the considerations and practicalities of working with people from diverse backgrounds and with diverse experiences and how these can be accommodated to ensure equal opportunity for involvement. Faulkner (2009) highlighted that this should go beyond the 'reasonable adjustments' of the Disability Discrimination Act (1995) and the Equalities Act (2010) to include what people may be familiar or comfortable with (Faulkner gives the example of an office environment but this could also be working collaboratively with a man or being openly critical of the prison service). Whilst these may be implicit in the equal relationships advocated by feminism and action research, the SUI approach makes it explicit. Such explicit consideration is important in the involvement of women in prison given that many will have needs in relation to mental health and substance misuse (Stewart, 2008) as well as considerations of anonymity and confidentiality outlined in Chapter 6. Faulkner sums up as *"The most important element is probably an attitude of flexibility, an openness to difference and an appreciation of people as individuals with something of value to contribute"* (p.15).

This research therefore utilised aspects of all three of the approaches outlined above. As described there are of course a number of commonalities but there remain enough distinctions to differentiate each. These are outlined in Figure 7.

Figure 7 - Similarities Between the Three Approaches Utilised



Gatenby and Humphries (2000) similarly combined feminism and PAR to develop a framework for Feminist Participatory Action Research (FPAR). Reid and Frisby (2008) argued that feminism strengthens the PAR process by attending to gender whilst PAR prompts feminists *"out of the academic armchair"* (p.94) to engage in transformative change through collective action with those who become involved. Reid and Frisby outlined six dimensions of FPAR and provided a number of guiding questions for consideration before, during and after the process. These included key aspects such as considering barriers to engagement, how experiences would be gathered, and in what forms action would be implemented. Reid and Frisby further argued that a fundamental dimension of FPAR is reflexivity, or the explicit consideration of

power relations in the research process. This consideration is perhaps even more essential in a prison environment given the inherent power dynamics. A key question raised is whether a truly equal, non-hierarchical relationship, as required by feminist principles, can ever be achieved in a hierarchical and patriarchal environment such as a prison? Issues of payment, environmental coercion, limits of confidentiality enforced by prison rules as well as the simple inequality in freedom afforded to the researcher and not the prisoner may inevitably result in a hierarchy or imbalance of power in the relationship.

The issue of gender is also pertinent and raises the question as to what extent a man can conduct emancipatory research of women's self-harm? Regardless of gender, one's own personal biases will inevitably influence the research process and these were considered. These challenges, however, do not mean feminist approaches will inevitably fail in a prison environment. Instead, they require reflection throughout the research process. For example Liebling and Arnold (2004) actively involved both prisoners and prison staff in the development of the MQPL through working groups or prisoners piloting interview schedules[55]. The resulting research however, was never explicitly discussed in relation to the power implications of such involvement or framed in the context of service user involvement in a prison setting. This research therefore sought to address this gap through the reflection on these issues as described in chapter 6 (Reed-Danahay, 1997).

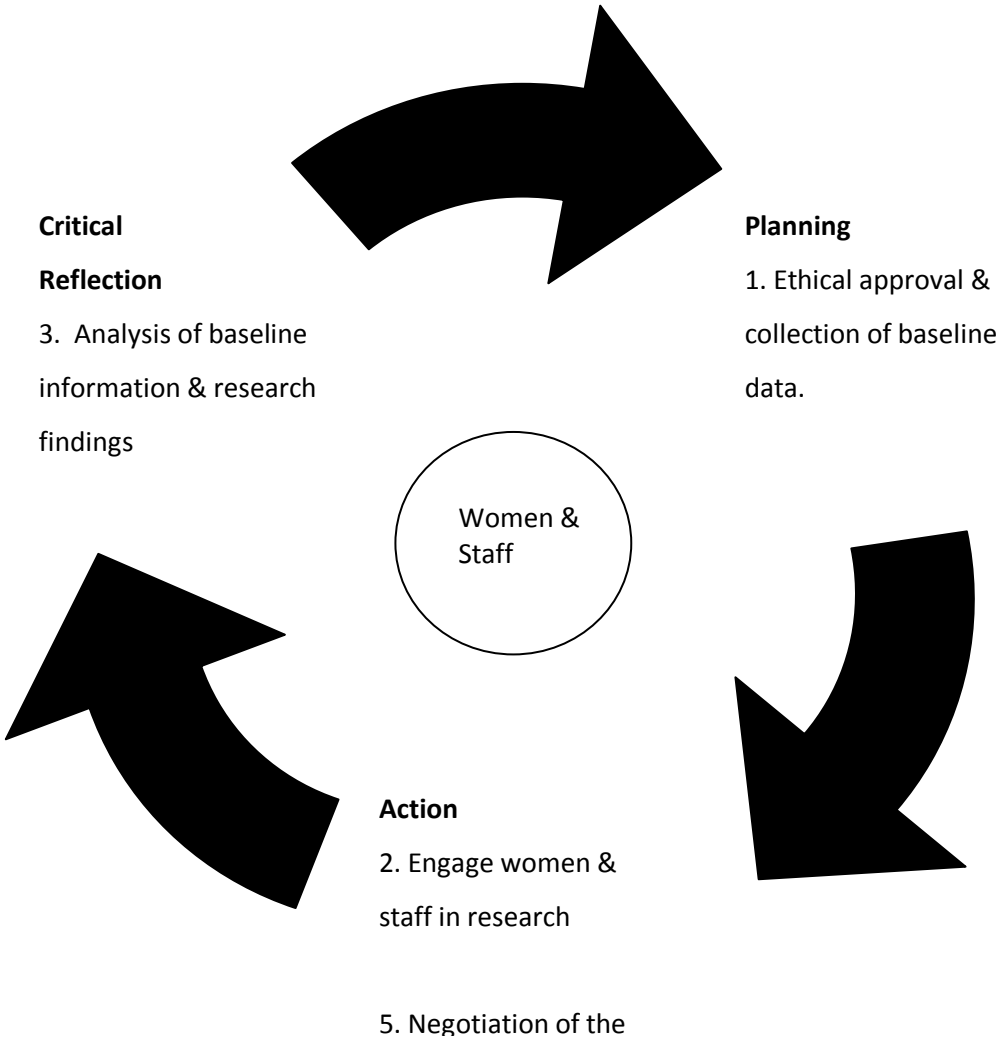
To attempt to describe this research in one sentence: it may be best summed up as the triangulation of mixed methodologies using a feminist participatory action research approach to engage women in prison and prison staff. The exact design of the research is described below. Before this, however, it is worth reiterating the context of the research project set out in chapter one. Whilst this thesis is interested in the realisation of emancipatory and action focussed methodologies in the prison environment this of itself is not necessarily about effecting change. Instead the thesis examines the application of these principles in the context of a Knowledge Transfer Partnership (KTP) project that aimed to reduce the incidents of self-harm within the prison whilst improving outcomes for women who continue to self-harm. The initiatives

developed through the FPAR process described below were done so with these objectives as the practical starting point (Swantz, 2008) having been identified as an area of need in the prison by the North East Offender Health Commissioners (a key stakeholder in the KTP).

The Research Design

In keeping with the cyclical nature of PAR (Dick, 2004) the project went through a number of cycles of planning, action and critical reflection. Figure 8 provides a simplified illustration of the first two cycles of the project, each stage being numerically ordered. In keeping with the principles of FPAR the women in prison were included in each of the three stages as much as possible.

Figure 8 - The sequencing of the research process



Research tools were developed in a sequential manner during the planning stage with each subsequent tool being informed by the previous one. An overall schematic (figure 9) of the whole research process is included at the end of the chapter.

Olsen (2004) suggested that the sequencing of survey methods such as questionnaires before qualitative enquiry, as used here, could be problematic if causal relationships between survey variables were to be assumed. This trap would be easy to fall into, for example, by assuming that traumatic experiences disclosed through questionnaires were necessarily causal in a woman's use of self-harm. However, adherence to, or at least awareness of, feminist principles in which the researcher explicitly does not assume any unique insight or knowledge safeguards against such presumptions and rather than inferring such causality, women in interviews were asked to share their own perspectives on their use of self-harm.

Qualitative information:
In all there were three sources of qualitative information:

- Process Mapping (PM) events were held separately for staff and women in prison. PM, a recognised approach in organisational development (Damelio, 1996), was used in this instance to provide a framework for women and staff to reflect on the stages of the prison pathway from arrival to release and the impact of these on self-injury. Although the groups were separate, inter and intra group feedback was facilitated to highlight good practice and gaps in services. PM was also used to engage women and prison staff early in the research in order to introduce the project and begin promoting the elements of action and ownership in the research process.

- Questionnaires (see appendices F and G) were developed based on the existing literature and findings from the PM events. Drafts were presented for feedback and refinement to the National Self-Harm Expert Reference Group (a cross government department group of professionals and service users). Questionnaires included a mixture of free text answers to

questions as well as scale and scoring questions[56]. These aimed to gain insight in to the function of self-harm for women, at the age this started and the antecedents of self-harm, by what methods harm was inflicted and how the prison environment impacted upon this. Women's opinions of current care for self-harm and ideas for the development of this were also sought. Questionnaires for staff explored staff's understanding of the functions and antecedents of self-harm by women in prison from their experience and also their opinions of care and ideas for development.

- Interview schedules (see appendices H and I) were designed in order to compliment the questionnaire information gathered and to provide narrative accounts of experience of self-harm, the effect of the prison environment and perspectives on care received. Interviews for women in prison focussed upon their personal experience of self-harm whereas those for staff upon their perceptions and experiences of self-harm by prisoners.

Quantitative data:
Similarly there were three primary sources of quantitative information:

- Baseline information relating to rates, method and timing of self-harm[57]

- Data relating to staff training in ACCT and Mental Health Awareness

- Questionnaire items including demographic information, self-reported frequency of self-harm and mental health difficulties, and questions asking respondents to indicate opinions of current services on a Likert scale (Likert, 1932).

Participants

Participants were women in prison and prison staff from a single women's prison in England. Participants were involved in the research/information collection phase from January 2010 – May 2010. Planning and actual action for

change, as depicted in the three stages of Figure 8, involved participants between July and December 2010. On-going delivery of the introduced services, evaluation of these and critical reflections of the research as a whole took place throughout 2011.

Sampling Strategy – Women in Prison

The inappropriateness of positivism for this research has already been discussed in the context of feminism's rejection of this epistemology. The aim of the research was neither epidemiological nor to develop evidence bases through the use of Randomised Control Trials (RCTs). As such randomised or statistical approaches used to acquire representative probability samples (Matthews & Ross, 2010) of the prison population were not required and not attempted.

Noy (2008) asserted that snowball sampling is consistent with feminist approaches in that it breaks from the traditional researcher-researched roles through placing control with the participant enabling them to determine who becomes involved (or is at least approached to be involved) in the research. Noy (ibid) also highlighted that snowballing approaches allow the *"organic social networks"* (p.340) that people exist in to be appreciated as a part of the research process as well as facilitating increased access to marginalised groups. Snowball sampling was rejected as a primary source of sampling for the research elements of the project on two grounds. Firstly, in the author's experience, privacy is extremely important to women in prison. Williams (1991) identified that prison breed's mistrust and prisoners rarely confide in one another for fear that information could be used against them. Women in prison often describe the difference between 'prison associates' and true friends. One concern about the use of snowballing was that suggesting a friend or peer become involved implicitly involved the identification of the suggested woman as someone who self-harms and therefore any connotations this may have about her mental health. Both of these are obviously private, sensitive matters. The distress or conflict that potentially could arise as a result of one woman discussing circumstances of another with a third party was an important argument for not employing snowballing.

A second consideration was that the women in prison may not have belonged to social networks in which identification as someone who self-harms was a primary characteristic. Although such networks exist in community survivor and service user groups, opportunities or even the desire to form such networks in the prison may not exist. Whilst the use of snowball sampling would identify a number of women, those who kept it private from other women in prison (but not necessarily from staff) would potentially be missed by this technique[58]. Vice versa the identification of women who hide their self-harm from staff but not from other women would have this confidence broken given that I would be 'required' to report hidden self-harm (see chapter 6). Whilst the use of snowballing was rejected as a primary method of sampling for the research elements of the project, they were not entirely dismissed and a number of women became involved in focus groups and service development based upon recommendations from other women or from having heard about the aims. Cases where women were 'recommended' by others were handled with care and the woman making the recommendation was asked to approach her associate - the woman they were suggesting - in the first instance. This avoided the possibility of anyone feeling they were being spoken about 'behind their back'.

Finally, theoretical sampling (see Glaser & Strauss, 1967) techniques were rejected for pragmatic reasons. The development of theory was not the primary aim of the research and given the limited resources and timescale of the project, a focus upon theory development may have been detrimental to the goal of implementing action towards change. Arguably, the sometimes rapid movement of women in and out of prisons (often described as a 'churn') does not lend itself to the concurrent data collection and sampling that theoretical sampling involves (Matthews & Ross, 2010). Instead it was much more feasible to have a finite period of research involving as many women as were in the establishment at the time that met the criteria for involvement.

It was decided that purposive sampling would be used to invite women to take part in the research process, having been identified through prison ACCT records indicating a history of self-harm whilst in prison. Purposive sampling is

the approach of choice when selection of participants is based upon a known characteristic(s) (May, 2011), for example women in prison who have self-harmed. This sampling approach also accommodates the in-depth research of the specific area of interest through the collections of a 'homogenous' sample (Ritchie & Lewis, 2003). Barbour (2001) highlighted that purposive sampling may create biases in the sample population and it is certainly the case that this method would miss women who's self-harm was hidden from staff (and so not recorded) or those who would self-harm in the community but not in prison.

It was felt, however, that given the nature of the prison environment and the limited access to resources, the number of women who do not disclose self-harm would be low. Similarly numbers of women who self-harm in the community but not in the prison are likely to be small. When considering the criteria laid out by Miles and Huberman (1994) for the evaluation of sampling methodology it was felt that purposive sampling met all six criteria. The technique was *relevant to both the research question and framework,* it could provide *rich information* from the relevant women that could provide *believable* accounts and that it was both *feasible* and *ethical.* The final criterion of Miles and Huberman was that the sample should enhance *generizability* of the research. To an extent this is true in that what was learnt from the women (and staff) would be developed in to action for change that was likely to impact upon all women who self-harm in the prison, if not all the women in the prison. However generalizations are inconsistent with the feminist approach. Again, any generalizations made were checked through focus groups and feedback to the women who participated.

On balance, it was felt that the advantages of individually approaching women with an invitation to participate and the opportunity this afforded to discuss issues of consent, choice, anonymity, and the aims of the research, outweighed the option of advertising for participants from the prison population as a whole. Although the original intention was to approach all the women in the prison who were identified through ACCT documentation, compromises had to be made. Agreements were reached with the prison's security department regarding the exclusion of 'high profile' women due to concerns about data security. In other cases, clinical teams asked that certain women were not included for fear of

exacerbating self-harm that was already potentially life threatening. The reality, therefore, was that some women who were eligible to participate, and would have undoubtedly brought a unique and valuable aspect to the research, were not even approached to participate. This implication for FPAR is discussed in more detail in subsequent chapters.

In total 56 potential women were identified through ACCT records and approached to become involved in the research process. Of these 9 women chose to become involved in the process mapping events. 50 chose to engage with questionnaires and of these 44 women consented to be considered for interview. It was only through the completion of questionnaires that women were asked to disclose some of their demographic information. The women's average age of 36 (range 18-58). 48 (96%) women returning questionnaires were sentenced, 30 (60%) had received a determinate sentence averaging 4.5 years in length (range 0.5 - 12 years). On average women had been in prison for 16 months (range 0-72 months).

Interviews represented the last of the data collection phases. Of the 44 women who agreed to be interviewed 15 were randomly selected. Random selection was chosen in order to ensure sampling remained intrinsic. In all previous stages of the research sampling was from a pre-determined group (i.e. women who self-harmed), to start to choose specific women from the group (for example from specific age groups, or offence types) would be to move to an instrumental form of sampling (Stake, 1994). To select women for interview based upon a demographic characteristic such as age; race, offence etc. would never fully accommodate the diversity of women in the prison. Given that, again, causality or epidemiology were not being sought such selection would not be relevant. Random selection was achieved by drawing participant numbers written on separate pieces of paper out of a cup. Those women who offered to participate in interviews but were not subsequently chosen may have, understandably, been disappointed or upset by this. The true impact of this was not formally sought by the project however throughout the women's involvement in other aspects of the project, and depite seeing me regularly in the prison this was never raised as an issue.

The subsequent focus groups aimed at effecting change were initially open to any woman who had participated in any of the research phases. As described above, however, on a number of occasions women joined the process as a result of being recommended by others in the group.

Sampling Strategy – Prison Staff

For similar reasons, purposive sampling was used to recruit staff to the research. Again, a discreet group of people, those whose job role required them to work directly with women in prison, were sought. This only excluded staff whose job role would be highly unlikely to require them to provide care for self-harm. Snowball sampling was rejected as the group did not reflect a marginalised or hard to reach cohort (Noy, 2008) and again probability sampling was rejected due to not seeking epidemiological or statistically significant results. In total 160 staff were approached to complete questionnaires with 68 returned (43%). 26 (38%) of respondents were from a discipline role (Officer, Senior or Principle Officer) with the remainder from multi-disciplinary groups spanning education, psychology, healthcare, drug workers and the chaplaincy.

35 members of staff indicated they would be willing to be interviewed. Given the multidisciplinary nature of prison staff and the potential implications job role has upon training and understanding of issues of self-harm and mental health it was felt necessary to instrumentally select staff for interview (Stake, 1994). This ensured representation from all departments that work directly with women in prison in similar proportion to those who had returned questionnaires. In all 13 members of staff participated in interviews. Three were from discipline grades (as above), two were mental health staff, and two were governors. One person from each of the Healthcare, CARATS[59], Psychology, Chaplaincy, Offender Management[60] and Education departments were also interviewed. Interviews with staff served the same purpose of supplementing questionnaire information with narrative accounts. Unfortunately, the process of releasing staff for interview proved to be challenging and their release for focus groups proved impossible.

Method

Planning Stages:

The stages of planning consisted of three main themes:

- Ethical applications
- Development of research tools
- Development of plans for action & negotiating change

The major ethical considerations of the project have been described in Chapter 6. In the planning for information gathering, a primary concern was the mental wellbeing of the people who chose to become involved in the process. Both 'prisoners' and 'prison staff' commonly have needs relating to symptoms of stress, often in relation to experiencing traumatic events (Coid, *et al.,* 1992; Wright *et al.,* 2006) or the pressures of living and working in a prison (Liebling et al. 2005; Schaufeli & Peeters, 2000). With this in mind all three aspects of qualitative information gathering included elements of appreciative enquiry (Elliott, 1999). Elliott described appreciative enquiry as a framework for the introduction of sustainable changes in organisations. It is thus highly compatible with the aims of feminist and action research methods. Liebling and Arnold (2004) used the technique to 'dig deeper' in to the prisons in which their research was based and also to identify positives of the prison system and not just negative responses, which they found much easier to elicit. In this research the use of appreciative enquiry served both of these purposes as well as a way of exploring protective factors that could be returned to if the questions being asked caused distress in the respondent. In particular, beginning interviews and completing questionnaires in an appreciatively enquiring manner provided information on useful coping or distraction techniques that the women in prison had previously used and that they could be reminded of during de-briefs. Similarly, positive aspects about job roles or times staff felt they had been effective in their work could be revisited should the person become distressed or despondent. Given that research suggests that women often keep their self-harm hidden due to concerns about stigma and shame (Sane, 2008) de-briefs also included, where necessary, direct questions about whether the woman was having thoughts of self-harm.

Most significantly, and what proved to be most useful, was the empowerment of the women in decisions on how they wanted to be involved, on what terms they wanted to contribute and how risk to themselves could be managed. In accordance with Faulkner's (2009) concept of accessibility (it being not only facilitating participation but also ensuring comfort in doing so), some women chose to be interviewed with partners and friends or around contact with mental health workers all of whom could offer support should they become distressed. Similarly, all those who chose to complete questionnaires were given the option of doing so on their own (with the option of a de-brief when they were collected) or with myself. Procedures were also in place for women to use a translation service if English was not their first language or be interviewed by a female colleague should they prefer. Neither of these options were required. In the case of the translator, this was due of the very homogenous population of the prison research site resulting in very few women for whom English was not their first language[61]. A female colleague was not asked for.

The final planning stage[62] (although arguably one that involves critical reflection) was the use of focus groups with women to discuss emergent observations and themes from the research phase. In these, women were encouraged to challenge and correct any observations, and the emphasis of themselves as the experts was highlighted at every opportunity. These stages also included brainstorming sessions for the development of existing services and the construction of new ones such as staff training. These were generally held in the prison's education department to allow the use of the resources available. The plans developed through these focus groups were then presented to the prison's senior management team and plans for action were negotiated, although these were not always successful.

Action Stages:

The action stages comprised of:

- Information gathering through process mapping, questionnaires and interviews with women and staff.
- Development of 'products' that were agreed with the prison's senior management team

- Delivery of the ‘products’.

The process mapping events were co-facilitated by a colleague and I over the course of one whole day. Participants were asked to identify key strengths and weaknesses in the care and management of self-harm at 5 key stages in the prison journey:

1. Courts, police, previous prison or other contact with criminal justice services prior to arrival at the prison where the research was based
2. Arrival at the prison
3. Day-to-day life on the wing
4. Significant life events during their time in prison (e.g. bereavement, child contact etc.)
5. Leaving the prison.

This process was initially conducted with women in prison. The emerging themes of this were then reported at the beginning of the event for staff. Staff representation from each prison function was sought.

Several weeks after the process mapping events questionnaires were distributed to staff. These were given out over the course of three months by the author through attending pre-existing team meetings or by approaching individuals. Questionnaires were returned anonymously via the internal post. Given that the focus of staff questionnaires was upon personal opinions of available services and their understanding of self-harm by women in prison it was not felt that this would cause a level of distress that would constitute the need for support in its completion. Information about staff support available in the prison was however included in the questionnaire pack.

During the same time frame women were individually approached and asked whether they would complete questionnaires. For those who wanted assistance with completing the questionnaires this was provided on a one-to-one basis, unless other arrangements were requested.

Women and staff indicated in questionnaires via an 'opt-in' tick box whether they would consider being interviewed in the future. All interviews were audio recorded and transcribed. Women were reminded of the limitations of confidentiality at each of the stages outlined.

In the development of the 'products' small working groups were formed with the women. Those who chose to become involved were encouraged to consider what they could contribute to the development. This resulted in some women contributing art work, others creative writing or factual accounts of their experiences, some women contributed ideas or supported the project through their continued interest and attendance in the groups.

Throughout these processes all participants were encouraged to choose when and how they would engage with the process. This resulted in just two women participating in all stages from process mapping to focus groups. Some women were just involved in the information gathering stages whilst others were only involved in the later stages of action, sometimes as a result of 'snowballing' - as defined above - or hearing about the work and asking to become involved. Opportunity also played a significant role in engagement due to significant numbers of women being released or transferred to other prisons over the course of the year.

The final stages of the action processes were the actual delivery of the 'products' for the KTP project. Again, in keeping with the principles of FPAR, women were involved in this stage as much as possible. In the case of the staff training session this involved one woman bravely co-delivering the session to members of prison staff acting as the voice of the working group who developed the package as well as contributing her own perspectives. Others (both staff and women) were involved in the distribution of resources created to empower women in their own care for their mental wellbeing. These, and the negotiation processes involved with the prison management have been described in more detail in chapters 6 and 9.

Critical Reflection Stages:

As described above, critical reflection was also incorporated in to the planning stage through the use of focus groups with women. Staff were involved where possible, although this was in a much more limited way and frequently involved the input from senior managers only. The groups were used to complement the questionnaire information through checking assumptions and interpretations made by the author (Bernard, 2000). It was decided that these groups would not be involved in the analysis of the raw information gathered. Whilst this arguably places me in the position of 'researcher' with the traditional position of authority in handling and interpreting the information, it was decided that given the small population of the prison, and the proximity in which the women live with each other and with staff that even anonymised information could possibly be linked back to an individual. Whether this risk would ever have been realised is unclear but the breach of trust that this would have represented could have been catastrophic for those involved and therefore the risk was not taken.

Reflections on the 'products' of the action stages were sought through evaluation and feedback. These included feedback forms for staff who attended training and awareness sessions, further focus groups, one-to-one discussions and feedback forms for women who accessed newly developed services in the prison or received training themselves. Information relating to incidents of self-harm and associated costs of care were also monitored over the duration of the project to ascertain whether there was any impact upon these objectives.

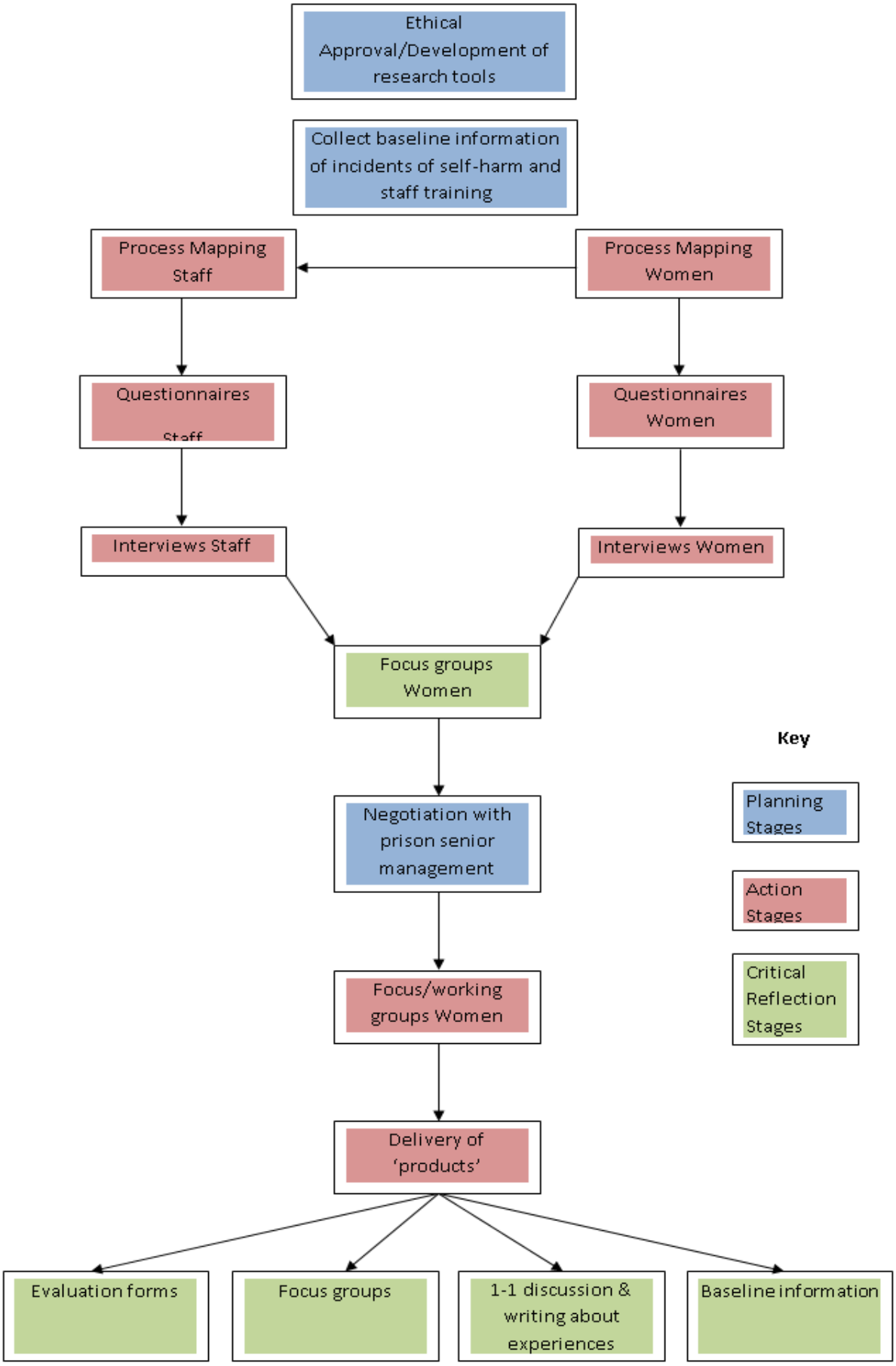
Finally a number of women who were involved in the project were also encouraged to reflect upon their experiences of being involved. Two women who had committed a significant amount of time and effort to the project were asked to contribute their experience as written pieces. These have since been published (Ward, Bailey, & Boyd 2012; Ward & Bailey, 2012) where Boyd is a pseudonym of a woman in prison.

Summary

> *"Multiple methods enable feminist researchers to link past and present, 'data gathering' and action, and individual behaviour within a social context…Multiple methods increase the likelihood of obtaining scientific credibility and research utility"* (Reinharz, 1992, p.197).

This research employed mixed methods in order to provide not only the credibility and utility that Reinharz describes but to also to deliver the depth and insight that the approach brings through the triangulation of information. Mixed methods provided women and staff with more options and control in choosing how and when they become involved in the research. This was in keeping with the principles of both feminist research and participatory action research and informs the approach and values that this research aimed to bring to the process of information collection and action towards change. These principles are particularly relevant in the prison setting where there has been criticism that research does not always produce change and where women and staff are arguably marginalised by a strict, structured and patriarchal system. Women and staff were sampled purposively for the research elements, however subsequent stages of the project were open to women who were interested in becoming involved. Critical reflection of information gathered and actions taken were incorporated throughout the process and where possible, and safe to do so, women and staff were involved in the process. The extent and limitations of how much both groups of participants were empowered by the process have been reflected upon in chapters 6 and 9.

Figure 9 Flow Diagram of the Whole Research Process



Chapter 8

Findings

This chapter will triangulate both the various methods used (process mapping, questionnaires and interviews) and the sources of information (prison records, women in prison and staff) in order to identify relevant themes in relation to the existing care and 'management' of self-harm, any unmet needs and the subsequent need for praxis.

Quantitative information from questionnaires and incident records of self-harm in the prison were analysed using SPSS and Excel respectively. The qualitative information from the process mapping events, open ended questions from the questionnaires and interview transcripts were coded using NVIVO. Through thematic analysis, a process during which qualitative information was read and re-read a total of three times, three overarching themes emerged:

1. The utility and necessity of self-harm
2. The prison experience
3. Current procedures and identification of change.

As may be expected each of these three themes are interrelated and necessarily impact upon each other. One clear example of this is the link between the woman's previous life experiences, the prison environment, and her current mental wellbeing. As Byrne (1998) highlights trying to describe these interacting factors can be to impose linearity where one does not exist. Where Byrne did not have the vocabulary to do anything other than *"worry"* (p.3) about this, I do not have the vocabulary to do justice to the complexity of self-harm for women in the prison. As such I can only try to best represent what I have been told. I have chosen, in the process of triangulation, to be predominately guided by the qualitative themes that have emerged, and especially those garnered through interview. The quantitative information is therefore used to either support or offer an alternative view. This has been done for two reasons. Firstly, in order to avoid drawing false assumptions about causality from quantitative/survey information (Olsen, 2004). Being guided by

the richer and personally relevant experiences shared through interviews will help avoid this and if any causal links are drawn they will be those of the interviewees (both staff and women) rather than my own. Secondly, although the use of mixed and quantitative methods in feminist research has been discussed (see Chapter 3) being guided by the lived experiences of participants, rather than the quantitative information of rates and types of self-harm gathered through data collection, is more fitting with the feminist ethos that this thesis aims to adhere to. In line with this ethos this chapter will not offer analysis or links to existing theory, it will simply collate the contributions in themes that I believe have emerged. Critique of these is given in Chapter 9. Instead it is intended that this chapter attempts to provide the *"space for the voices of marginalised people"* that Maggie O'Neill (2012) describes as the aim of PAR. This is done in the acknowledgement that my own subjectivity is inevitably reflected in the themes identified. Again, the extent to which these may or may not reflect the experiences of women and staff is discussed in the following chapter.

Each source is coded with the method it was gather by (Questionnaire (Q), Interview (I), Process Mapping (P)); the source (Women (W) or Staff (S)) and the individual case identifier assigned to the person. Thus a quote from the Process Mapping with staff by 'participant number' 6 would be labelled PS6, and interview with a woman IW4 for example. First however the quantitative information relating to the 'profile' of self-harm within the prison will be presented.

The Incidence of Self-harm in the Research Site

Safer custody information relating to the numbers, types, locations, and timings of incidents of self-harm, as well as the numbers of women involved, were collated from January 2007 to December 2011[63]. Figure 10 illustrates the yearly rates of recorded self-harm, the numbers of women who were recorded as having self-harmed and the average annual population of the prison.

The Utility and Necessity of Self-Harm

Women often discussed the utility of self-harm for them as a method of expression and survival. This often involved intense emotions, especially anger, with self-harm being a method of release or communication for feelings. The lack of control that women in prison experience was one of the causes of these feelings and in these instances self-harm became a method of exercising control. Whilst discussing the importance of self-harm in fulfilling these functions women also made clear arguments of the necessity for a harm reduction approach rather than the management and cessation goals of the prison service. Each of these sub-themes will be discussed in order.

Self-Harm to Survive Intense Emotions

Anger was the most commonly reported emotion for women prior to self-harm with 29 women (58%) who completed questionnaires identifying this as their primary emotion before self-harming. Women's anger was commonly linked with previous experiences of abuse as borne out by 33 (66%) women completing questionnaires who stated that 'thinking of the past' was the most common antecedent of self-harm:

> *"I do [feel anger] towards me uncle, yeah because he only got 2 years' probation for what he done to me…because I can't get hold of him now because he's dead but if he was still alive then I'd probably say something now because I'm not a kid no more"* (IW1)

Women often described situations where, bored by the prison regime and the large amounts of unoccupied time this imposes, they were left to ruminate upon their past, feel anger at this and left with no outlet for this emotion. As one woman wrote:

> *"Bored, alone in your room. Your mind works over time and you find it hard not to do what your head is telling you: SELF-HARM!"* (PW Anonymous)

Others felt angry at a system which:

> *"dismembers us, psychologically speaking, into 'manageable, bits but which fails to communicate with the dismembered parts… [I] feel so angry it can overcome my strong will to live"* (QW42)

Self-harm therefore provides the release or expression of anger that is otherwise unavailable to women in prison, or as one member of staff suggested unavailable to women altogether:

> *"socially it's still men that can be angry and violent, women have to be more passive, they still have the same emotion"* (IS3)

When discussing anger I often found it necessary to reassure the women that feeling angry was OK and understandable given their experiences.

Often self-harm was described as being inwardly directed anger, the result of the frustration that living in prison causes. Some described how the prison environment exaggerated these emotions to an extent that even small inconveniences became serious matters:

> *"if someone goes on the phone and you is booked down for that time, oh my god something just as little as that three years ago would have wound me up that bad that I would have either have actually hit her or go and cut up, do you know, it's just loss of control because the little bit we have got control of, when someone takes that little bit away as well you just get so angry, frustrated and you get all anxious, you get butterflies in your stomach and you just build yourself up and build yourself up until you end up getting the razor and just cutting yourself"* (IW3)

> *"you can't do nothing in prisons, if someone annoys you, you can't get that person so the best thing to do is just cut so that's what I do"* (IW6)

One analogy that was often used by women was that of a pressure cooker in which the internal pressure of their frustration and anger would be released by the act of self-harm:

> *"Your body just gets so angry like and everything, you know what I mean and when you're angry you can't get it out so the way to get it out is to cut up, you try something else like the Play Station or whatever and it doesn't work then you're only option is to cut up"* (IW6)

This release was also true of other emotions and especially the pain associated with surviving abuse and violence. The impact of imprisonment or experiencing so many emotions at once it is overwhelming. The pain caused by self-harm therefore becomes a mechanism to block out the emotional pain:

> *"as long as you focus on the physical it pushes the emotional stuff out and the physical pain is a lot easier to deal with than the emotional stuff"* (IW2)

As previous survivors have described (e.g. Pembroke) self-harm for some is a strategy for surviving the intense emotional burden that women in prison carry:

> *"It just takes away, like when you cut yourself it just takes away like the pain, I don't know, it's hard to explain really, it just relieves"* (IW6)

> *"I'd have killed myself, I would have just took an overdose [if self-harm hadn't been used]"* (IW10)

Self-Harm and Control

The woman quoted above discussing the frustration and anger that small inconveniences in prison can cause (in her example not being able to use the phone) identifies that, for some, the underlying issue is the total lack of control. 12 women (24%) completing questionnaires identified that self-harm helped them to feel 'in control', seven of whom indicated that this was the most common reason for their self-harm in prison. Imprisoned women are required to engage with the regime that dictates their movements, activities, access to resources and, for some, monitor their communication with the outside world.

> *"Anger?, oh yeah, I forgot to mention that, you know when I get, it's mainly because, you know because you haven't got much control of anything in here"* (IW6)

> *"I just want to do it to have control"* (QW18)

For one woman who I interviewed this disempowerment extended to the Probation Service not recommending release as she would not agree to leave her partner, someone she felt was a source of support for her:

> *"I've been told that I'm not going because I won't leave me partner. Now that's starting to get me mad now, angry because what right have they got to tell me to leave my partner, I feel so angry towards* [the Offender Manager]" (IW1)

For another, mistakes with her medication left her without pain relief and having left her mug in a friend's room without the ability to make herself a hot drink:

> *"I'd worked myself up so bad that I was crying and screaming with a temper. I went 'I'm fucking gonna cut me throat then, fuck the lot of ya's' and they went 'go on then' and I said 'well I'm going to watch Eastenders and Coronation Street first'. So I sat there and I watched them and then I did it, I just cut my throat"* (IW7)

Control therefore may not just be in the act of choosing to self-harm but also in its timing.

A number of women felt that the prison's system of managing self-harm, including the use of 'safer cells'[64] or the removal of items that could be used to cause injury, further exacerbated feelings of helplessness against the system. This in turn increased the risk she posed towards herself:

> *"when you are suddenly stripped of every bit of control and you're feeling vulnerable and they take away something like a telly, a radio…and all they've got in their head is self-harm and that is a dangerous point…I've done it in my safe cell, I've used my fingernails and I've cut quite deep because if you're in that mind you will. You've had all the control took away so you want some control back for yourself" (IW10)*

Staff recognised that self-harm was often mediated by a need to exert control with 58 (85%) members of staff completing questionnaires citing this as a reason for self-harm and 7 (10%) citing this as, in their experience, the most common reason:

> *"some women self-harm for control, what they'll say is I've got nothing outside, I've got you telling me when to eat, you tell me when to sleep, you tell me what to do, this is the one control mechanism I've got."* (IS3)

> *"maybe it's because they can't control anything that's at home, they can't control anything that's within the prison, what they can control is their self-harming"* (IS5)

Yet it was clear that for some staff the lack of control the prison places upon prisoners could be forgotten. In one example of this a member of staff expressed frustration at women forgetting to take everything they need from a cupboard in one go in order to clean the wing. Another examples was the failure to ensure they had enough toilet rolls before being locked in their cells for the night. The member of staff expressed *"at home you have a stock of toilet rolls, you wouldn't dream of running out of them!"* (SI5). This however appears to be a vicious circle with staff becoming frustrated at the woman's apparent inability to take responsibility for herself whilst at the same time the prison environment removes the woman's ability to do exactly that.

The Need for Harm Minimisation

It is clear that whether self-harm is used as a method for managing, expressing or surviving overwhelming emotions, or as a way to assert an element of control over her life, it is often viewed as important to the individual. This is apparent from the importance women place upon access to materials with which to self-harm and the potential consequences of not being able to self-harm:

> *"that bit of glass is the most important thing to you in your life"* (IW10)

> *"I always managed to have a razor and if they took that away… well I know it's a lot more dangerous time for myself because I started thinking oh god because it's like a safety mechanism"* (IW3)

Several women described having to resort to ligaturing after they had razors removed which effectively took away their method of coping with distress. As already discussed, the prison's approach to the management of self-harm is to promote cessation without recourse to harm minimisation. The removal of items such as razors from women is one common example of this. Despite this it is clear to staff that self-harm will never be entirely prevented:

> *"one women said that to me, she can't have this and she can't have that but we can't stop her doing that to her body, it's her body and if she wants to do it she'll do it and we can't stop her"* (IS4)

This mirrors the need of the woman quoted above who self-harmed using her finger nails in the safer cell and highlights the possible futility of the prison service's preventative approach. Another member of staff acknowledged that the removal of glass from the 'lifer' wing made no impact upon the rates of self-harm and yet they would still not condone a harm minimisation approach:

> *"I've seen women self-harm with false teeth and with shards of toenails which are thick and sharp…What I would be against is any suggestion of issuing blades, issuing bandages so you can go and cut safely and then hand the stuff back but I think that's very risky, I don't know how you'd explain to a coroner that something had wrong and you gave them the equipment to do it"* (IS7)

This position, of simultaneously acknowledging that self-harm will occur no matter what lengths the prison goes to whilst rejecting a harm minimisation approach, seems contradictory. This also undoubtedly causes stress and frustration in frontline staff who are required to provide appropriate care whilst adhering to the prison policy.

Not all staff though were against the concept of harm minimisation with some seeing the pragmatic benefits of the approach:

> *"from a harm minimisation idea it will actually help to allow them to just get on with it [self-harm] and would probably be safer and cleaner"* (IS3)

> *"the fact that they* [the staff] *feel so compelled all the time to stop somebody self-harming, there's nothing around just getting them to self-harm in a more safe way"* (IS6)

One drug worker who reported that one of the most satisfying elements of her job was the teaching of harm reduction for substance use, wondered:

> *"why can't we do that here like a blade exchange or something like that (laughs) you know, an amnesty where they hand everything in and they get safety blades"* (IS8)

The argument for harm minimisation is further strengthened by a number of women reporting in interview that they had self-harmed in secret whilst in prison and managed to keep this undetected:

> *"there's one particular friend I've got who self-harms pretty bad, sometimes she doesn't even tell staff until she like needs staples and it's gaping all wide open"* (IW7)

> *"it's very rare that an officer will know I've done it"* (IW10)

> *"some of the women self-harm and don't tell you and that's quite worrying"* (IS4)

Finally one woman indicated that she had received a form of harm minimisation whilst in another prison:

> *"they give me this pack, it had 2 bandages in it but obviously you wouldn't be allowed bandages in it, they give you sterile strips, those swabs, basically a cut up pack so then so basically if you cut up you've got it all there…I bet you any money the* [self-harm] *rate would go down if those packs are given out" (IW3)*

It is unlikely that this practice was officially sanctioned and may have reflected a local policy or practice that was never agreed by the Safer Custody policy team. Some nurses who I spoke to informally confirmed that in the past they had

given out dressings proactively (i.e. prior to self-harm) but this was never officially supported through policy and the practice was stopped, which they felt was unfortunate.

The Prison Experience

In questionnaire responses 26 women (52%) reported that they self-harmed more frequently in prison than in the community. Of these two women stated that they had never self-harmed before being imprisoned. Being away from family (7 women (14%)), and finding the prison environment threatening (5 women (10%)) were the two most common reasons given for the increase in self-harm. By comparison 14 women stated they self-harmed less in prison whilst 10 reported no change in frequency. Three themes emerged from the data that specifically related to the prison environment, these were i) relationships, ii) hostility and moral codes (Cresswell & Karimova, 2010) around self-harm and iii) the impact upon the woman's mental health.

Relationships

The importance and difficulties of relationships within prison were often discussed by women within the context of their self-harm. This theme can be further differentiated: relationships with family, staff and with other women in prison.

<u>Family</u>

On the whole maintaining family links whilst in prison was considered to be an important protective factor for women against self-harm. Family offers some women support, an opportunity to discuss problems with someone they could trust, and hope for help upon release:

> *"I can talk to them about my feelings, here you don't trust no one in prison, I just keep things to myself until I see my family"* (IW6)

> *"I've been in XXX prison [research site] for 3 months now and I have self-harmed 5 times. I was in [another prison]*

> *for 7 months and I never self-harmed once because I was getting visits there and I have not had any here"* (PW3)

For some thinking of their family, and the potential upset self-harm could cause them, prevented the woman from self-harming:

> *"Family is a big, big thing for me. That's one big thing that stops me from self-harming is the fact that I don't want to lose any of my family and I don't want any of my family to lose me"* (IW12)

However family and separation from them is also a cause of stress and 25 women (50%) cited missing their family as a reason for self-harm in prison 5 women stated this was the most common reason for self-harming. As with the quote above, several women stated they were too far away to see their family and this was particularly difficult when access to children was restricted:

> *"I don't get visits off my son, I'm too far…alright I speak to him on the phone but it's not the same, do you know what I mean and the issues* [that] *were happening with him, I couldn't help him, I felt helpless"* (IW7)

> *"I'm away from my family too far; I don't get visits, that's hard"* (IW6)

For one woman the implications of her family maintaining contact with her children when she was not able to was devastating. Others often described guilt at their current position and the feelings of having abandoned their children:

> *"3 years ago I took an overdose because I found out that my parents were going to see my children and I couldn't deal with that I thought everything was gone and I didn't feel anything anymore"* (IW2)

Not wanting family members to worry and a lack of understanding about self-harm also caused stress that required women to *"make out that everything was alright because I didn't wanna worry them"* (IW13). Family could also misunderstand or fear self-harm and this impacted upon their reaction which, in turn, impacted upon the woman in prison:

> *"the shame, the pity on their faces, all sorts of things, especially my mother, 'you've let me down' then puts you back into that cycle of 'do you know what, right, just get out of my face because I just want to do it again now because you just made me feel even worse"* (IW10)

Finally of course some family relationships are evidently toxic, not borne from misunderstanding but from relationships that have totally broken down or are abusive. These can have the effect of exacerbating self-harm with some women even feeling provoked into it:

> *"When I ask for photos [of her children] it'll be 'well I'll send you a calendar with the bairn's photo on to mark your effing days off"* (IW4)

Staff-Prisoner Relationships

As may be expected the relationships women describe with members of staff is varied and relies upon the individuals involved. Women generally identified a member of staff as being 'good' when he/she spent time listening and talking. The development of a relationship in which differences in the woman's demeanour may be noticed and followed up was also important for a number of women. Those that had the opportunity to develop such relationships could identify examples of positive care for self-harm:

> *"there's some people I talk to and that's it really, I have a laugh with Ms C, she's a laugh"* (IW6)

> *"she told me about her mum dying and I just thought she's just basically letting me know that she knew what I was going through and she took the time out to listen, you know rather than just the quick 'oh you're not alright, oh well you will be, try to do something to cheer yourself up"* (IW3)

> *"when I told her she didn't close the conversation down, she didn't dismiss it, she sat there and she cried with me and then asked me to talk about it if I wanted to and that was when I first started to say ok, I'll open up a bit here"* (IW10)

> *"Miss G, she's brilliant, she really is, I think she's sound and there's another one Miss K"* (IW7)

Conversely women were able to identify practices by staff that were at best unhelpful or even more likely to increase the woman's risk to herself. Poor care often involved staff being judgemental, distant or even abusive and threatening:

> *"it's the attitude of the officers, the fact that there's no support* [after self-harm]*, you feel alone, nobody cares"* (IW9)

> *"Spoke to like a child. Staff judged by looking at the crime, not the person. Staff can be very blunt, called by surname or number, does not make me feel safe or human"* (PW anonymous)

> *"No one asked if I was OK. I felt alone, helpless, angry and confused. No one came to talk to me or even ask if I was okay. Why? Why didn't they realise I only wanted someone to talk to?"* (PW1)

> *"certain people will shout at you and scream at you 'what the fuck have you done that for?' I'm in here, I'm still a human being, don't shout at me, don't scream at me, don't demand from me and they can frighten you and I mean some SO's ways of stopping you from self-harming is to come into your cell and scream and I mean scream and shout and threaten you with this, that and the other and the rest of the lasses on the wing are sitting there going 'oh my god, that girl's gonna cut up even worse now' and it makes you feel ten times worse."* (IW10)

This division in experience of care was also reflected in the questionnaires completed by women. As can be seen in figure 13, 24 (48%) women disagreed or strongly disagreed with the statement 'Staff show concern for me when I self-harm' whereas 28(56%) women agreed with the statement 'Staff listen to me when I have problems or feel like self-harming' (see figure 14)

Figure 10 Responses to Questionnaire Item 20b.

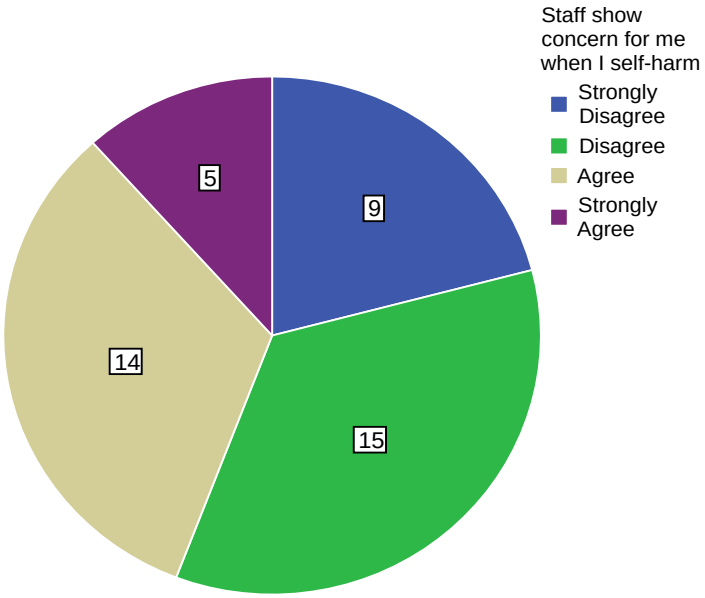
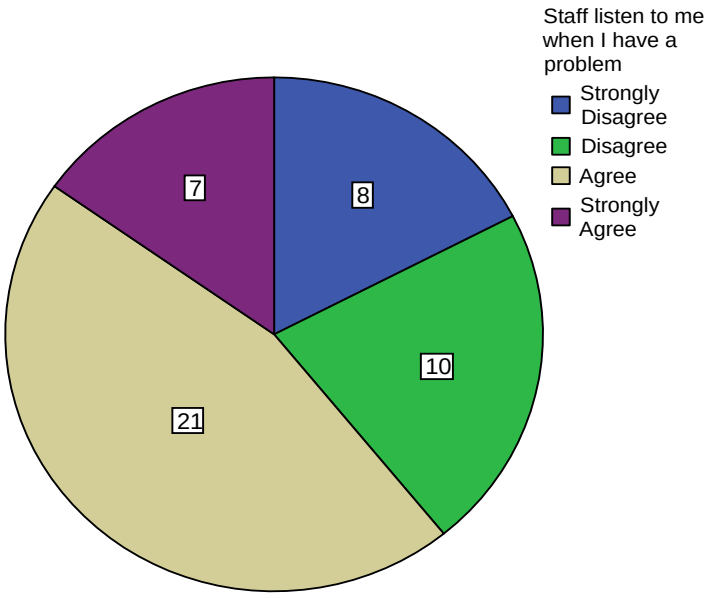
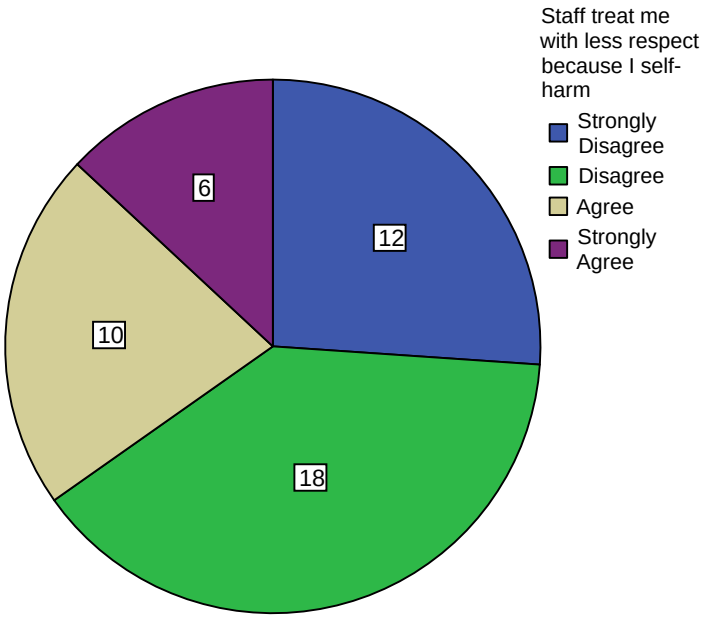


Figure 11 Response to Questionnaire Item 20c



Similarly although 30 (60%) women did not feel that they were treated with less respect because of their self-harm (see figure 15) this means however that just under half of the women who completed questionnaires felt that they were treated differently as a result of their self-harm.

Figure 12 Response to Questionnaire Item 20d.



All of the examples of good practice identified by women were by female members of staff. It is not clear how well this represents a gender divide in care as most examples of negative care were not ascribed to individuals and so the individual gender is not known. One woman however was very clear on the importance of gender in the care for women in prison:

> *"I think it should be a women that should come* [respond to self-harm] *because a lot of these girls have been abused by men, they don't want to be sat in there with some big fucking bloke, they're both not small are they…why would they want to sit there and talk to a man that's not really taking them serious, that blatantly has got written right across his head 'you're a fucking idiot for cutting up', why would you want to sit there and talk to him?"* (IW3)

The possibility of gender differences in care was perhaps reflected in some of the statements by staff with the need for relationship building being more commonly acknowledged by female members of staff:

> *"They* [women in prison] *seem to appreciate somebody's noticed without actually having to say they're in desperate straits, so kind of 'are you alright"* (IS3, a woman)

> *"the fact that you can learn to gain their trust and sometimes they'll talk to you when they wouldn't talk to others and it can be like an opening point for them"* (IS1, a woman)

Of course this is not always the case as one female officer commented "*you know, sometimes you forget sort of like they're human with families*" (SI9). Gender as well as job role and ability will likely impact upon such attitudes however it was more common for male members of staff to perceive an importance to keeping a distance or described care in a more managerial style:

> *"I thought that was good, to be detached from it, I think people can get too involved sometimes, you know, there's a time for that but I think sometimes you've gotta take a step back…some of them would cut to the bone to get a reaction, that didn't really bother me because I would think well I'm not related to you, you're not somebody I know well"* (SI7 a man)

> *"The staff on the induction unit, we coached [a woman] through a period of quite intense management"* (IS11 a man)

Staff capability is discussed later in this chapter in which the issue of distance and understanding of self-harm will be explored further. What is clear however is the importance of the working relationship between women and staff in relation to self-harm.

<u>Relationships with other women in prison</u>

From the questionnaire information gathered it would appear that women enjoy much more supportive and caring relationships with their peers than they do with staff. 31 (62%) stated other women showed concern after they self-harmed, 30 (60%) felt other women listened when needed and only 15 (30%) felt they were treated with less respect because of their self-harm. These are all more positive than the women's experiences of care from staff but again vary depending upon the individuals involved. During interviews women often highlighted the shared experience and time that other women in prison gave as being particularly beneficial:

> *"I find, especially on my wing, they're* [staff] *that busy they haven't got time to talk to you so you talk to other inmates*

> *and rely on them, I have got a good friend and I can talk to her"* (IW1)

> *"I've got other self-harmers to talk to and it's not a taboo subject and I can go and say to my friend 'do you know what, I'm really struggling and I really just want to cut up' and they'll talk to you"* (IW10)

However, women's experience of the prison environment was also that of hostility and mistrust. Throughout my career in the prison women often described the distinction between 'associates' and 'friends' and how friendships rarely developed in prison due to mistrust and broken confidences:

> *"they [other women] go around and talk about your business; they're quick enough to talk people's business"* (IW8)

> *"certain people will only come to me, talk to me and then in that conversation they'll go 'oh, have you got any tablets for sale"* (IW7)

Outside of the Listener scheme, the value and use of peer support was met with some scepticism by staff because of the mix of the women who would be involved or suspicion as to the motivations of the group members:

> *"you're mixing with a population there who have really limited tolerance skills anyway so they're gonna be more likely to be verbally aggressive, you know, quite acidic in the way that they attack… you're not dealing with the most benevolent population anyway so it's difficult really"* (IS6)

> *"I heard a rumour when I first started, that it wasn't a self-harm* [group]*, no was it, they did a stitching, stitch and bitch group or something and it got pulled because they were swapping ways to self-harm, they were giving each other tips"* (IS8)

I too had heard the rumours about the 'self-harm' groups but had never seen any evidence that they encouraged women to self-harm and my understanding was that it was not a formal support group but an unsupervised and unstructured meeting of women to knit.

It is clear that relationships, whether these be with family, staff or other women are key and can support or exacerbate the woman's need to self-harm. What is striking is that the discussion around beneficial relationships are not focussed upon prison-therapist relationships but everyday interactions with those they see the most, usually prison officers and peers. Relationships also influenced women's perception of the prison environment as being hostile due to the moral positions held often held by others in relation to self-harm.

The Hostile Prison Environment

> *"I wasn't self-harming outside because I didn't feel like it, I could handle things outside, here I can't, I find it hard in here"* (IW6)

So far this chapter has described the impact of imprisonment in relation to the experience and survival of intense emotions, the removal of control, and the effect upon relationships, and how all these impact upon self-harm. The impact of the prison environment itself however is also a key consideration. The second most common reason (after being away from family) for increased use of self-harm in prison (compared with the community) was finding the prison threatening (n=5, 10%) One woman described the process of coming in to a prison for the first time:

> *"some of the things you will feel, don't suffer on your own! Worried, tearful, lonely, shaken, scared, sad, paranoid, anxious, quiet and frightened."* (PW3)

The experience of prison for many women interviewed therefore appears to fluctuate between fear and boredom. Whilst for some this gives time to ruminate on the past for others it is just frustrating, especially if the prison no longer can offer progression through their sentence:

> *"Frustrated, stagnated, monotonous, do you know what I mean, bored, flat, lonely, it was all that and I'd just had enough"* (IW13)

> *"there's nothing for me to do here now, I've done everything, I've done my courses"* (IW6)

The intense experience of living so closely with other people and under constant scrutiny is also difficult for some to manage. The lack of privacy often results in some women having to live the experiences of others as one woman described how someone else's distress can trigger her own. This however can often be misconstrued as 'copycat' self-harm:

> *"ya get watched all the time and it batters ya head more"* (QW10)

> *"I've used more drugs at longer periods of time inside prison than outside prison, I don't know why it is, I think it's because we were all so close together and it's always there and it's always about and it becomes just a habit and a way of life"* (IW7)

> *"it's like a trigger it is, one does it and somebody else is going to do it, I get so depressed that I end up doing it because them cutting up is bringing back my problems in my head, it's making me do it, I'm not cutting up because they're cutting up it's just because I have a wave of problems coming to hit you in the face"* (IW5)

> *"I think some people do a little bit of copycat self-harming, they're quite impressionable some of them"* (IS9)

This dialect (Olsen, 2004) between the experiences of self-harm is seen in perceptions of the behaviour and the perceived function that self-harm serves for women in prison. Questionnaire information demonstrates this in which 57 (83%) members of staff indicate self-harm is used as a method of gaining attention compared with just 9 (18%) women. Similarly whilst 49 (75%) staff members suggest self-harm is sometimes used to manipulate only 2 (4%) women reported this as a function of their self-harm. These differences in experience will undoubtedly cause tension and suspicion as to the motivations for self-harm. However as table 3 highlights staff overestimated the prevalence of all the possible underlying factors for self-harm.

Table 3 Reasons Given or Understood for Self-Harm

Reason given or understood for self-harm	Women's response (%)	Staff response (%)
Express emotion	66	90
To cope with mental health difficulties	50	76
To survive unbearable experiences from the past.	46	76
To punish self	38	72
To feel in control	24	85
To get help/attention	18	82
Enjoyment/get a 'buzz'	12	29
Sexual pleasure	0	23

These tensions however do not just exist between women and staff but within each of these groups too and figure 16 illustrates the varying judgements about self-harm of staff and women in prison. In addition to the overt hostility of negative judgements a number of women were also concerned that their self-harm would be detrimental to their chances of release *"They think you're unstable don't they"* (IW11). Whilst the parole board were adamant that risk to self was not a consideration for release or progression (personal communication) this concern was also recognised and shared by some members of staff : "*it's a very strange thing to say that just because somebody self-harms, they're a risk to the community"* (IS6)

Figure 13 Varying Judgements about Self-Harm in the Prison

"I think some women do use it to manipulate to get their own way which is quite sad" (IS9)

"I don't go to the dining hall now because the first time I went to the dining hall and got 'you're dirty' you know, 'dirty bitch' and that there and 'oh she's probably got Hep C'" (IW5)

"We have prolific self-harmers and others that just sometimes do it for attention…I think is terrible because I do think some of the self-harm is because they're ill but a lot of it is because they're bad and I say, it's usually staff that suffer" (IS12)

"it moved to getting attention, to getting burn packs, I was putting big holes in my arms for a burn pack but I think my head had gone…You name it, if I thought I could get something out of the system like a phone call to home I would cut up" (IW3)

"Staff [need] to have a better insight and a better attitude towards girls on ACCTS and more understanding about how girls really feel" (PW5)

"I think one big issue is people need to see it not as a form of manipulation, that really, really offends me when people say that they are self-harming because they want attention" (IS6)

"that attitude that people are being silly, it's made things worse. The pressure to come off the ACCTs before they feel that they're ready, has actually made things worse for some of them" (IS3)

"I think some of the officers don't understand self-harm and should be trained more because I feel that some of them think its manipulation" (PW1)

Judgements about self-harm in the prison will be returned to in the consideration of staff capability with a discussion of what functions these moral positions may serve for those who hold them. It is apparent however that the prison environment is experienced as being hostile. This is due to the attitudes of others (both staff and women), the frustration and the boredom the environment instils, or due to the proximity with other women.

Mental Health

All that has been reported so far will inevitably have implications for the mental health of women and staff in the prison environment. The implications for staff are discussed in the following section so here I will consider the mental health of women in prison.

25 women (50%) who completed questionnaires stated that self-harm was used to cope with mental health difficulties. 40 (80%) of the 50 women directly linked their use of self-harm to previous traumatic experiences. 18 (36%) women stated self-harm was used to end flashbacks and three women (6%) cited this as the most common reasons for their self-harm. When women felt able to share these experiences they were commonly ones of repeated sexual and physical violence, often perpetrated by family members. These left women feeling shame and guilt and experiencing nightmares and issues with their body image:

> *"it's the underlying shame and guilt, I've always felt… it leads to all sorts of problems it eventually led to me stopping eating (which is another form of self-harm) to self-loathing because I didn't like the way my body looked…from one event and that one event made me think my body was wrong"* (IW10)

> *"I was drug free and I had suffered like nightmares, suffered with sleeping, how can I explain it, you feel like, you feel really heavy like you've got walls of worries… I wasn't eating and the past came back and all my emotions was back so I just used to do it to feel better"* (IW7)

The prison environment itself can exacerbate symptoms of post-traumatic stress and increase the feeling for women that they are not safe, especially around male officers at night:

> *"sometimes I get flashbacks…if a male officer says a certain word it's a flash back cus I've heard that before when I was a kid and like to be honest I don't really, well I do get on with male officers but I don't really speak you know, chat with them"* (IW7)

> *"It's like a certain voice, you know like a male voice and I think 'he's coming to get me' things like that, especially at night time and I hear staff walking down the corridor and they stop and you think 'he's trying to get in my room' it's horrible"* (IW1)

Despite the prevalence of mental health difficulties women in prison experience many felt that mental health resources were inadequate or there were gaps in service provision. The lack of counselling was an issue for many and one that was also noted by the Chief Inspector of Prisons in inspections in 2009 and 2011 (HMCIP, 2009, 2011). One member of staff who provided bereavement counselling reported that her waiting list was running to 12 months. One woman believed that counselling would not be beneficial unless its principles were more widely embraced by the prison regime:

> *"Counselling services might be helpful if it were to change the way the prison is run – otherwise it is a wasted exercise and could make matter worse i.e: by opening up personal vulnerabilities leaves us more vulnerable to the abusive aspects of the prison"* (QW42)

> *"each of my [ACCT] care plans have been 'refer to counselling, refer to counselling'"* (IW3)

There was a level of distrust in the Listener programme after a number of breaches of confidentiality; generally women did not feel that they could use this service to talk about their mental health. Although some could identify other women to talk to this was not always possible due to the prison regime. Furthermore the perceived[65] lack of 24 hour mental health care left some in crisis waiting for an appointment the next day. When women were in contact

with mental health professionals the impression given was that this was more about containment and maintenance rather than a recovery orientated approach:

> *"they say I've got border split personality or something like that, but I don't think I have, he hasn't even talked to me properly he's just came up with that the psychiatrist, like he just gives me anything to shut me up"* (IW7)

There was also understandable frustration at a lack of continuity in mental health care between the community and prison. Several women spoke of developing positive relationships with community services only to lose contact when imprisoned and having to start again from the beginning rebuilding trust and recounting their traumatic experiences:

> *"When my CPN comes to see me I feel I can't be truthful with her and I've tried working out why this is and I have spoken to a screw about it but it's something I need to work on as I am not really getting the help I need. When I was here last year I was doing CBT and things were going well, then I got out and was seeing my old mental health worker. I just got to trust him again and [came back to prison], now I have to build my trust back up with mental health team here."* (PW4)

The experience of prison for most women therefore is one of fragmented relationships both with loved ones and services. Those relationships which are more consistent, such as with other women and staff, require a balance to be struck between a need to develop meaningful bonds and suspicion of others' motives. The environment is generally hostile and the conditions of living intense and whilst, for some, the prison offers protective factors against self-harm for many others the experience exacerbates the need to find the relief that self-harm provides them. Both women and staff can be critical of the resources available in the prison and the next section will examine the current procedures for the care of self-harm and what alternatives and improvement are suggested.

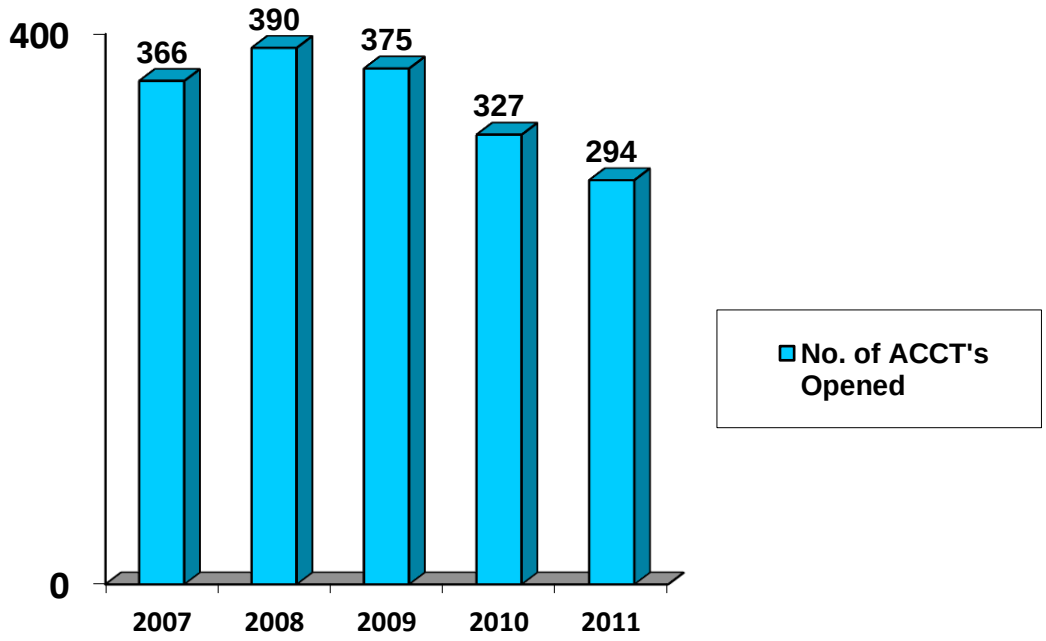
Current Procedures and Identification of Change

Once again three themes have been identified under this overarching theme and will be discussed individually. These are i) the ACCT process, ii) Staff capability and iii) identified areas for action and change.

The ACCT Process

As previously described the ACCT process is the primary mechanism for care and management of self-harm and risk of suicide. The ACCT process can be initiated by any member of staff if the prisoner is judged to be a risk to themselves, or following an actual incident of self-harm or attempted suicide. The process is intended to provide a psychosocial assessment of the person at risk as well as multidisciplinary case management are care planning. As can be seen in figure 17 the annual rates with which ACCTs have been opened between 2007 and 2011 have reduced after peaking in 2008.

Figure 14 The Annual Number of ACCTS Opened



Women's perception of the usefulness of ACCT was mixed. As illustrated in figure 18 more women disagreed or strongly disagreed with the statement 'ACCT helps me to stay safe' whilst 29 (58%) women reported feeling

embarrassed or ashamed when ‘on an ACCT’. Despite this more women agreed or strongly agreed with the statement ‘I am listened to in my ACCT reviews’ than not (see figure 19).

Figure 15 Responses to Questionnaire Item 20f

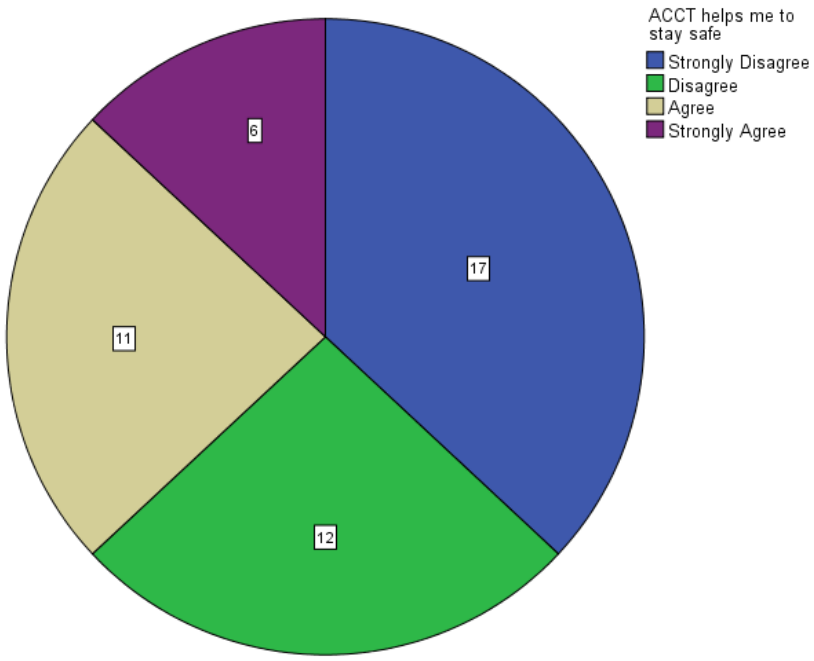
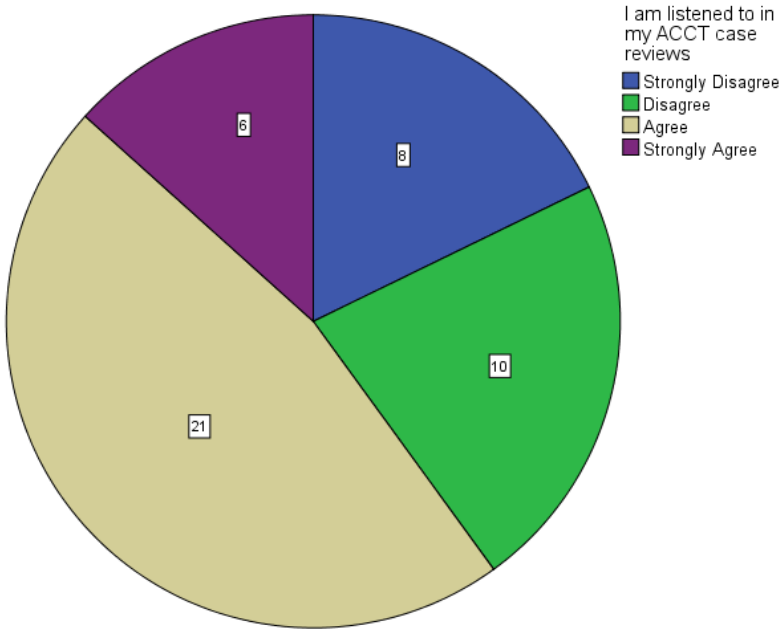


Figure 16 Responses to Questionnaire Item 20h



The reasons given as to why ACCT was not helpful were often due to the increased observation that the procedure placed women under and the disruption of sleep that being observed through the night entailed. This was often recognised by staff who felt that their hands were tied in the opening of ACCTs and adherence to procedure:

> *"I hate them…Because they watch you 24/7, like every 15 minutes they come and check"* (IW6)

> *"They make you worse, they come every 15 minutes, every 15 minutes they're at your door and during the night a big bang on your door to wake you up to make sure you're still awake, that makes you 10 times worse"* (IW4)

> *"even being on an ACCT right, I know this is gonna sound mental but even that can wind you up because when your head's all messed up and you're trying to get sleep and you just fall asleep and they turn your night light on and they look in and because they can't see you moving, they kick the door and wake you up again, well obviously then you're awake again and your head's like going again so in the end you end up sitting up at night and then ending up like cutting up and stuff"* (IW3)

> *"You see if somebody was waking me up 4 times an hour through the night, that would make me suicidal, you know, sometimes it's more negative than positive"* (IS9)

For some women the process of ACCT becomes a tool in order to be able to access services quicker; this was experienced by a number of staff in the process mapping event as ACCT being another tool with which women try to manipulate. A number of women also found ACCT to be just an unavoidable aspect of their self-harm and something to try and get off as quickly as possible. In both cases it is unclear what value the women actually placed on the process. The amount of paperwork involved in opening an ACCT and a subsequent reluctance in some to initiate the process was a theme raised by both women and members of staff. For staff this caused conflict and concern about the woman's safety whereas women interpreted this as disinterest in their welfare:

> *"they don't really want to listen to you because it's too much and if you did self-harm it's like 'fucking hell, we have to do like paperwork'"* (IW8)

> *"they'll report that they're encouraged to come off it before they sometimes feel ready…'we're told we don't need to be on it even if we feel as though we do', there is a certain amount of that goes on"* (IS12)

> *"I went to open an ACCT document, and the officers said "what you doing that for", you know its constantly like that, a real battle to open an ACCT"* (IS8)

The ACCT process requires an agreed number of observations of, or interactions with, the person at risk. This can vary from once a day up to constant observation, very often though a minimum number per hour is set. For many women this 'level of obs' is the key feature of ACCT and represents the prison service's main method of attempting to enforce abstinence from self-harm through direct observation. There is also a perception this is intended to provide protection to the staff from blame or litigation. As such many women do not perceive the process to be of benefit to them:

> *"I have self-harmed quite a few times being in jail and in my honest opinion ACCT'S do not work, for other people maybe, but if someone wants to self-harm, a few pieces of paper and an officer checking on you now and again isn't going to stop you."* (PW7)

> *"They put you on an ACCT and that's it, they've covered their own arses and they're not interested"* (IW9)

> *"The ACCT procedures which themselves can be quite traumatic, they have to sit through ACCT reviews; they have to sit through the whole process of assessments and reviews"* (IS11)

For those women who are assessed as being the greatest risk to themselves, either through self-harm or suicide, constant observations and safer cells are available through the ACCT review. Both of these resources were widely criticised as being punitive, distressing and unhelpful and a number of women reported that rather than reducing risk they had the opposite effect. Constant observations were also felt to be a wasted opportunity for the member of staff to sit and talk with the woman instead of just watching without interacting:

> *"It is also wrong putting you in the safe cell because it can make you feel worse than it did at the start because they have taken everything away from you so all you have to do is think about things, so the safe cell is like a form of punishment"* (PWanonymous2)

> *"most of us are so scared that we'll get stuck in a safe cell"* (IW10)

> *"you shouldn't go then and put a person in a room which they think is safe, it isn't, it's fucking far from safe… when they used to throw [another woman] in there she fucking cut up with a vengeance wouldn't she?"* (IW3)

> *"I think its* [constant obs] *degrading, you feel dead uncomfortable, you're sat in your room, you're watching telly but you can feel someone's eyes burning in your head just watching you. You've got to be watched having a bath or a shower, all that stuff, I don't like them me. I don't like them and it's not like they sit and talk to you about your problems, they'll have a conversation with you about where they've just*

been on holiday. You don't want to fucking hear that when you're in a place like this, you don't" (IW3)

Not all comments about the process were negative and some could see the value of the ACCT process attributing short comings to the way it was locally implemented rather than systemic failures. Some women described the process of observation as keeping them safe whereas staff commonly saw the strength of ACCT in the opportunity for a multidisciplinary approach:

"I think the ACCT process works pretty well when it's managed properly, that depends on the person who's the case manager really…if an ACCT's managed effectively and there's a multidisciplinary approach and in that the women herself is consulted" (IS6)

However multidisciplinary attendance in ACCT case reviews is usually the exception rather than the norm. In a brief audit of 63 case reviews in the first 6 months of 2010, 47 were attended by discipline staff only, 12 of which two Senior Officers were in attendance. 23 reviews were attended by healthcare staff but just one was attended by a member of the psychology team. There was no recorded attendance by the chaplaincy, education or work parties. As the above quote highlights the value of the procedure may be down to the capability of those who manage it.

Staff Capability

The OED (2012) defines capability as *the "Power or ability in general, whether physical or mental; capacity."* I have chosen to explore the execution of care and procedure in terms of staff capability in order to include both the group's ability, whether through personal attributes or training, as well as the power and capacity in which they can fulfil their job roles.

As noted already there was a perception by women that staff were sometimes uncaring or cynical towards self-harm. For some this was as a result of not fully understanding the behaviour with 33 (66%) women completing questionnaires indicating they did not agree with the statement 'staff understand why I self-harm':

> *"what gives them the rights to criticise when they don't know why you do it, they do not understand"* (IW9)

> *"People can be very rude, even some of the staff can look at you, I think it's mainly because they just don't understand and there should be a course for prison staff but there just isn't"* (IW5)

Staff too felt that they did not have adequate training about self-harm and that this contributed to their lack of knowledge and subsequent ability to provide care. The prison's training records indicated that in 2009 of the 410 staff in the prison 29% had not received any training in ACCT, despite this being mandatory for prison staff. Additionally 82% had not received any mental health awareness training whilst in post (Ward & Bailey, 2011). Of the staff who completed questionnaires 30 (40%) identified that they felt their knowledge of self-injury was a strength in their job role whilst 19 (28%) identified it as the 'biggest challenge they face in dealing with women who self-injure'. When answering the open question 'What would you like to help you support and help women who self-injure more effectively?' 29 (43%) responded that they needed training to develop their knowledge of self-injury. Written comments included:

> *"More training on how to deal with self-harm, not procedural systems"* (QS15)

> *"More help understanding self-harm issues"* (QS52)

It was apparent from these findings that staff felt they needed greater insight in to self-harm and not procedure as highlighted by the comment above. In comparison only 2 (2.9%) of the questionnaire respondents felt that their lack of knowledge of the ACCT process was a challenge they faced. This was a theme that also emerged through the interviews with staff:

> *"I think there might be an element of not understanding the reasons behind the self-harm with some staff so that might slightly hinder women"* (IS12)

Whilst understanding may certainly increase with additional training some of the criticisms levelled at staff by women appeared to relate more to attitude and a willingness to empathise with women.

> *"I don't think, especially* [Mr X] *and* [Mr Y] *know how to cope with self-harmers…he seems to run away from it, I tried telling him one day when it was my brother's anniversary, I tried telling him, do you know he walked straight off the wing, he wouldn't even stop"* (IW3).

Several members of staff discussed the importance of maintaining an emotional distance from their work, and by extension the women they work with:

> *"In essence I'm going to say something quite horrible, you treat them as like (pause) not human, I don't mean to say that, that's horrible, I don't mean that, you distance yourself from the person… I didn't mean to say they're not human, what I meant to say was I have to step outside of that and treat it erm almost as though it was an issue that I had to deal with rather than a human being, do you understand what I mean?"* (IS11)

This statement reflects the difficulty a number of staff had in describing how they managed the emotional impact of their job often through the objectification of women in prison. Staff also described how dealing with self-harm impacted upon their own mental health, sometimes making it more difficult to cope with difficulties in their personal life or previous traumatic experiences they have encountered in their working life. Yet despite this there was an expectation that they would still perform their duties:

.

> *"for me it's a feeling of hopelessness because I mentioned a couple of quite specific cases in* [Ms C] *and* [Ms G], *they're the extreme, they're the people who you struggle to deal with their self-harm because it's on-going, it's perpetual"* (IS11)

> *"I can think of one scenario* [when] *a woman set herself on fire. The two staff that found her and tried to save her, put the flames out, they were soaked, their uniform was soaked, they had burning skin still attached to their fingers but he* [the duty governor] *made them go out in the escort* [to hospital] *as well instead of getting somebody fresh to go out in the escort. So they were quite traumatised"* (IS7)

All of the prison officers I have spoken to over the last eight years have at least one 'horror' story of their own and many during interviews described the cumulative effect of self-harm upon them. Several members of staff described symptoms of post-traumatic stress including 'flashbacks' and anxiety.

Despite the levels of trauma experienced in prison resources available to staff to address these issues are as equally deficient as they are for women in prison. In questionnaires, 33 (48%) members of staff identified peer support as a significant strength in their job, only 17 (25%) indicated that their management were supportive and overall just 13 (19%) felt that they were adequately supported personally. 11 (16%) requested additional personal support for the impact self-harm has upon them personally. It was felt however that the prison environment not only contributed to mental ill health in staff but also prevented staff from seeking help with their wellbeing. For one member of staff this was an issue of gender however across the prison it was felt that asking for help was perceived as a weakness:

> *"there's a lot of bravado with the way men portray themselves"* (SI11)

> *"Staff don't want to look weak/can't cope so don't access Care First[66].* [support] *Could be mandatory!!"* (PS5)

This was particularly the case for wing staff who do not have access to the clinical supervision that healthcare and psychology staff do or the external support chaplaincy services do. This is despite prison officers often being those first to respond to incidents of self-harm.

Finally in respect to staff capability, capacity was frequently raised as an issue. A lack of time was the most frequently identified challenge in the care for self-harm in questionnaires (n=48, 70%). This was reflected in comments by women and staff. A lack of time was also identified as not creating enough *"space"* (IS6) in which staff could reflect, wind down or debrief from incidents. This lack of time as well as causing staff stress can also cause guilt or a feeling that they have not fulfilled their job role properly:

> *"*[following an incident] *they'll feel guilty because they'll say 'if I could have just had another 15 minutes with her, if I could have just sat down and spoke to her or you know she came and she asked to speak and I couldn't go at that point' or they'll go back later and somebody's cut up and they'll say, the women tried to say 'well I did try and come and speak to somebody but the staff weren't available' I think that's when staff feel guilty"* (IS4)

Interestingly the bureaucracy associated with completing incident report forms, the ACCT process and maintaining other records was cited as the reason for a lack of time and not necessarily the rates with which women self-harmed:

> *"we've got so much paperwork these days, so much computer work to do, I've got to get that done and you do get bad tempered sometimes"* (SI9)

> *"I know this sounds awful but* [what comes] *with self-harming is all your paper work and that sounds really quite cold and not very nice, but from the staff's point of view, when they're on a landing and they've been on that landing for 12 hours and somebody is self-harming all the time…"* (SI4)

Staff's capacity is also reduced by the prescriptive procedures which do not necessarily allow the time or flexibility for a truly individualised approach to care:

> *"The prison service in general is very focused on procedures, we have a set of procedures, you will follow those procedures but with an ACCT document… every self-harmer is different, every self-harmer has a different set of needs, every self-harmer has a different set of requirements… The problem is that we believe that as a service, we can introduce these procedures and that's it, that's the prison service, it ticks a set of boxes and that's our care provision"* (IS11)

Identification of Action

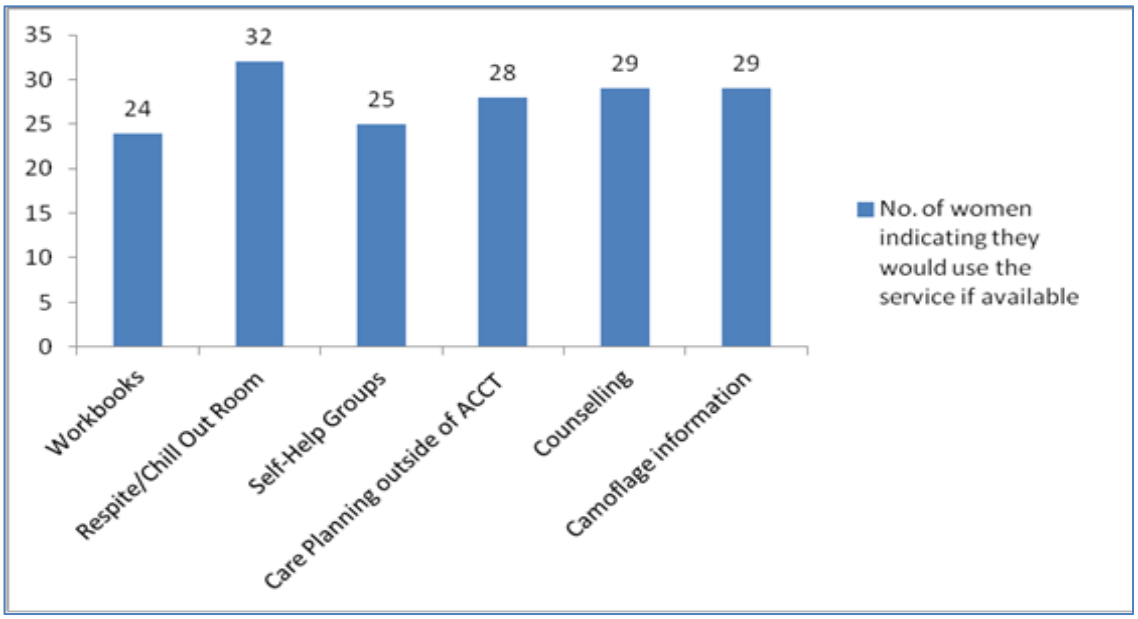
Throughout this chapter, whilst there has been acknowledgement of good practice by women and staff, the opinions about the prison environment, the care for self-harm, and the existing practices have been largely critical. The research process was not designed just to gather the experiences of those who

gave their time but also identify areas for change. Generally where there were criticisms clear actions for improvement could be identified.

Figure 20 illustrates the six services women most commonly said they would access if made available. Although, as can be seen, more women said they would access a 'chill out room' (a number of women reported having benefitted from similar resources in other prisons) and more formal intervention such as counselling and trauma focussed therapy (identified by staff), the opportunity to access peer support emerged through all methods of enquiry. Some women felt that this would be best accessed through a group whilst others felt a buddy or one-to-one mentor would be appropriate. However this was organised, it was clear that women felt the experience of those who self-harmed themselves would be invaluable:

> *"maybe like a self-harm group or something…I think they need to have a place where they feel safe, where maybe they'd be able to talk about the issues that's going on for them or whatever cus sometimes you can feel alone, you know what I mean so it would be nice to have a group I suppose"* (IW3)
>
> *"I'd love to be able to use all my energy that I've got now into helping other women and helping them"* (IW12)
>
> *"I think you should be allowed to have your friends in when you're feeling low to talk to them"* (IW1)
>
> *"it could be like one afternoon they might do a bit of therapeutic painting or whatever and then the next session would be where everyone's sitting down talking you know, over a cup of tea and a biscuit and that, it's just the little things that go a long way, that's what I find anyway"* (IW13)

Figure 17 Additional Service Needs Identified by Women



It was also clear that women were keen to be involved in making changes within the prison beyond taking part in questionnaires and interviews although they were well aware of the limitations of what was possible in the prison:

> *"oh I'd love to help someone else, you kind of get fulfilment out of it for yourself…but obviously with my record, my past and reputation etc, etc, I don't think they'd let me be in a position to do something like that which guts me because I know it would also help me"* (IW7)

With regards to what women wanted to happen immediately after they had self-harmed, 26 (52%) women wanted someone to listen to them whilst 15 (30%) preferred to be left alone. When considering care for their injuries just 5 (10%) wanted someone to dress the wounds for them compared to 17 (34%) who stated a preference for being able to care for themselves.

In response to criticisms about the ACCT process being finite and care plans not being carried forward when ACCTs were closed, women wanted workbooks and resources with which they could develop their own care plans and use structured self-help material.

Additional training and support were the two most common suggestions made by staff with the aim of impacting upon the culture and understanding of self-harm in the prison:

"I think we've got to change staff's attitudes towards the women who self-harm" (IS9)

"I think staff generally across the board would benefit from much better training on self-harm, functions of self-harm, what it is, what it's there for, what purposes it serves for that individual and what goals they're meeting through that" (IS6)

"aspirationally I would like to see a support service in for all staff, but for that to happen you'd need to be able to fund it which is a big issue and you need to be able to release those staff to attend which is an even bigger issue" (IS7)

"I would like to see training, and I'd also like to see some sort of supervision for them. I think it's very important for staff that they're not keeping those images and discussions to themselves" (IS5)

Conclusions

The themes that I believe have emerged from the research process highlight the necessity of self-harm for some women in prison, often as a result of their life experiences and the impact of these upon their mental wellbeing. This is further compounded by a hostile environment which restricts supportive relationships, can be abusive or trigger recollection of the experience of abuse, and which does not recognise the necessity of self-harm for some women. What also emerged from these findings are the opportunities for praxis and an eagerness by both women and staff to contribute to this. Chapter 9 will critically reflect upon the implications of these for emancipatory research, policy and practise as well as consider the limitations of the research and of the summary presented above.

Chapter 9

Critical Analysis

This chapter critically explores whether the original aim of the thesis, namely the development of a feminist informed framework for transformative research in a women's prison, has been achieved. Whether the aim has been realised will be discussed in relation to four key areas, already laid out in the thesis, and which are consistent with the FPAR approach the project aimed to employ. These are:

1. Praxis and achievement of institutional change
2. Methodological and theoretical frameworks
3. Ethical frameworks
4. Impact and implications for policy

Praxis and Institutional Change

Given that praxis is fundamentally linked to the notion of feminism (Lather, 1991) it is appropriate that this is the first criteria by which the research is critiqued. Lather (ibid) asserted that:

> *"In praxis-orientated inquiry, reciprocally educative process is more important than product as empowering methods contribute to consciousness-raising and transformative social action"* (p.72)

To what extent has the research process undertaken here, been mutually educative and consciousness raising? Undoubtedly both women's and staff's contributions have highlighted that the failure of prison policy to adequately consider aspects of gender has resulted in failings of care for women in prison. This is reflected in calls by women to have a choice of same sex ACCT case managers, a recommendation in the Mainstreaming Gender Report (DH, 2003), and criticism of the ACCT process and the consistent stress by women (both prisoners and staff) of the importance of good relationships in the delivery of care. These findings, along with placing gender at the centre of enquiry, are not unique and were previously considered by Corston (2007). What is unique,

however, is that this is the first attempt at emancipatory research specifically focussing upon self-harm within a women's prison.

Lather considered consciousness-raising as feminists answer to Gramsci's call for "praxis of the present" (in Lather, 1991). Whether the process has been consciousness-raising for the women involved specifically in relation to their oppression as a result of their gender (Sarachild, c.1978) is perhaps unclear, but was not the specific intention of the research. Women in prison are acutely aware of their position and oppression within the system as evident in the way they described the lack of control they could affect in their day to day lives and how this impact upon their use of self-harm. It can also be seen in the way women described how they were spoken to by some staff members and in the way some staff distanced themselves from prisoners through objectification. From discussing self-harm with me I doubt that there was any more insight to be gained than their daily lived experiences provided. The extent to which women's experiences differ from those of men's and how this may be a result of patriarchal hegemony would be interesting to explore in future research. Examination of the women's experience of the criminal justice system may be an area in which future feminist informed research could more readily achieve consciousness-raising of women's position. Consciousness-raising was achieved in other ways however, and in this sense I am confident that the process women became involved in and shaped enabled them to reflect more upon their own mental health, self-harm and the opportunities for change. I believe these to be more immediate concerns that, through addressing, will provide quick benefits which could form the foundations of future consciousness-raising. As evidence of this, I offer two pieces written by two women who gave their time to the project and who wrote of their experiences as stakeholders in it. I have deliberately not abridged their accounts as both women were keen to provide context and information about themselves and their lives. Although both women were keen to use their real names the prison has required the use of pseudonyms. The first is from a woman who generously gave her time over the whole three years of the project. She undertook most aspects of the research, in doing so contributing her experience

and artwork to produce staff-training, information for other women and visitors and consultancy on the development of a number other ‘products’.

My name is Sarah, I am a prisoner. I have an Indeterminate Sentence for Public Protection.

I self-harm and have done since a very young age. I went through a bad time when I was growing up and to me it was bad, but compared to some people’s lives it wasn’t. I lived with my grandparents from being born I called my Granddad Dad and I couldn’t do without them. I was 9 years old when they both suddenly got ill and then died within 6 weeks of each other. I was devastated and my life and world was destroyed within a couple of weeks. On the day of my Nan’s funeral I went to live a new life with my Mum, step dad and 4 siblings who I hardly knew, they were strangers to me. I felt uneasy around my step dad and felt him leering over me. I was never comfortable in the company of the strangers that had become my new family. I was always fighting with my brothers and sister, there were also physical fights with my step father neither of us was hurt but it took its toll. One day when I was 11 years old I released the sharp, silver blade from a pencil sharpener and cut a ladder of perfectly, neat rungs down the inside of my left arm. The surprising thing was that it didn’t even hurt and I didn’t feel that I was doing anything wrong. I knew though that I had to hide my secret escape-ladder. For the first time since my parents died I felt an immense relief from my tormented world of trauma, upset and grief. I felt alive again. I felt as though I could speak out loud, scream without anyone hearing me, because all that time, I was screaming inside and was about to explode.

A number of years down the line in prison, I met James who was working on research at the prison. He approached me to see if I wanted to take part in some work on self-harm and put a

staff training package together. I had more self-control by then and had been diagnosed with Bipolar Disorder and receiving help for that. Still I went away to give myself some time to think about the potential consequences of getting involved in something that was so close to me and was actually a part of me. I wasn't sure if I was willing to let strangers delve into my past and to know so much the where's and why's of my life. From discussing it, it turned out that it wasn't invasive at all, so I thought I'd give it a shot.

Taking part helped me in many ways including channel some pent up anger. We put together a small group of women who use or who had used self-harm to create a training package. People use it as a way of getting what they want to say across, but can't' express themselves in any other way. We created the training to particularly help staff, but also women in prison, to understand why some people self-harm and to explain what degrees someone is willing to go to for a release from the reality of the world they live in. I also worked with James to put together leaflets and posters with some of my art work and pieces of writing to show and describe what self-harm is all about, what it is and what it isn't.

I feel really proud of what I and others produced. It gave me a feeling of belonging and I didn't feel that I was the only one who had ever harmed myself because that's how self-harm made me feel, it like an outsider, alone, weak and unable to cope with life. I now feel as though I have got my point across and explained my part and why I do what I do without embarrassment. Taking part also gave me an insight into things I didn't quite understand about myself. I hope that it will help others to understand and maybe have a bit more empathy, not "sympathy" for those who self-harm in the future. I think we also showed that there are many reasons why people use self-harm and many types of

ways and that people harm themselves. I am so pleased that I was approached, but mostly pleased that I was given this chance, because now my problems are shared and now halved.

Thank you for taking your time to read this little snippet of my life that's so similar to that of many, many other people:

I am Sarah and I am a self-harmer, but I am also still human.

The second contribution is from the woman who had the courage to contribute to and deliver the staff training package.

My name is Sian and I am 29 years of age. I have one older sister and two younger brothers. My parents split up when I was young and I lived with my mum until I was about 7 years of age. A little while after my mother and father had split up my mum met a new partner who subsequently sexually abused me and all my siblings. Eventually the abuse came to light and we all went to live with my father. The abuse case came to court and my abuser was given 9 years imprisonment. My mother stuck by her partner and we never had any contact with her for the rest of our childhoods. I met my children's dad when I was 15 and at that time he was 20 years older than me. I had two children with him, my first being at 17 years old and the second when I was 18. I found being a young mum hard and on top of that my partner became very violent. I turned to drugs and eventually lost custody of my children to social services. My children have now been adopted for the past 7 years and I have no contact other than 'letter box' contact twice a year.

Before coming to prison I was committing crime on a daily basis in order to fuel my drug addiction to Heroin and Crack Cocaine. I was arrested for Robbery in 2005 and received an indeterminate sentence for public protection (IPP) with a tariff of

at least 2 ½ years to serve until I could be considered for parole. To date I have served 5 years 3 months and am due to sit my parole in 2 days. I have struggled throughout my life and sentence with regards to my mental health and have had issues surrounding the loss of my father in 2007. I had a bad drug habit for the first 2 ½ years of my sentence. My drug use certainly contributed to the many 'breakdowns' that I have had. When first coming to prison I did not have a good rapport with most of the staff, but as I have grown up and come to terms with my sentence and the death of my father I have become more willing to work with staff.

I have been diagnosed with a few mental health problems, the most recent being a personality disorder. I have in the past suffered auditory hallucinations, paranoia, threat and social anxiety, emotional disregulation and obsessive compulsive disorder (OCD). I have also been told that I have traits of Post-Traumatic Stress Disorder. I am quite an intelligent person and I have an exceptional insight into my own mental health problems, but it has only been since working with the 'At Arm's Length' project that I actually accepted I had self-harmed a lot more than I was ever willing to admit i.e. obsessive washing. Accepting that OCD has nearly always been a form of self-harm has made me accept that I will need help for years to come instead of putting it down to being "just a little stressed". It has been a relief to admit to myself that I am a self-harmer in regards to me OCD as I don't beat myself up about it as much as I used to.

I have always been able to have a good relationship with other prisoners, this is mainly due to the fact that I have been in prison many times before and have a reputation as being a firm but fair person. I also have the ability to empathise with other ladies in prison as there is not much I haven't been through myself.

People interest me and I will always give someone a chance. I have better relationships with people when I am in prison and I am not focussed on drugs all of the time. When I used to be out of prison I had no time for anyone, all that interested me was taking drugs.

I have been resuscitated a couple of times after tying ligatures but I don't 'cut up'. I have self-harmed through limiting my food intake and washing obsessively. I have had a lot of experience of being around others that self-harm and believe that I have a good understanding of the reasons why they do it. Even though I have been in prison a long time I still find it hard to deal with. The way staff deal with self-harm, in my opinion, is quite good. You do get staff that aren't helpful but then you get staff that will always go out of their way to try to help and understand. You get good and bad in all areas of life and prison is no different to that.

I didn't know anything about the 'At Arm's Length' project until I found out that my name had been put forward as someone who had the ability to deliver PowerPoint presentations. Once I was introduced to James, the research associate, I had a look over the material and decided that it was something I would like to be involved with. I did have reservations about my ability to deliver presentations to staff, not because I didn't think I was capable, I just doubted myself being able to put aside the irrational assumptions I was thinking in regards to staff opinion of me. But I decided to stick it out regardless. I felt that, as an prisoner, I had somewhat of a responsibility towards the girls who had worked with James to make the project as they had put so much work in to it and in a way I felt like I was representing them. There were times when, mostly due to nerves, I didn't want to turn up but I did and I am glad not that I was as determined as I have gained so much confidence from it. My self-esteem and

confidence have grown since getting involved with the 'Arm's Length' and I have greater understanding of self-harm. The most important thing to me though is that I feel like the presentations are making a difference.

The response from staff has been a lot different than what I expected it to be. When we first started to roll out the presentations I thought that most staff would be sitting there thinking it was wrong for a prisoner to be telling them about anything, let alone self-harm which they deal with first hand on a daily basis. I assumed they would be looking at me with the opinion I had no right to tell them nothing as I was a prisoner. How wrong I was! The staff listen to what I have to say and it appears they appreciate the insight in to self-harm they get being as they get it from an prisoner's point of view. This is also reflected in the questions I get asked after almost each presentation and the comments that are written on the feedback forms. In my opinion I feel that the staff are different towards me as it seems they now feel they can approach me and ask me things without them worrying whether or not they are going to offend me.

I think that the awareness sessions have made a big difference and have given the staff a better understanding of self-harm in general. I believe the officers now feel that what they are doing is right which makes making them more confident in dealing with and helping self-harmers. Most importantly I believe it has gone a long way in addressing the prisoner-officer divide and as a prisoner it has been overwhelming the support and the positivity shown towards me. The staff's eagerness to engage and learn more, not just about self-harm but other subjects such as drugs, domestic violence etc. The staff are also utilising the packs[67] and I have seen them using them with confidence. The activity boxes[68], in my opinion, in the past have been viewed as nothing

more than a waste of time, whereas the packs are being used as a legitimate tool that can help not only the women help themselves, but also help the staff help the women. I don't think that there is a prison in this country that wouldn't benefit from the same kind of awareness programmes.

For these women, their active involvement was consciousness-raising and reciprocally educative in a number of ways. For both it helped them better understand their own and other women's mental health whilst reducing feelings of isolation. For Sian involvement provided an opportunity to acknowledge her own needs which she found a *"a relief*". Their involvement in the training of staff challenged the concept of staff as experts and was informative in terms of the degree of change women in prison can effect. Their involvement also encouraged them to consider other women's mental health. Sarah said she would now strive to have more empathy for her peers whilst Sian clearly described to staff how self-harm impacts upon the lives of other women on the wings and how in the past this caused her frustration and resentment. The benefits for Sarah and Sian appeared to go beyond the educative, with both women describing the positive impact contributing to change had upon their self-esteem and confidence.

Lather (1991) rejected 'products' as an aim of praxis in favour of consciousness-raising with the intention of social action. Millen (1997) however expressed concern that such consciousness-raising without institutional change undermines women's existing ways of coping with oppression, ultimately leaving them more vulnerable. I maintain that the establishment of a lasting political movement aimed at *"changing their own oppressed realities"* (Lather, p.76) is not possible within the current prison system for a number of reasons. Firstly the security structures that exist would not allow the formation of such an overtly political group. Secondly women in prison are generally so disenfranchised and their circumstances so marginalised that their lifestyles whilst in prison do not provide the time or the resources with which to establish such a group. Finally the short sentences women receive, the lack of access to prison once released, and the large geographical spread once released means

it unlikely a coherent group could form from which social action could develop. Whilst a social movement organisation within prison may be desirable, I maintain that the most pragmatic way of effecting change is through the development of tangible 'products' developed through FPAR which aim to impact upon the immediate circumstances of women in prison as well as impact upon the custodial culture. Such a specific problem-solving approach, therefore, does not leave women vulnerable or remove current methods of coping but effects change and challenges the power dynamics that exist.

As was illustrated in the previous chapter (see figure 20) women who participated were clear about immediate courses of action that could be undertaken to improve the care they received. Similarly, staff were clear about resources that could be made available to them to assist in their delivery of care. In all, five significant 'products' were developed and implemented as a direct result of the contributions to the research by the women and staff. The development and implementation of each product was discussed in focus groups with women before and after negotiation with the prison management based upon the suggestions and findings of the research phases.

As alluded to by Sarah and Sian above, in response to requests by both staff and women for additional training about self-harm, a brief 30 minute 'awareness session' was developed. Written by a small group of women the session aimed to convey both their experiences of good and bad care for self-harm, the impact of the prison environment and to offer guidance on care based upon these insights. Entitled 'At Arm's Length' the session was co-delivered by Sian to 109 members of staff including the prison's Senior Management Team. Primarily intended to increase the confidence of staff in responding to women in crisis, the session stressed the importance of empathy, listening and positive working relationships. Through Sian's delivery the session also challenged the power relationship by placing the women in the position of being the expert. This was very much reflected in the senior managements concerns about a 'prisoner training staff' and how this would be received. One example of such a concern was in the concession made to describe the package as 'staff awareness' and not training. These concerns however, proved to be unfounded and whilst

attendance to the session was not compulsory, those who did attend reported finding the experiential expertise (Beresford, 2000) of the women useful in their day to day work. Whilst SUI in training is well established (Gregor & Smith, 2009) and packages exist for self-harm in relation to secure environments' (see work by Harm-Ed or Moores, Fish & Duperouzel, 2011) this is, to my knowledge, the first example of SUI in training by women in prison. A fuller description of the package and its development has since been published (Ward, Bailey & Boyd, 2012).

Given that 80% of women directly attributed traumatic experiences to their use of self-harm a 'Trauma Service' was developed by the prison's contracted mental health providers and implemented through this project. In response to women's requests for self-help groups and their experience of isolation in relation to their mental health, the central tenet of the newly developed service was the establishment of peer supportive, democratically directed groups in which women could share experiences and decide the format and the content of future sessions. This broadly reflected the feminist therapy of Liebling and Chipchase (1996) and again challenged the dominant medical discourse of mental health services by empowering through choice and acknowledgement of experiential expertise. Women who accessed the groups stated that the self-directional and relational elements of the groups were the most beneficial aspects. To further empower women in their own care for their mental health, a library of self-help and educational material was purchased as a part of the service and was freely available to all women in the prison through the library. This was established with similar intents to that of the women's health movement (Evan, Head and Speller, 1994) to empower women to understand and begin to meet their own health needs (Hastie, Porch, & Brown, 1995) as well as 'normalise' mental health particularly in relation to abnormal experiences such as abuse (Herman, 1992).

It was with similar aims that we (women and myself) developed 'therapeutically informed in-cell activities'. These were created following criticism that the then current distractions available for women to have in their room were either too difficult for some (e.g. crosswords) or not age appropriate (e.g. colouring books)

and that women felt they were not always heard in ACCT case reviews. The workbooks were developed to assist women in developing their own care plans by considering ways of increasing their own wellbeing whilst in prison and identifying sources of support they could enlist to achieve this. Women were given control over the completed workbooks and over who had access to them but with the suggestion that they could be shared with ACCT case managers (should she be on an ACCT) or other sources of support in the prison. Key sources of peer support, including Listeners and Welfare Representatives, were given the workbooks as part of packs which also included information about self-harm (written by the same women who wrote the training package), and other distraction activities such as creative writing exercises, notebooks, emotion stickers and puzzles. The packs were supplemented by the fourth major initiative of the project, the training of women in peer support roles in Mental Health First Aid. This again challenged the existing norm of mental health knowledge being held solely by clinical services and promoted the knowledge and discussion of mental health issues amongst a wider group.

It is also worth noting that support and funding was secured for the development of a sensory room. Having been identified as a useful resource by women who had used them in other prisons, a multi-sensory room was installed which aimed to use light and sound to create a calming environment, away from the wing, and in which women could try to calm feelings of anger that often resulted in the self-directed aggression women described.

One area in which institutional change was regrettably not possible was that of self-harm minimisation. Policy implications are dealt with later in this chapter; however it was clear that the prison service's policy regarding harm minimisation is contradictory. This was clearly reflected in the discrepancies between PSO2700 and PSO4800, and the services position regarding harm minimisation for substance misuse. It was clear from the accounts that a number of women gave that the removal of means by which to self-harm, and the abstinence that the prison tries to enforce, is not only futile but potentially dangerous. The prison services position of requiring cessation and not allowing for self-harm minimisation result in what I consider to be the key dialectic that

influences the care for self-harm. On the one-hand, both women and staff recognised the necessity of self-harm for women in prison and the potential benefits of self-harm minimisation in promoting control and ownership of self-harm, as well as reducing risk to the individual. Yet despite this, and the contradictions in relation to other high risk behaviours, there remains no accommodation for self-harm minimisation resulting in a culture of fear which does not consider positive risk taking. On the one side hand of the dialect is the emphasis of staff's role to stop or prevent self-harm. On the other side the women's inability to do so results in pressure upon both parties and further contributes to the 'them and us' division that typifies prisoner-staff relations. As seen in women's accounts, this resulted in secret self-harm, escalating severity and the use of more desperate means, arguably increasing the risk of unintentional injury or complications.

Efforts were made to develop harm-minimisation and a proposal to provide dressings and materials usually available 'over the counter' to suitably assessed women was made (see appendix J)[69]. Whilst the proposal was supported by the PCT's Clinical Governance Committee, the prison service's Safer Custody Policy Team did not support it and were concerned that it undermined the services 'duty of care'. A second compromise proposal was developed following discussions with the prison service (see appendix K) yet this was never agreed and I suspect the policy team stalled knowing the finite timescale of the project. That the proposal was not accepted was not surprising and, unlike the other products that were successfully introduced, the harm minimisation agenda did not receive any support from the prison's senior or healthcare management. Despite this lack of local support the agenda was taken to a national level, moving beyond Liebling's (2001) 'prudent engagement' due to the importance of self-harm minimisation to the women in prison and the impetus I felt to ensure women's voices were heard at a policy making level regarding this topic. It is worth stating that whilst self-harm minimisation is an agenda that should be pursued this needs to be done in such a way as to balance empowering women with choice and responsibility for their behaviour and without absolving the institution of responsibility. Fairweather (1979), criticised the male left for adopting a pro-choice stance on the abortion debate

as a way of conveniently absolving men of responsibility for their sexuality. It is possible to level a similar criticism at the adoption of the harm minimisation debate by suggesting it absolves men of responsibility for the abuse of power that is often the cause of self-harm. Harm minimisation in prisons (or any other organisation) should not absolve the institution of responsibility towards the person. On the contrary, the practice should form the basis of the duty of care to the individual for the reasons of compassion, acceptance and pragmatism laid out in chapter 5. It is, perhaps, the prison services inability to provide care for women who have been victimised that prevents the adoption of self-harm minimisation. Rather than accept this shortcoming it is more politically acceptable (for the prison service not those in prison) to create a duty of care that precludes self-harm minimisation.

Despite the inability to develop a harm minimisation agenda I assert that, in respect of praxis and institutional change, the project was successful. These were achieved however not through Liebling's (2001) prudent, reserved engagement, but through pragmatic assertion. This I define as the challenge of power when required whilst conceding to power when compromise is necessary in order to achieve a greater goal. Power, in this instance, being defined as the decision by the prison's senior management to allow the introduction of an initiative or not. As previously highlighted Liebling's concept of prudent engagement was used to describe a necessary sympathy for both the prison authorities as well as the prisoners. Whilst an understanding of the power dynamics that even senior prison managers are subject too is necessary in pragmatic assertion I argue that assertion is the opposite of reserve. 'Reserved' as used by Leibling could be defined as

> *Averse to showing familiarity; slow or reluctant to reveal emotion or opinions; cold or distant in manner, formal; reticent, uncommunicative* (OED, 2013)

Or

> *Limited, restricted; restrained, temperate, cautious, sparing* (OED, 2013)

In either case the use of reservation to discuss such emotive and radical concepts such as harm minimisation would have been to do a disservice to the women involved. There was no place for reservation of emotion when highlighting the emotional distress that women who are prevented from self-harming experience. Nor was there place for reservation through limitation or caution given the risk averse nature of the prison environment. Simply put pragmatic assertion was used to push for certain changes even with the knowledge that perhaps those that were being pushed (usually the Governing Governor) were limited in their own power. Whilst this may or may not have been uncomfortable for him to not have asserted the importance, to have been more reserved, would have likely to have resulted in less chance of change.

Pragmatic assertion therefore was used to pursue the harm minimisation agenda in the face of a lack of local and national support from most colleagues (with the exception of my academic supervisors). It was also used to insist upon a woman in prison delivering the training to staff despite the concerns outlined above. The other side of this being the concession that non-injurious ways of causing pain such as wax strips and elastic bands could not be introduced, nor could we provide red marker pens to simulate cuts due to concerns of graffiti to prison property. Deciding which battle to fight in a pragmatically assertive way was based upon the weight of importance the women involved placed upon each proposal. Although this was never quantified it was clear through our discussions in focus groups that for some the introduction of harm minimisation was potentially a matter of life and death. This is also borne out by the testimony of women during interviews. Similarly emphasis was placed upon the need to develop staff's understanding of self-harm in order to improve care, and there was a strong feeling that this would be better furthered by women with first hand expertise in the subject. By comparison although it was acknowledged by the group that non-injurious forms of self-harm are beneficial for some, for others they are not. The decision whether to assertively pursue an initiative therefore was the product of not only the perceived importance of initiative by the women but also the utility of it to the wider population of women. As is evident with the example of the harm minimisation agenda such an approach does not guarantee success however I

believe that it managed to progress the issue further than a reserved, prudent approach would have done.

I am confident that the approach used was not only consciousness raising for Sarah and Sian but for all the women who contributed and subsequently saw the change that their work created. The products developed have not only provided additional resources to women and staff for the care of self-harm but also challenged the existing power structures within the prison. Women were empowered through the acknowledgement and utilisation of their expertise in the development of the products and in training staff. Empowerment was also realised through providing women with information and choices regarding their own care. Unfortunately, the project was unable to extend this to include self-harm minimisation yet I would argue that there is still a degree of success to be gleaned from this as not only was the original proposal accepted by Clinical Governance but that dialogue about the issue also opened up. Of course, effecting change alone is not sufficient to claim that this research used feminist and emancipatory approaches. To further explore whether this was the case the methodology employed and how it was informed by the theoretical framework will now be considered.

Methodological and Theoretical Frameworks

The methodology employed throughout the project was informed by feminist principles and the characteristics of action research. This was challenging given the constraints that the prison environment imposes.

The research employed both methodological (Olsen, 2004) and data (Guion, Diehl & McDonald, 2011) triangulation to increase depth of knowledge and compare different perspectives. This was entirely compatible with a feminist approach (Oakley, 1998) and did not lessen the primacy of women's voices. Throughout the analysis women's narratives were given the privilege that they deserved and demanded but were also supported through the survey and quantitative data collected. Whilst I do not assert that this added 'validity' to the women's accounts it will be a consideration for some, especially given the empirical approach most usually adopted in the study of self-harm. That

women's accounts of the impact of the prison environment and its regime were confirmed by other sources of information surely dispels any doubts or scepticism about the 'truth' of women's testimonies that may arise, especially due to their status as offenders. As identified in the literature review the use of mixed methods is underused in the study of self-harm and, despite recommendations for more qualitative research (NICE, 2004), it does not appear to have happened. In the case of psychosocial interventions this has resulted in inconclusive evidence, the use of irrelevant treatment targets and a failure to consider the experiences of those who access the services. Where service user organisations have employed mixed methods (BCSW, 1994a; 1994b) these have never accounted for women in prison. Whilst the use of questionnaires and process mapping may not be typical of feminist approaches they were conducted in a way that was informed by feminist principles. For women who requested assistance in completing questionnaires this was done in a discursive way and I either read aloud the questions and discussed the woman's response or gave concrete examples of clarified questions as was required. This was also similar to the process mapping events in which we discussed systems of care both as a whole group or sub-groups of women. In both instances there were more similarities than differences between these methods of data collection and the interviews. (My relationship with the women is discussed in the context of ethics and power below).

Through the inclusion of both women's and staff's narratives, dialectics were discovered that gave a more detailed and complex accounts of self-harm in the prison. These were uncovered through a methodological framework that was accepting of people's perspectives and allowed women to discuss their relationships with staff, opinions of care and experiences of self-harm. Women's self-harm could not be understood without giving consideration to the relationships and experiences they had with prison staff, which in turn were influenced by staff's own moral codes towards the behaviour (Cresswell & Karimova, 2010). In addition to the dialectic between women's need to self-harm and staff's need to prevent or stop it, an important tension also exists around the utility and function of self-harm. Prevalent attitudes about the use of self-harm to manipulate, seek attention or to achieve personal gain are

undeniably stigmatising and detrimental to care (Pembroke, 1994; Kenning *et al.,* 2010) and continue to be found (Saunders *et al.,* 2012) despite being highlighted by Pembroke 18 years ago. This research demonstrated that staff over-estimate these as reasons for self-harm. This is further complicated however, by the recognition that these perceptions were also held by women and evidenced in the claim, by some, that they had used self-harm as a resource with the hope of obtaining tobacco, care, or some other need that was met through an external source. This appears to create an environment in which suspicion as to the motivation for self-harm results in disengagement (Shaw, 2002) leaving the woman, who is already disempowered by her position, even fewer options to meet her needs, thus increasing the likelihood of the use self-harm as a tool for meeting such needs.

The inclusion of staff's narratives provided an appreciation from their perspective and it is clear that disengagement from self-harm also represents an attempt at self-preservation, due to the lack of support received to manage the trauma staff experience in the prison environment. This was most clearly seen in the accounts of some staff who (sometimes reluctantly) acknowledged dehumanising women who self-harmed in order to perform their job roles.

The use of triangulating mixed methods and sources therefore provided a depth of knowledge beyond what was *"easily measureable"* (Liebling & Arnold, 2004) and insight as to the relationship between women, staff, and prison policy. It also ensured a holistic approach to the study of self-harm as advocated by Warner and Spandler (2012) to account for thoughts, feelings and behaviours in relation to self-harm and the care given and received. This was invaluable in being able to acknowledge the strengths as well as the weaknesses in staff capability and prison policy; in turn this strengthened the position from which to negotiate change whilst remaining sympathetic to both women and prison staff who may also have been subjugated by the system (Liebling 2004).

Not all women or staff were included in the research. This was particularly the case for women whose participation was prevented as a result of mental health staff's concern about the possible negative impact of the research. Arguably,

these were the women who are most marginalised by the system and removal of their choice to become involved was just one example in which their choices were restricted. Similarly, staff who hold particularly negative attitudes towards self-harm may have chosen not to participate and contribute to the research. Whilst this did not detract in any way from the narratives that were collected (I was not concerned about 'representativeness') it remains imperative that these people's experiences are heard as they are the most likely to be accessing care or delivering poor care. Similarly the experiences of women who did not self-harm but who, nonetheless, will have been affected by other women's self-harm were not sought. Again these perspectives would further enrich the understanding of self-harm in prisons and the dynamics that exist around this. In this instance resources would not permit such a wide scale engagement of the whole prison. It is only through conducting detailed research on high-risk behaviours such as self-harm and highlighting that, far from the concerns that REC's and healthcare professionals have about increasing risk, the opposite is true that such fears will be allayed. Positive outcomes stem from using methodologies which share responsibilities with service users, rather than approaches which seeks to protect and in doing so patronise (Faulkner, 2000) service users. This sharing of responsibility allowed women in prison to co-ordinate their own appointments and identify sources of support to use during interviews.

With regards to available resources one clear solution would be greater service user involvement, for example recruiting women as researchers. With the exception of Fine *et al's.,* (2004) PAR work I am not aware of this being done and consideration would need to be given to issues of maintaining confidentiality in such an enclosed environment. Service user led research is clearly desirable though and would yield a greater depth of knowledge, act as a consciousness raising exercise and provide research skills for women. NOMS is becoming increasingly open to the politics of SUI, as evidenced by its recent commissioned report completed by Clinks identifying best practice of SUI in prisons and probation trusts (Clinks, 2011). The training package 'At Arm's Length' was recognised as one example of this. There were, however, no examples of service user led projects in the report. I believe that this research,

through challenging some of the existing structures around expertise, has in some respects paved the way for future service user led research in prisons and that this is more likely to be politically acceptable than when this project started in 2009.

I am also confident that the project fulfils the definition and obligations of PAR and provides just the second example of the frameworks use in a prison. Wadsworth (1998) and Mills (2000) define PAR as the participation of different stakeholders in the research. This was certainly the case throughout this project and is reflected in the involvement of both women and staff. Through engaging both of these groups it was possible to get a fuller understanding of and influence upon the culture that surrounds self-harm and its care. Similarly Baum, MacDougall & Smith (2006) characterise PAR as being vigilante of the power relationships that exist within research. The power dynamics present during this project have been comprehensively discussed. Baum *et al.,* (2006) concede that the degree to which involvement in health research will vary, as will the willingness of individuals to become involved. Given this I would assert that despite acknowledgements that greater involvement would be desirable, and maybe possible in the future, the fact that aspects of this research did not involve staff or women does not detract from it being PAR in nature. Finally Baum *et al.,* (2006) and Hanson & Lown (2010) describe the process of PAR as cyclical, cumulative and reflective. This has been followed in the way information gathering has been conducted in stages throughout this project and through the use of focus groups and discussion to reflect upon the information gathered prior to action being planned.

Whilst triangulation of methods and data sources is not unique in prison research, this is the first time it has been used to study women's self-harm in prison. I have already established that there has been little feminist critique or account of the situation of women in prison and whilst feminist survivor movements have tackled the issue of self-harm, again this has failed to enter the prison environment. Whilst the methods and theory employed in this research are far from perfect I would maintain that they provide a framework for future emancipatory research in a prison environment. The use of mixed methods provides an additional depth of knowledge and information that does

not detract from the experience of women but instead compliments it through providing context and an institution-wide perspective. Similarly, the combining of feminist research with the problem solving approach of PAR has enabled both the 'safe' empowerment of women who are marginalised through challenge to the existing hegemony as well as the delivery of specific 'products' that change the women's immediate care experience. The use of both mixed methods and FPAR is the first time that these have been used in the exploration of self-harm in a women's prison and provides the opportunity for the development of truly responsive care at the centre of which is the recognition of differing gender needs.

Whilst the methods employed are compatible with a feminist approach, Millen (1997) highlights the problems of situating feminism purely within a methodological context, asserting instead that feminist research is better defined by epistemology and the values with which research is conducted. These relate to the theoretical underpinnings for FPAR that I aimed to adhere to. In chapter 3 I characterised feminist research in three ways: the epistemology, the purpose, and research relationships. In this discussion I have already covered epistemology in the methods by which information was obtained and the primacy given to women's accounts. I have also covered purpose in the discussion of praxis and institutional change. I will now consider my relationships with women who became involved and issues of their empowerment in relation to an ethical framework.

Ethical Frameworks

> *"It is not really possible for two persons to have a free relationship when one holds the balance of power over another"* (Sawyer, 1974 in Tolson, 1977, p.20)

Sawyer refers to the imbalance of power in social relations between men and women and the hegemony of successful masculinity being that which has dominance over women. As a man working with women this was relevant and

magnified by the masculine environment of the prison and the power my position as 'researcher' brought.

A considerable amount of time was given to emphasising free choice in participation and trying to make the process of involvement as democratic as possible. However, was this enough in order to address the obvious power imbalances that my position afforded me in relation to women in prison? Arguably not, and it would seem conceited and dishonest to suggest that reiteration of a woman's right to withdraw or choice in how and when she was interviewed was enough to address such a differential in power or the complexities of consent in a coercive environment (Dubler, 1982). The concept of truly equal researcher-researched relationships in any research has been criticised as illusionary (Kelly, *et al.,* 1994, p.27) and if this is true, to suggest this was possible in prisons seems ridiculous. As such I cannot totally deny that elements of coercion (the antithesis of equal relationships) may have been present during the research process. However, to suggest coercion was a tool for recruitment or involvement is to deny women in prison any agency at all and to overlook the self-doubt and lack of confidence that often results from the position women in prison find themselves. Prior to delivering the staff training Sian often expressed anxiety, concern and doubt and each time I offered support, encouragement and reinforced the positive aspects of her work. There were times when I was required to give similar encouragement to women during interviews or focus groups. I do not consider this coercion but a way of discussing and addressing the causes of these feelings that the women experienced. Just as I have had to reflect upon my own anxieties and doubts. This I believe to be the essence of a collaborative working relationship and a necessary tool in making women aware of their skills and abilities to effect change.

I was also privileged in the interpretation of the information women gave me, especially in this thesis but also in the presentation of findings to the prison and Primary Care Trust. Millen (1997), however, highlighted that analysis of experience does not necessarily amount to exploitation highlighting that even misinterpretation by the researcher will not change the construction of the

experience for the woman herself. Whilst women were, perhaps, in the difficult position of having to disagree with my interpretations, I am confident that through our working relationship it was understood that I was open to critique. I do accept, however, that given my position and my masculinity this may have been difficult to do. My masculinity has undoubtedly had a bearing upon the research findings. My masculinity may have negatively impacted on my ability to form the type of close relationship that can lead to greater depth of information (Oakley, 1981) especially if I accept Seidler's (1991) assertion that as a man I am inculcated to be divorced from my emotions. However, my otherness to women was not solely a result of my being male but also a result of my position within the prison, a position that would set apart any researcher regardless of gender. Carlen (1983) described the Catch 22 position women in prison find themselves in with regards to discussing their private lives and how once these are discussed they become *"public property"* (p.102). Carlen describes how, from her observations, women in prison were often reprimanded for being too needy if they disclosed how they were feeling or too distant if this was kept private. In either case the woman is considered an attention seeker. As discussed in Chapter 6, the prison is a hyper-masculine environment which expects a disconnect from one's emotions and that is at odds with the accepted construct of women being emotional. This disconnect is part of the problem with the current system of care in that it silences women and prevents discussions and relationships developing with staff. In this respect, too, women who self-harm experience "outsiderness" (Naples, 1996), possibly as a result of the expression of emotion that self-harm conveys. This is clear from requests for additional peer support and better understanding about self-harm. For some women the purpose of self-harm, including substance use and deliberately not contacting family whilst in prison, is to disconnect from overwhelming and distressing emotions. The establishment of emotional connections through close relationships is potentially harmful for someone who does not have the coping strategies to deal with the possible consequences in an environment that is poorly equipped to care for women in distress. As such, is it really necessary to develop an emotional connection in order to effect change? I would argue that whilst an emotional connection is desirable it is not a requirement. Throughout the three years of the project I developed different relationships with

different women. For some these differences will have been a result of my masculinity, for others it will have been other factors. In many cases I used my 'insider' status to develop relationships through my knowledge of the prison system and an appreciation of its effects, whilst simultaneously stressing outsiderness to women's experiences but a desire to learn from them.

I am confident that the relationships developed were collaborative, respectful, mutually educative and beneficial. Whilst my position and knowledge lead me to 'veto' some suggestions (such as the Rubik's cube) so too did women's experience and knowledge reign in some of my ideas (providing elastic bands for example) and contributed more to the projects products than I could have. I would argue that in relation to Rose's (2003) continuum, overall this research was placed between collaboration and user led research with various aspects of the process moving along this line. Whilst this was empowering to those involved a pertinent question would be *'have women been empowered to do what was required of them and not necessarily what they want to do or express?'* (see Bowes, 1996). It is hard to argue that this isn't the case given that the research agenda, methods and analysis were not set or done by the women themselves. However, empowerment is a relative concept. Hannah-Moffat (2000) criticised the Correctional Services of Canada's definition of empowering women in prison as a sham due to the limited options presented to the women. Even service user led organisations working in prison such as User Voice have a set agenda (reducing re-offending) and acknowledge that prison is a limited democracy in the establishment of their prison councils. Similarly the aims of Michelle Fine's FPAR project, to establish an educational programme, already had a set agenda. Given the systematic curtailing of liberties that occurs in prisons it is doubtful that a fully democratically chosen research topic is achievable. To attempt or promise such freedom in setting an agenda is to offer Fraser's (1990) concept of a bourgeois version of democracy that attempts to ignore the stratified culture that exists within prisons. Regardless of the limitations of this research it is clear from the discussion above that women have been relatively empowered through greater access to information and peer support, the acknowledgement and the use of their knowledge and recognition of their expertise in self-harm. The products of the project have also

resulted in greater access to self-help material and information and choice in treatment. Although the agenda was chosen, the high rate of participation by women (89% of those approached completed questionnaires) and the disproportionate levels of self-harm within women's prison indicate that this is a topic that should be open to feminist critique. The changes in the involvement of service users prior to REC ethical clearance that has now come in to place would undoubtedly have allowed for greater collaboration in the way information was collected had this been available at the time and should form the basis of future emancipatory prison research.

Informing the PAR process with the values and principles of both feminism and SUI has provided resolutions to the ethical challenges that the prison environment presents. Values, including the emphasis upon the experience of the individual, the respect for the expertise that this brings and the sharing of goals and responsibilities, have overcome constraints such as limited confidentiality and the power imbalances that this brings. Some of the obstacles could not be overcome to the same extent that they could be in community settings and I cannot foresee research of any kind that would involve truly equal relationships in the prison environment. However, I would argue that one of the achievements of this project was the laying of a foundation through the improvement of care that, in the future, may allow for closer relationships (and consequently perhaps greater emotional connection) which in turn could develop further the care that women in prison receive.

Impact and Implications for Policy

Despite SUI being increasingly seen on the NOMS agenda over the last three years this has not yet resulted in specific policy relating to involvement in the development of services. Whilst the Clinks (2011) report illustrates some examples of best practice, the Sainsbury Centre's (2008) report highlighting a *"dearth"* of SUI seems as equally applicable today as when it was written. The concern about allowing a prisoner to train staff suggests a reluctance to implement SUI, probably as a result of suspicion as to the motives of 'offenders'. This suspicion is also seen in the care delivered in which staff misattribute the motives for self-harm. Yet the achievements of this project

indicate that this cynicism is misplaced and that given the opportunity for a stake in effecting positive change, women in prison will not abuse or corrupt this but give their time and effort, even when they cannot expect to directly benefit from the changes themselves.

The development of specific requirements for the involvement of offenders in the development and evaluation of systems of work would address a number of deficits in the current NOMS and offender health policies. SUI would enable the institutions to deliver truly responsive services and in the case of women's prisons ones that are sensitive to gender. That ACCT and prison policy, on the whole, remains gender neutral is not an inconsiderable oversight given the requirements of the Gender Equality Duty and recommendations by the Mainstreaming Gender (DH, 2003) and Corston (2007) reports. Requirements for SUI would also address the discrepancies between national health and offender health policies in which the latter does not accommodate for involvement despite the benefit that it brings. Guidelines such as those of the NICE (2004) highlight the damage that negative moral judgements around self-harm can cause and this is reflected in recommendations around appropriate language and equivalence of care. This has undoubtedly been a product of the awareness-raising of survivor activists. The women's narratives demonstrate that iatrogenic harm in prison is not just a result of negative moral judgements but also results from the regime itself whether this be boredom or the induction of flashbacks of abuse. If cultural and institutional changes are to be achieved in prisons then service users similarly need to be involved in highlighting detrimental practice, just as survivors continue to do in community settings. SUI will also increase accountability for delivering change which is particularly relevant given that only a small number of accepted recommendations from the Corston report have been implemented.

The highlighted need for additional training by both staff and women indicates that current training policy is inadequate. It appears that the ACCT process leaves staff feeling de-skilled, removing their ability to exercise judgement due to an aversion to risk whilst simultaneously increasing risk in women who find the process of observation intrusive and distressing. ACCT itself may not be

the problem but the way it is conducted (possibly due to the pressure that staff are under to prevent or manage self-harm) and the removal of responsibility and ownership from women that this entails. Again the incongruent policy that prevents harm minimisation also contributes to this. It would appear, just as survivor activists have been advocating, that a cultural shift is required within prison policies that moves away from the *management of self-harmers* to *care for people who self-harm*. This is comparable to the Mental Health Foundation's (2006 p.12) recommendation that healthcare providers need to examine their core values in the delivery of care. The argument that prison staff are not healthcare providers does not stand given i) the level of mental health problems people in prison experience, ii) the duty of care that, the service argues, prevents the implementation of harm minimisation and iii) the recommendations made by the Bradley (DH, 2009) and Improving Health Supporting Justice (DH, 2009) reports. That prison staff feel inadequately trained to provide mental health care strengthens the need for a reappraisal of the training policy and consideration of the impact SUI in training staff could have. This final point is reinforced in the comparison of the sheer amount of policy around the management of self-harm (e.g. PSO2700, PSO4800, Prison Standard 60 and local instructions) to the key messages of empathy and warmth that women stated were the fundamentals of good care. Warner and Spandler (2012) highlighted how policy based upon 'evidence based practice' fails to account for the individuality of self-harm and emphasises treatment (i.e. cessation) rather than principles of care, as proposed by the women in this research. It would appear that a focus on evidence based practice has resulted in a medicalisation of self-harm that leaves front line staff (officers who are not primarily trained in mental health) feeling further deskilled and unable to deliver care. This further results in distancing from self-harm at a time when women find an empathic response to be the most helpful.

A Framework for Future Emancipatory Research in Prisons

Throughout this thesis the balance between the principles and characteristics of feminism, service user involvement and participatory action research and the realities of the prison environment and life in prison for women and staff have been discussed. The research developing care for self-harm for women in

prison has sought to practically test this and has resulted in praxis. However the aim of this work is to develop a framework for future emancipatory and transformative research in prisons. Whilst there is no active service user movement within prisons it will be incumbent upon those instigating and conducting research in prisons to adopt and approach that is both emancipatory and transformative. It is impossible and undesirable to be prescriptive in the way such research should be conducted however I believe there are three major considerations in the planning and execution of emancipatory research in prisons. These are i) the principles and values in preparation for research ii) practicalities in involvement in research and iii) change through research.

i) Principles and values

The principles and values relate to personal qualities and dispositions that are required of those wanting to instigate emancipatory research in prisons. Many of my own values have been discussed through reflective autoethnography in chapter 6. In the development of a useful framework however I have attempted to reflect upon the personal attributes that would be required of a person wishing to undertake such research with little or no experience of the prison environment.

Just as Levinson (1998) asserted a need for continuous reflexivity to guard against the power differential his gender afforded him, reflection is also required to understand personal values and motivations. 'Researchers' are required to embrace the principles of feminism and service user involvement in relation to their epistemology, relationship dynamics and praxis as discussed throughout this thesis. Rather than a detached, 'scientific' method such research demands a person centred and compassionate approach that is willing to engage those that are disadvantaged and to include those that are excluded. Oakley (1998) describes this as the moral obligation for researchers to treat the researched as they themselves would want to be treated. This may not always be easy, given the nature of offences people in prison are likely to have committed, especially for those who are perhaps not desensitised to the prison environment through

exposure to it. Those with a strong sense that prisons are for the purpose of punishment and deterrence may find embracing such principles impossible.

Reflection is also required to remain mindful of the inevitable power differentials that exist between people in prison and those visiting or working in prison. Consideration as to how this imbalance can be reduced, and how the residual imbalance can be openly discussed is required. This will include considerations from how to explain what the researcher is hoping to achieve to their interpersonal style and ability to empathise and negotiate boundaries as described in the ethical considerations of this thesis. Reflection will also be required to identify gaps in personal knowledge in order to address these and also to learn from mistakes, for example in the way relationships are formed with prisoners and staff in order to involve them and take ownership of the process.

Resilience is also a consideration. Emancipatory research is likely to be met with scepticism or even hostility from prison staff and prisoners who have been *researched*, but not *involved* in research before. As such those wanting to activate change through research may be required to challenge negative opinions, win over those living and working in the prison and be willing to argue and negotiate. Resilience to the trauma of prison life and the life of prisoners is also required as is the ability to work with uncertainty and compromise in methods and approaches. This should be complimented with rigorous supervision and occupational health considerations. A personal resilience to imperfection and compromise is also a requisite. As discussed throughout emancipatory research in prison is not likely to be ethically or ideologically perfect and compromises will have to be made. There will be limits to the extent that those becoming involved can be empowered and limits to the change that can be achieved. Striving for perfection and an inability to accept compromise is likely to cause stress.

Finally a personal resilience to take a third perspective is also required. Prison is often a polarised ‘us and them’, ‘prisoner and staff’ culture. Liebling (2001) highlights that the successful researcher is required to be sympathetic to the

power imbalances that impose upon both prisoners and staff. This however requires the adoption of the status of a total outsider trying to occupy the space between the two poles of the dialectic that is created. This is not to remain neutral or impartial but to be able to have sympathies (if required) for all.

ii) Practicalities

The practicalities relate to the practical preparation and delivery of emancipatory research in the prison environment. Whilst continuous reflection around values is necessary throughout, the practicalities are the 'next step' towards establishing the research project.

Firstly allowing enough time is fundamental. The length of time required to satisfy ethical requirements is discussed in chapter 6. In addition however the prison environment presents challenges to time allocated. Differing and competing priorities for prisoners and staff, incidents and even poor internal communication can hamper even well laid plans and result in lost days. Whilst time can often be at a premium it is also vital in the development of close working relationships with those who the researcher hopes to become involved. At least at the start of the project quick conversations or rushed explanations of aims is unlikely to result in the development the required relationships to ensure success. As a minimum time frame for such research, based upon the experiences laid out here, I would suggest is three years and longer if possible.

Service users and staff should be engaged as early as possible in the process. In order to fulfil the prison's requirements for research applications, researchers external to the prison service may not be able to engage prisoners and staff in order to set the research agenda through involvement. As in this research, in these instances those with experiential expertise should be consulted and involved. This could be in the form of collaboration with charities such as User Voice, or through approaching probation or other community based statutory services.

Similarly prison staff and even national policy teams should be involved as early as possible. This not only ensures guarding against an intellectual

hegemony towards prisoners (Liebling, 2001) but will ensure compliance with security and procedural requirements.

I would advocate, regardless of the area in which change is sought, that a mixed methodological approach is most suited to research in prisons that's aims to empower. Quantitative information is routinely collected by prisons and access to this can provide an insight in to context, as in this instance in the rates and nature of self-harm. The collection of qualitative information provides the discourse and insight in to the dialectics that exist between prisoners, staff, policy, procedure, care and justice. Mixed methods also provide those wanting to become involved a range of ways in which they can from perhaps the passing involvement of the completion of a questionnaire to a greater commitment of time in interviews and focus groups. In cases where prisoners and staff can become involved in information gathering mixed methodologies again offers a greater variety of options to suit the range of skills that will be available.

A final practical consideration is the research teams familiarity with prison policies and procedures. Early involvement of prison staff may help secure advice and steering from a single point of contact within the service however the individual or group of people attempting to generate change through research will be required to understand and follow the set process, particularly in relation to the management of risk.

iii) Products for Change

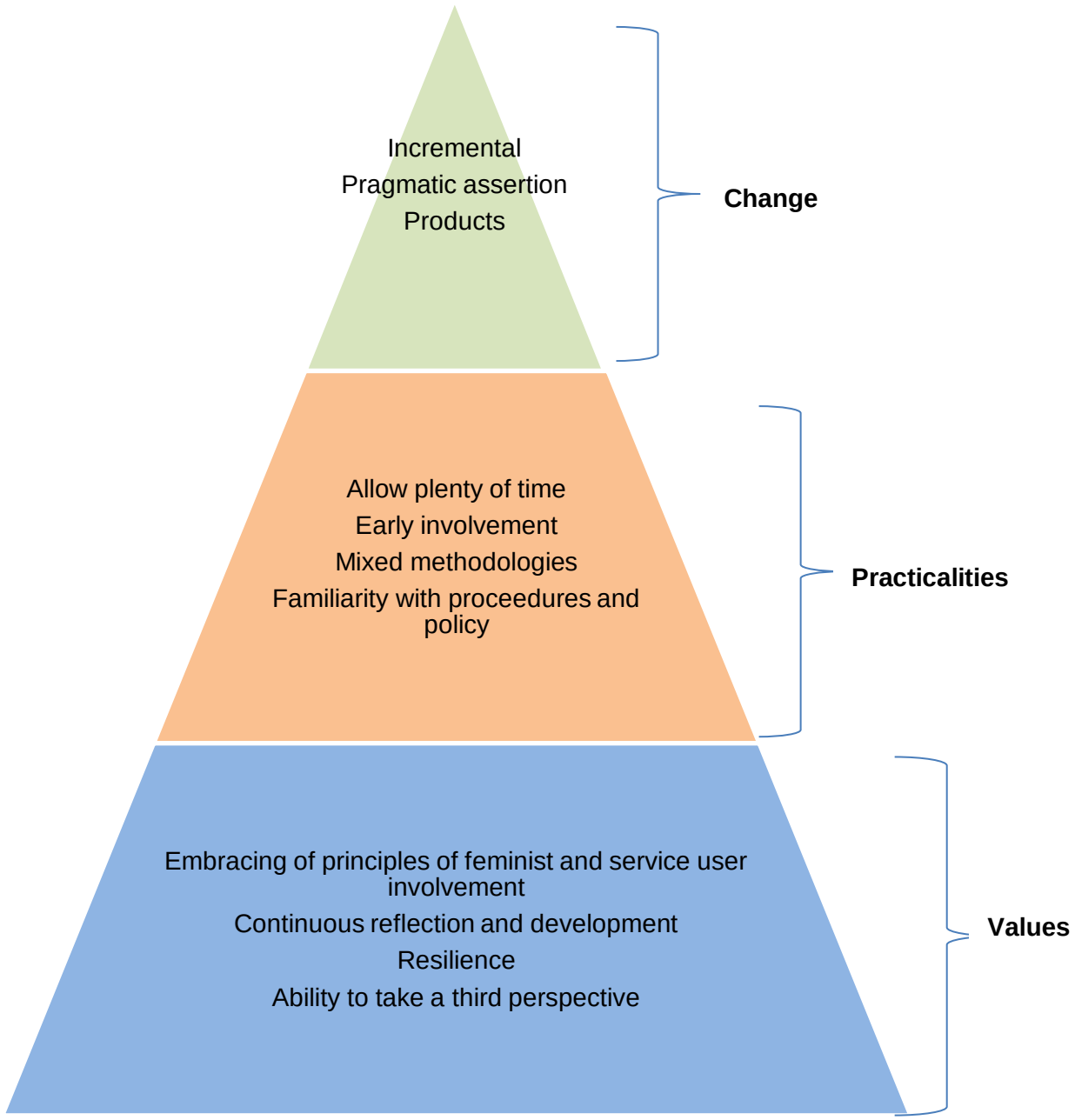
I would advocate that specific products for change are sought through emancipatory research and believe that through this a degree of consciousness raising will be achieved. The importance for those prisoners who become involved has already been discussed. In addition I would argue that products provide tangible benefits for the prison staff and so make the prospects of the research more appealing.

It is perhaps only through the laying of firm foundations through the values exuded and the practical steps taken, as outlined above, that lasting and useful change will be achieved. Through displaying care for both staff and prisoners, through an understanding of the way prisons operate and most importantly through the development of sound relationships will those negotiating change be able to firmly hold the third position between the dialectics that exist and practise the pragmatic assertion that has been described. In describing the conflicts that exist between researchers and managers Churchman and Schainblatt (1965) describe those that that fall between these two positions as *'persuaders'* (p.73). In the case of persuading change in the prison environment this will involve choosing which products of change are to be fought to implement, which perhaps are to be compromised and how to manage the relationship dynamics that this will inevitably cause. This willingness to 'fight' for some changes to be unadulterated whilst accepting compromise in others is a key feature of pragmatic assertion.

Finally the incremental nature of change in an institution such as the prison service should also be recognised and that small achievements that may be common place in community settings, such as the involvement of prisoners in the training of staff, can be significant. For the foreseeable future any further emancipatory research in prisons will be still be laying the foundations of empowerment.

A summary of the framework is described in figure 18 below.

Figure 18 Summary of the Framework for Future Emancipatory Research



Conclusions

In order to provide conclusions it is necessary to consider to what extent is emancipatory and transformative research possible within a prison environment? The achievements of this project from successfully navigating the ethical dilemmas the secure settings raises, to the production of change and

the empowerment of women through recognition of their expertise, validation of their experiences and increase in choices, suggests that emancipatory research is possible.

It is apparent that the framework and standards for transformative research in prisons are required to be different in many ways from similar work in community settings. Issues of power and how this manifests in participant-researcher relationships are likely to be magnified and not totally resolvable in the prison environment. Prisoners can never be empowered to the extent that free people can, to do so would mean they are no longer prisoners. I also believe that given the multiple ways that people in prison are disenfranchised and marginalised and the consequences of this for their health and mental health requires more immediate action to resolve their immediate needs. These challenges, as has been seen in this research, can be overcome through the application of feminist principles and the problem focussed structure of PAR.

Through being informed and guided by feminist principles in this project I have reflected upon the imbalances of power and the meanings of this. Rather than ignoring the issue, or not attempting emancipatory research because of it, the dialogue and collaborative relationships that developed with women in prison and staff allowed the differentials in power to be acknowledged, understood and worked within. This was equally as useful in recognising the limits of staff and prison management as it was of my relationship with women. Being guided by these principles also informed which battles to fight. Moving beyond reserved and prudent engagement in important issues (such as harm-minimisation and service user involvement in training) and yet recognising that to try and fight each battle with the same vigour was to potentially devalue the struggle for such key issues and to ignore the sometimes powerless position staff can find themselves in. Working within, and where possible around, these imbalances resulted in finding ways that women could be empowered whilst still in prison without jeopardising their security and without instilling false hope. Through having the courage to become involved women have empowered themselves and provided opportunities for others to do so as well as produced change that had immediate impact upon care for themselves and others. This, and

hopefully future, transformative research which addresses such needs can lay the foundations for which to develop more existential feminisms.

The benefits of such a research framework, however, are not just for the women in prison. The greater involvement of service users in the development of services for self-harm is surely the only way in which effective care is possible. The sheer amount of inconclusive positivistic research is testament to this. More effective care services will result in more efficient use of resources and potentially improved staff-prisoner relationships. Involvement, when it moves beyond consultation, also ensures responsive and encompassing policy formulation and practice that is not only responsive to gender, age or any other demographic group but, more importantly, responsive to the individual.

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Appendices

A. IRAS application
B. Information sheet for women
C. Information sheet for staff
D. Consent form for women
E. Consent form for staff
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G. Questionnaire staff
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I. Semi-structured interview schedule staff
J. Original proposal for the provision of dressings
K. Revised proposal for the provision of dressings

Appendix A

NHS REC Form | Reference: | IRAS Version 2.0

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Developing a pathway of care for female offenders who self-harm

1. Is your project an audit or service evaluation?

◯ Yes ◉ No

2. Select one category from the list below:

◯ Clinical trial of an investigational medicinal product
◯ Clinical investigation or other study of a medical device
◯ Combined trial of an investigational medicinal product and an investigational medical device
◯ Other clinical trial or clinical investigation
◉ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
◯ Study involving qualitative methods only
◯ Study limited to working with human tissue samples, other human biological samples and/or data *(specific project only)*
◯ Research tissue bank
◯ Research database

If your work does not fit any of these categories, select the option below:

◯ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	◯ Yes	◉ No
b) Will you be taking new human tissue samples (or other human biological samples)?	◯ Yes	◉ No
c) Will you be using existing human tissue samples (or other human biological samples)?	◯ Yes	◉ No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead R&D office be located?

◉ England
◯ Scotland

DRAFT

Appendix B

Improving services for women who self-injure.

Participant information sheets.

Introduction:

This guide is designed to help you decide whether to take part in a study I am conducting. It will outline what might happen during the study, what you might be asked to do or discuss and what I hope the results from the study will be. Importantly it will tell you what your rights are during the study and what you can expect and what to do if you're not happy at any point.

I will talk to you about all this as well; this is a paper copy for you to keep.

By the end of this guide you will hopefully be able to make an informed decision as to whether you want to take part. That means you fully understand what you are agreeing to.

The Study:

I (James) am doing a three year study project looking into how to improve services for women who self-injure in Low Newton. Hopefully by the end of it, with the help from everyone in Low Newton, we will be able to offer better services and options for women who want to stop or reduce their self-injury. It is also expected that the well-being of everyone in the prison whether they self-injure or not will be improved by this.

It is expected that the study will have a number of parts to it, these will include:

1. **Completing surveys and questionnaires**
   Participants in the study may be asked to complete psychometric questionnaires and surveys about how they feel; their experience both now and in the past and how self-injury affects them. Everyone will be given help to complete these.

2. **Access to records**
   To help me get a full picture of what people who self-harm needs are as well as asking you I will also ask for access to your medical records held in Healthcare and your prison record.

3. **Interviews**
   Some but not necessarily all participants will be interviewed by me. This will be about a wide range of aspects of your life both in prison and before you came to Low Newton. If you agree interviews will be recorded so I can get everything that you say as accurate as possible.

4. **Focus Groups**
   Focus groups will be used to give you information about what the research has found so far and to discuss options for services that we could bring in to Low Newton. No specific personal information will be discussed or revealed in these. There is a separate information and consent form for focus groups that you will be given at a later stage.

I understand that what may be discussed during the interviews and focus groups may be difficult for some people and bring some issues up. During the study you will be supported as much as possible to cope with any difficulties that you have as a result of taking part. A part of this may be support from other people in the prison and I would therefore like to let people like your personal officer, psychologist (if you have one), or anyone else you think might be helpful, know that you are taking part. I will not discuss with them what has been said in interviews or give them any details unless you ask me to. If you'd prefer no-one knows you are taking part then tell me.

You need to be aware that all we are offering you is the chance to take part in a piece of research. Although we will try to make sure you are OK before, during and after this is not a therapeutic service and I cannot offer you therapy or counselling. If you have any questions about this please ask before agreeing to take part.

You should also be aware that the information will also be used to enable me to achieve and academic qualification alongside improving the services in Low Newton. Any information used for the qualification will also be totally anonymous and treated with absolute confidentiality. If you have any concerns about this please ask.

What happens with the information?

I will let the General Practitioner (GP) you see in the prison know that you are taking part in the study to ensure that you receive the best care possible but they will not be given any details of what you say or what is discussed. If you want anyone else to be informed that you are taking part, such as psychiatrists, CPNs, Psychologists let me know and I will talk to them.

All information such as completed questionnaires and interview tapes will be locked away and kept safe. Only a few people will have access to these myself (James Ward) and my supervisors (names are available on request). If you want to see your records you can do so by asking me.

A database will be made of personal details; this will be used to study whether what we bring in is effective. It will not be possible to identify who's who from this.

At the end of the study a report will be completed in which I might want to include what was said during interviews and people's experiences. If I want to include something you have said I will ask for your permission, I will also make sure that NO ONE reading the report will be able to identify who said what. I will give people false names and you will be able to choose what you would like to called in the report.

Information you give about your experiences and feelings and your past will be kept confidential in the way describe above. I cannot offer to keep everything confidential though and as with all interviews in prison I will have to report anything that:

- Breaks prison security
- Suggests you are danger in anyway
- Relates to the harm of children or adults that is not already known about.

Information will not be used to make changes to your sentence plan or OASys and you will not be set any new targets from taking part. You might be given the option of using the new services we develop but this will be your choice.

Your rights if you take part:

If you agree to take part in the study you can change your mind at anytime by letting me know. If you do change your mind and don't want anything you've done so far to be used then I will destroy what's been done.

If you want to take part in some parts and not others that is OK, just let me know what you would like to take part in and what you don't.

If you are interviewed it is likely that you might be asked questions that you find difficult to talk about, although it will be helpful to get as much information as possible you do not have to talk about anything you are not happy with.

If you are happy to take part in the study but do not want to be anonymously quoted in the report let me know and this won't happen.

You will be treated with respect and sensitivity at all times regardless of your background, religion, sexuality, race or any other aspect that makes you a unique person. If you do not feel that this is happening you need to let me know straightaway.

You are of course still entitled to make complaints using the prison's request complaint or diversity process or through your solicitor.

You have the right to your opinion, it is only by listening to you that we can make changes to what is offered at Low Newton.

If anything happens or is discussed during the study that upsets you, you will be offered further support and help.

We will discuss and decide what will happen if you take part in the study but become ill or are no longer able to take part.

What next?

If you think you'd prefer not to take part in the study that's OK, thanks for reading this and meeting with me.

If you think you do want to take part then I will ask you to sign the form on the next page. I will sign it too as a witness.

If you have any questions at any time ask!

Appendix C

Research into developing a new pathway of care for women offenders who self-injure.

Participant information sheet for staff.

Introduction:

This guide is to help you decide whether to take part in the research that is being undertaken at Low Newton. It outlines what will happen during the research, what you might be asked to do or discuss and what I hope the results from the research will be.

It is hoped that a cross section of staff from the prison will take part to gain views and experience of working with women who self-injure, opinions on the provisions already in place and suggestions for development.

The Research:

The research is split into a number of different parts, including interviews and surveys with offenders and staff. There will also be a phased implementation of a new pathway of care for the offenders who self-injure and evaluation of this. If this goes well it is anticipated that this could be rolled out across the prison. This will have obvious implications for the way we work at the moment and so staff input is very important. It's hoped that by the end of the three years we can have implemented new systems of work that will benefit staff as well as the offenders.

As mentioned I hope to include a range of staff including discipline, healthcare, psychology and other support staff those who choose to participate can decide how much they want to be involved, for example deciding to complete questionnaires but not be interviewed. Interviews will be recorded using audio equipment.

For the purpose of the research we have defined self-injury as any act which involve inflicting injuries on ones own body or inciting others to inflict injury. For the purpose of the research harmful behaviour such as eating disorders or substance use as self-injury is not being included.

What happens with the information?

All information such as completed questionnaires and interview tapes will be locked away and kept safe. This will only be accessible to me and my supervisors (names available on request) and no-one else within the prison.

All information included in reports and used to shape with pathway of care will be anonymous. Opinions, discussions etc will not be traceable to an individual. Interviews will be treated as confidential within the bounds of the Local Security Strategies and PSO's.

Your rights as a participant:

You can withdraw your consent to the research at any time. If you do this and want any information you've given so far not to be included let me know and I'll destroy it.

What next?

If you think you'd prefer not to take part in the research that's OK, thanks for reading this and meeting with me.

If you think you do want to take part then I will ask you to sign the form on the next page. I will sign it too as a witness.

If you have any questions at any time ask!

Appendix D

Consent to take part in the research developing services for women who self-injure.

As discussed the research will be made of many different parts, you can chose to take part in some, all or none of these. Please tick to indicate whether you agree to:

	Yes	No
1. Complete questionnaires and surveys that are relevant to the study.	□	□
2. Take part in interviews and focus groups, and having these will be recorded using audio equipment.	□	□
3. Allow the information you give being used to help develop services in Low Newton through staff training.	□	□
4. Having my details kept on a database and that this data will then be used to carry out research into whether the services work. I understand that this data will not be able to identify me.	□	□

Please read the following and tick to say whether you agree with the statement or not.

	Yes	No
I have a copy and been given time to read the 'Guide to Consent'.	□	□
I have been given the time to ask all the questions I wanted to. Those questions have been answered fully.	□	□
I understand that I can change my mind at anytime and withdraw from the research.	□	□
I understand that if I disclose anything that suggests there is a threat to myself, someone else or the security of the prison that this will be reported to the appropriate department.	□	□

Print Name……

Signed …… Date …….

Appendix E

Consent form to take part in the research to develop services for women who self-injure in HMP Low Newton.

As discussed the research will be made of many different parts, you can chose to take part in some, all or none of these. Please tick to indicate whether you agree to:

	Yes	No
1. Complete questionnaires and surveys that are relevant to the study.	☐	☐
2. Take part in interviews and focus groups, and having these will be recorded using audio equipment.	☐	☐
3. Allow the information you give being used to help develop services in Low Newton through staff training.	☐	☐
4. Having my details kept on a database and that this data will then be used to carry out research into whether the services work. I understand that this data will not be able to identify me.	☐	☐

Please read the following and tick to say whether you agree with the statement or not.

	Yes	No
I have a copy and been given time to read the 'Guide to Consent'.	☐	☐
I have been given the time to ask all the questions I wanted to. Those questions have been answered fully.	☐	☐
I understand that I can change my mind at anytime	☐	☐

Print Name……

Signed …… Date …….

Appendix F

ID No……..

Questionnaire for Women in Low Newton

Thank you for agreeing to answer this questionnaire. We are trying to collect as much information as possible about your experiences of self-injury both in the past and in Low Newton so that we can try and improve the care you receive.

To do this it would help us if you could answer the following questions.

If there's anything you don't understand or want to talk about afterwards please ask James when he comes to collect the form from you.

If you need help completing the questionnaire we can do this with you.

Thank you for your input James and Di.

James Ward, Project Lead, Low Newton, contact details

and

Di Bailey, Reader in Social Work,
Elvet Riverside ii
University of Durham,
DH1 3JT
Phone: 01913341478
di.bailey@durham.ac.uk

Self-Injury Questionnaire

To begin – Please tell us a little bit about you

1. How old are you today?

2. How long have you been in Low Newton?

   Have you been in Low Newton previously?

   Yes ☐ No ☐

3. a) What is your current status in prison?

   Sentenced ☐ Remand ☐

   b) If you are sentenced how long a sentence did you receive?

4. What offence are you convicted or charged with?

---

5. How would you describe your ethnic origin?

6. Which departments in the prison do you use/have contact with at the moment?

Health care ☐ Chaplaincy ☐ Listeners ☐

Education ☐ Psychology ☐

7. Do you have any physical health problems currently? Can you tell us what they are? Do you receive any treatment and if so is this helpful?

---

8. Do you have any mental health/emotional problems currently? Can you tell us what these are? Do you receive any treatment and if so is this helpful?

Your history of self-harm – Please tell us how your self harming started

9. How old were you when you first injured yourself?

10. What did you do when you first injured yourself? (Please tick as many of the following as you need to)

Cut yourself ☐
Punched something hard ☐
Self-strangulated (ligatured) ☐
Overdosed ☐
Burnt yourself ☐
Swallowed an object ☐
Inserted an object ☐
Banged your head ☐

Deliberately got in to a fight ☐
Punched yourself ☐
Broke a limb ☐
Interfered with a wound ☐
Problems with eating ☐
Other ☐ (please tell us what this was below)
……
……
……
……

11. Did you self-injure before you came to prison?

Yes ☐ No ☐

12. How did you first discover self-injury?

Saw someone else do it ☐
Saw it on TV or read about it ☐
1st time was an accident ☐
Someone suggested you try it ☐
Don't remember ☐

Other ☐ (please tell us how below)

……
……

13. Have you ever had any help, treatment, medication or intervention relating to self-injury in the past?

Yes ☐ No ☐

If you've answered yes please write below what was it and whether it was helpful in anyway. (For example you could write anti-depressants – not helpful).

……
……
……
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……
……
……
……
……

We would like to know a bit more about whether being in prison affects your self-harm

14.

A) Has being in prison changed the amount you injure yourself? (Please choose one of the following statements)

I injure myself less in prison ☐
I injure myself about the same amount ☐
I injure myself more in prison ☐

B) On an average week how often do you self-harm? (Please tell us even if you do this secretly, for example a couple of times a day, 3 times a day, once a week, once a month)

C.) If you have said being in prison changes the amount that you injure yourself why do you think this might be?

……
……
……
……
……

15. In what ways do you injure yourself now in prison? (Please tick as many of the following as you need to)

Cut/scratch yourself ☐
Punch something hard ☐
Self-strangulate ☐
Overdose ☐
Burn yourself ☐
Swallow objects ☐
Insert objects ☐
Bang your head ☐
Ligature ☐

Deliberately get in to fights ☐
Punch yourself ☐

Break limbs ☐
Interfere with wounds ☐
Eating problems ☐
Bite yourself ☐
Suffocate yourself ☐

Other
☐ (please tell us what this was below)
.....
.....
.....

16. Is the way you injure yourself in prison different from how you injure yourself when you aren't in prison? If so how?

.....
.....
.....

We know that the reasons people self-injure are very different for each individual. We would like to know more about <u>your</u> particular experiences of self-injury.

17. Please tick any of the statements you agree with below.

A) Self-injury helps me to:

Manage my anger ☐
Express how I feel ☐
Keep people away ☐
Cope with cravings or urges ☐
Enjoy myself ☐
Calm down ☐
Get help ☐
End flashbacks ☐
Punish myself ☐

Feel in control ☐
Relax ☐
Get a buzz ☐
Feel something else ☐
(Please state what)
.....
Get what I want ☐
Cope with or block out negative feelings/despair ☐
Cope with mental health problems ☐
Get sexual pleasure ☐

B) From the list you've just ticked in 15 A (above) please underline the one that most closely explains why you self-harm.

C) Please tick any of the statements you agree with below

I self-injure when I:

Think of the past ☐
Feel frustrated ☐
Am bored ☐
Miss my family ☐
Feel trapped ☐
Can't get things right ☐
Can't tell people how I'm feeling ☐
See others doing it ☐
Am faced with a problem & don't know what to do ☐
Feel numb ☐
Feel Worthless ☐

Avoid suicide/doing something more serious ☐
Can't cope with being in prison ☐
Think of the future ☐
When I can't get drink or drugs ☐
Feel sad ☐
Feel anxious ☐
Feel ashamed ☐
Feel happy or good ☐
Another reason (please state) ☐
.....
.....
.....

D) From the list you've just ticked in 15 C (above) please underline the one that most closely describes why you self-harm.

E) If you do self-injure what do you find helpful or want to happen? (please tick as many as you like)

Not be left alone ☐
To have someone look after my wounds ☐
Someone to talk to who will listen ☐
To be able to carry on as usual ☐
A listening service ☐
To be by myself ☐

To be able to dress my own wounds ☐
Be able to talk to someone who has experience of self-injury ☐
Anything else? (please tell us) ☐
.....
.....
.....

Often people tell us that they self-injure because of traumatic experiences that have happened to them in their lives do you think this applied to you?

18. Do you self-injure because of painful or traumatic things that have happened in your past?

Yes ☐ No ☐ Not sure ☐

Please tell us what kinds of trauma you have experienced and how you think this links with your self-harm?

---

19. A) When you feel like injuring yourself are you ever able to stop yourself from doing so?

Yes ☐ No ☐

B) When you feel like injuring yourself are you ever able to delay yourself from doing so?

Yes ☐ No ☐

C) If you've said yes to 12 a) how are you able to stop or delay injuring yourself?

.....
.....
.....
.....

We would like to understand what responses you get from staff and women in Low Newton when you self-harm.

20. On the scale below 1 – 4 where 1 is strongly disagree and 4 is strongly agree please show how much you agree with each statement by circling a number

1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree

a) Staff in Low Newton understand why I self-injure:

1 2 3 4

b) Staff in Low Newton show concern for me when I self-injure:

1 2 3 4

c) Staff in Low Newton listen to me when I have problems or feel like self-injuring:

1 2 3 4

d) Staff treat me with less respect in Low Newton because I self-injure:

1 2 3 4

e) I am more isolated in Low Newton because I self-injure

1 2 3 4

1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree

f) ACCT helps me to stay safe:

1 2 3 4

g) I feel embarrassed or self-conscious when I am on an ACCT:

1 2 3 4

h) I am listened to in my ACCT case reviews:

1 2 3 4

i) Other women in Low Newton understand why I self-injure:

1 2 3 4

j) Other women in Low Newton show concern for me when I self-injure:

1 2 3 4

k) Other women in Low Newton listen to me when I have problems:

1 2 3 4

l) Other women treat me with less respect in Low Newton because I self-injure:

1 2 3 4

21. A) Please tick which of the following services you might use if they were made available to women who self-injure.

Self-Harm work books developed by women who have self-injured ☐

'Drop in' clinic/advice centre ☐

Respite area (somewhere to go and stay for a couple of days if you're feeling vulnerable or likely to injure yourself) ☐

A 'buddy scheme' using other prisoners on the wing ☐

A self-help group for women who Self-injure ☐

A safety plan that was drawn up with you and which stayed with you throughout your time in prison regardless of whether you are on ACCT or not ☐

Counselling services ☐

A group encouraging good mental health for all women in Low Newton regardless of whether they self-injure or not ☐

Information about scarring, body image issues, skin camouflage ☐

B) Do you have any other ideas for what could be done in Low Newton to help women who self-injure? Please tell us what would help:

……
……
……
……
……
……

22. Last question; is there anything else that you think would be useful for us to know about your self-injury? If so please do so below.

Thank you for taking the time to complete the questionnaire, if you have any questions please let us know. If there's anything that you want to talk about or you have found any part of the questionnaire distressing please also let us know.

The information you've given us will be held securely and used as a part of the research project.

During the next phase of the project you may be asked you to take part in an interview to discuss some of the issues around self-injury and the support you feel you need in more detail. Please put a cross in the box if you wish to be interviewed ☐

We will also be keeping you informed of the findings from the study as they emerge and letting you know of any action plans for improving care as they develop.

If you change your mind about taking part in the project after you've finished the questionnaire please let us know and remove your information from the research

Thank you again for your participation.

Appendix G

Questionnaire about Self-Injury in Low Newton

As you are hopefully aware there is an ongoing research project in Low Newton looking to improve care for women who self-injure, which in turn we hope has a positive impact for staff and provide better support for the difficult job you do. Part of the research is to ask for your opinions and ideas of how to do this and get an idea of how self-injury impacts upon you as a member of staff. If you could please take a couple of minutes to complete this questionnaire it will help us achieve this. All responses are completely anonymous and there are no right or wrong answers so please answer honestly as you can. Thanks!

1. What is your role within Low Newton? (e.g. Officer, S.O., Teacher, Nurse etc)
   ……
   ……

2. Could you please indicate whether you have any of extra responsibilities below:

ACCT Assessor	☐	Personal Officer	☐
ACCT Case Manager	☐	Enhanced ACCT case Manager	☐

3. Which of the following factors do you think are the biggest challenges facing you in dealing with women who self-injure

Lack of time	☐	Lack of support for how self injury affects you	☐
Lack of knowledge about self-injury	☐	Lack of support from my colleagues	☐
Lack of knowledge about ACCT	☐	Other (please say what below)	☐
It shouldn't be part of my job role	☐	……	
Lack of support from my managers	☐	……	

4. Which of the following factors do you think are the biggest strengths for you in dealing with women who self-injure:

Time to spend listening to the prisoners ☐

Knowledge of self-injury ☐

Knowledge of ACCT ☐

Dealing with the emotional demands of working with women who self-injure ☐

Support of my colleagues ☐

Support of my managers ☐

Support for how self injury affects you personally ☐

Patience ☐

Other ☐
(please say what below)
.....
.....
.....
.....

5. Please tick any of the reasons below why you think women in Low Newton may self-injure (tick as many or as little as you like)

To express/communicate how they feel ☐

To feel better ☐

To get attention ☐

For material gain ☐

Boredom ☐

To compete with other people who self -injure ☐

To feel in control ☐

Because they're in prison ☐

For enjoyment ☐

For sexual pleasure ☐

They're told to by others ☐

To end negative or upsetting thoughts ☐

They're mentally ill ☐

They have a Personality Disorder ☐

To punish themselves ☐

To manipulate those around them ☐

To feel something ☐

To survive unbearable feelings or circumstances ☐

Another reason ☐
please state what
.....
.....

6. From the list in question 5 could you please circle the reason that you think is the most common cause of self-injury in women in Low Newton.

7. What would you like to help you support and help women who self-injure more effectively?

……
……
……
……
……
……
……
……

Thank you for completing this. If you have any questions please let me know. During the next phase of the research I may ask you to take part in an interview to discuss some of the issues around self-injury and staff support in more detail. This will be from a random selection of staff and not based upon this questionnaire which will remain anonymous. We will also be letting people know what we've found and what we'd like to do with the finding as soon as possible.

If you have any questions or concerns please contact

James Ward
j.ward1@nhs.net or ext 4271

or

Di Bailey
di.bailey@durham.ac.uk or tel: 0191 3341478

If you have been affected by any of the issues raised by the questionnaire we will be glad to discuss this with you. Alternatively support for staff is available from Care First tel: 0800 174319 or via the Care Team.

Appendix H

Interview Schedule with Women

Thank you for agreeing to take part in an informal interview as the next part of the research in to developing services for women who self-injury in Low Newton. The interview will build on what you've already told us in the questionnaire which I have here and we can both use as a reference.

The interview will be recorded to make sure we can accurately record what you tell me. The tape will be typed up by someone we employ outside of the prison. For the purpose of confidentiality and to protect your identity we need to think of a name I can refer to you by - what would you like to be called.

Re-iterate the limits on confidentiality and participants rights to consent/withdraw.

Self-injury (general):

Could you remind me how you want to talk about your self-injury, do you prefer the term self-injury, or self-harm or something else?

How do you feel about your self-injury? (Positives and negatives e.g. helps me cope, feel ashamed)

On a scale of 1 to ten (with one being not at all important and ten being extremely important) how important would you rate self-injury for you?
Why do you rate it so high/low
How did it become this important to you?

If you were to wake up tomorrow and by some miracle you no longer used self-injury what would different? Any concerns?

Do you want to change anything about your self-injury? (stop, reduce, be safer)?

What do you think would help you do this?

Protective Factors:

Is there anything that helps you to avoid or delay self-injuring? Have you ever managed to stop, even for a short time in the past?

Is there anything important to you that self-injury affects or messes up?

What do you not like about the fact that you self-injury?

Are there any situations that self-injury can be bad or unhelpful for you?

What keeps you safe?

Self-injury (functions):

Do a brief recap of questionnaire responses, e.g. methods of self-injury, the purpose of self-injury for them.

*[If applicable]*Why do you sometimes use different methods to self-injure? (Does cutting help in different ways from ligaturing etc)

How do you choose in what way to self-injure?

Why do you self-injure on different parts of your body? For example does cutting your legs do anything different for you from cutting your face?

How does self-injury help or improve things for you?

What generally happens before you self-injure? [Refer to most common form of self-injury as indicated on the questionnaire and the common antecedents indicated e.g. anger, frustration etc]

- What makes you feel….(angry etc)?
- What are you thinking?
- What are you doing?
- Do you have any Physical feelings?
- Do you experience voices or flashbacks?
- What are other people doing?
- What did you want to happen?

What generally happens whilst you self-injure? [Refer to most common form of self-injury as indicated on the questionnaire]

- How are you feeling as you self-injure?
- What are you thinking?
- What are you doing?
- Do you have any Physical feelings?
- Do you experience voices or flashbacks?
- What are other people doing?

How do you feel after you have self-injured? [Refer to most common form of self-injury as indicated on the questionnaire]

- Positive feelings
- Negative feelings
- Physical pain

A lot of women have told us that they self-injure because of trauma in their past or because of missing their family in prison. Can you tell me whether this the case for you?

If not why do you think you self-injure?

How could we help you cope with these issues differently whilst in Low Newton?

Have the reasons you've self-injured always been the same?

- If not why not? What different reasons?

Are there any links between self-injury and suicide for you?

Self-injury in prison:

Since you have been in prison can you think of a time that has been a particularly good or particularly bad experience in terms of the care & support you have received after self-injuring?. Please can you tell me about this in as much detail as you feel able to share?

[If the woman can't think of a specific example, use these more directing questions]

[What's it like living in Low Newton?]

[How does the prison affect your self-injury?]

[What's the worst thing about being in prison?]

[What do you think of the prisons response to self-injury?]

Thank you for sharing your thoughts with me, do you have any questions you would want to ask me? Before we end the interview I want to make sure you are feeling ok. How are you feeling now?

Before you go back to the wing/education etc can you tell me what you will be doing in the next hour?

If necessary review protective factors, what keeps the woman safe or discuss skills if appropriate. Spend time talking about other things, their day, family, plans for the future as appropriate. Check whether they want referral to any other services or support in the prison.

Appendix I

Interview Schedule Staff

Thank you for agreeing to take part in an informal interview as the next part of the research in to developing services for women who self-injury in Low Newton. The interview will build on what we've already been told by staff from questionnaires.

The interview will be recorded to make sure we can accurately record what you tell me. The tape will be typed up by someone we employ outside of the prison. For the purpose of confidentiality and to protect your identity we need to think of a name I can refer to you by - what would you like to be called?

Re-iterate the limits on confidentiality and participants rights to consent/withdraw.

Self-injury

How does your job role bring you to work with women who self-injure?

What do you enjoy most about the work you do?

What skills or strengths do you particularly use in your work with women who self-injure?

In your experience why do women in LN self-injure?

In what ways do you think self-injury hinders or impedes the women in Low Newton?

In what ways do you think self-injury helps or is useful for the women in Low Newton?

Since you have been working in the prison can you think of a situation that has been a particularly good or particularly bad experience in terms of the care & support you have provided after one of the women has self-injured? Please can you tell me about this in as much detail as you feel able to share?

[If the interviewee can't think of a specific example, use these more directing questions]

[What do you think of the prison's response to self-injury?]
[What works?]
[What doesn't work?][
[Do you find ACCT useful in managing self-injury on the wing?]

If you could make changes to the way women who self-injure are managed in LN what would they be?

What are the most difficult aspects of working with women who self-injure?

A number of staff have told us that working with women who self-injure affects them personally, is this the case with you?
Has this had any lasting effect on you?
Have you received any support in relation to this?

How do you cope or manage working with women who self-injure?

What support or guidance do you receive for working with women who self-injure?

Can you think of a time when you encountered stress at work and handled it well? What happened and what did you do?

Can you think of a time when you encountered stress at work and handled it badly? Again what happened & what did you do?

What qualities or attributes do you think you have that helps you do your job?

What would you like to see for staff to help them in their job, working with women who self-injure?

Appendix J

A proposal for the provision of self-care items to women who use self-injury in prison.

A briefing for the consideration of the Offender Safety, Rights and Responsibilities (OSRR) group.

1. Background

The proposals contained in this briefing have emerged from the ongoing Knowledge Transfer Partnership (KTP) project, a collaborative research programme between the North East Offender Health Commissioning Unit, Durham University and HMP YOI Low Newton. The project aims at increasing the understanding of self-injury and its use by women in custody, and utilising this knowledge to improve outcomes for both the women and staff in the prison.

Specific objectives include:

I. The reduction of self-injury in Low Newton and its associated costs.
II. Increased staff awareness of the issues around self-injury and increased confidence to manage such behaviour
III. The promotion of service user involvement in the process of change in the prison.

These objectives will be met through the implementation of a pilot pathway of care for women who use self-injury. The pilot and its composite parts will be informed by the existing knowledge of self-injury and the research findings of the project. The pilot will be evaluated in line with the 3 objectives above.

Currently there is an omission in prison policy relating to self-care for prisoners who use self-injury. Prison policy relating to the management of self-injury is set out in Prison Service Order (PSO 2700) whilst policy relating to women prisoners in PSO 4800. PSO 2700 makes no reference to the provision of general health related information or specific practice relating to pro-actively supplying wound dressings to those who are known to use self-injury. PSO 4800 currently advises the provision of *"Interventions… include advice on harm-minimisation"* (p.15) The PSO does not define harm-minimisation.

The existing knowledge and experience of healthcare professionals supports a significant body of literature that differentiates between people who use self-injury intermittently and those who use self-injury repetitively (Yates 2008). As well as a difference in the frequency, the method and severity of self-injury differs between these two groups. Yates' findings indicate that recurrent 'self-injurers' more frequently engage in more dangerous behaviour such as self-strangulation and ingesting harmful chemicals. They also need to receive outpatient medical attention more frequently than those who use self-injury intermittently.

The difference in the use of self-injury is attributed to the difference in function of the self-injurious behaviour. Research reveals that intermittent self-injury is more commonly used as a means of communicating distress and the management of the individual's relationship with others. In contrast recurrent

self-injury relates to the regulation of intrapersonal factors and an associated experiencing of overpowering emotion.

This proposal is rooted in the research that suggests that the degree of control an individual has over their self-injury will be greater for those who self injury more intermittently using less serious forms of behaviour.

As part of a Tier 1 stage of the pathway of care for women who self injure in custody it is proposed to provide:

1. An information pack based on self-help materials and workbooks that already exist in relation to self injury
2. Distraction focussed resources such as colouring books
3. Self-care items to assist with the prevention of self injury

Based on the evidence from Health Services Guidelines, a review of the literature and direct feedback from17 women we suggest that there are three compelling arguments for the pro-active provision of dressings for women who use intermittent and non-life threatening self-injury in custody. These are set out below.

1.1 Current Clinical Guidance and Evidence of Efficacy for 'Self-help' Provisions

NICE clinical practice guidelines (16, 2004) on the short term physical and psychological care of self-harm recommends Advice regarding *"self-management of superficial injuries, harm minimisation techniques, alternative coping strategies…for people who repeatedly self-injure."* (p.64); the use of tissue adhesive is also recommended. This is not currently available for women in prison. One set of basic dressing plus information and distraction resources would be made available to a woman following a screening assessment as part of the induction process in the gaol.

Reasons for self-injury are varied and individual. However experiencing a lack of control or using self-injury to exercise control is a common theme (Sane, 2008; Sinclair & Green, 2005; Wichmann et al, 2002; Burstow, 1992). This theme was echoed by the current research project with women discussing both the negative effect of the removal of control by the prison environment and the positives of feeling they had a sense of autonomy. Promoting control is also a key theme in existing self help materials for self injury (Arnold 1998, Leader 1995). The negative effect of the removal of power is highlighted by the women who are required to seek medical attention for minor injuries that would not require medical attention in the community due to their free access to plasters/dressings for minor wounds. Based on the evidence we would suggest that allowing a woman who self-injures a degree of choice and control over her wound care and distress management will have an empowering effect that may provide a protective factor against the exacerbated use of self-injury in custody.

1.2 Effective Infection Control

Given the prevalence of transmittable blood borne diseases within the prison population (National Aids Trust, 2007; Skipper et al, 2003) and the communal and often shared nature of the prison environment effective self-care can reduce the risk of passing blood borne infection to others. Provision of a set of dressings for care of minor/ superficial wounds would be consistent with the Health Protection Agency's harm-minimisation strategy for the transmission of hepatitis C in the prison population (HPA 2007). This currently includes the provision of sterilising tablets to prisoners.

The provision of wound care has the potential to also reduce the risk of infection to the woman herself. Women in the community have written of postponing or failing to seek medical attention for superficial wounds due to the treatment they have previously experienced (see Pembroke, 1994). This increases the risk of the wound becoming infected and more urgent treatment being required at a later stage. Women's feelings of shame and embarrassment with regard to self injury (KTP project 2010) are consistent with the current research projects finding and exacerbated by an inability to administer self-care. Although the rates of undisclosed self-injury in custody are unknown the provision of a set of dressings is likely to reduce the infection risk for these who delay the reporting of their self-injury.

1.3 Equality of Provision

The proposed provision of one set of dressings in the first instance equates with what would be readily available to the woman, over the counter, were she in the community. We would suggest therefore that the provision of self-care items would work towards the aims of prison healthcare *'to give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service'* and the aims of the Improving Health Supporting Justice delivery plan. We argue that the provision of dressings whilst promoting alternative strategies and interventions is parallel to the policy of methadone prescription and abstinence based programmes currently being employed in prisons (Crispin, 2009).

2. Proposed provision:

It is suggested that one set of 'over the counter' dressings such as steri-strips and/or Mepore dressings would be provided as they would be accessible in the community. A clinical waste bag will also be provided for the disposal of used dressings. These will be included in a 'pack' which would also provide a woman with information and alternatives to self-injury and the means to prepare their own care plan for sharing with staff and appropriate peers. Items to distract from thoughts of self-injury such as puzzles or art equipment and items to encourage the woman to express herself in alternative ways including a diary and workbook would also be included. At the point at which a pack was given to a woman with a history of previous non-serious intermittent self-injury the content would be explained including the protocol for a further supply of materials.

The main purpose of the pack is therefore to provide information, insight and alternatives to self-injury for women in Low Newton whilst addressing the important benefits of self-care outlined above.

2.1 It is anticipated that for some women provided with self-care items an element of education in attending to and dressing wounds may be required. In these cases the healthcare professional will provide instruction following best practice guidelines. Written information for wound care will also be included in the packs.

3. Specific concerns

We are aware of concerns that encouraging self-care could i) reduce the reporting of incidents of self-injury which might impact upon monitoring of severity and method of the injury ii) be construed as condoning or promoting self-injury and iii) would be in opposition to the prison service's duty of care. We would offer the following evidence in support of the pilot:

i. Only one set of dressings would be given to an individual at anyone time. The proposed protocol (see section 4) requires the individual to seek consultation with a healthcare professional (e.g. a nurse) in order to replenish her initial set of dressings. At this point recording and monitoring of incidents of self-injury would be completed in line with current ACCT procedure.

ii. Based on direct feedback from women who use self-injury intermittently the provision of dressings would not condone or promote self-injury but symbolically acknowledge that it is a behaviour many women in prison choose to employ as a coping strategy. Providing information and alternatives in addition to a dressing therefore increases the options of women not to self-injure and the chance of remaining free from infection and complication should she choose. As highlighted by Louise Pembroke, "If we are going to harm it is safer to do so with information on…first aid, wound care, correct usage of dressings" (Pembroke, 2007)

iii. Clinical judgement as to the woman's frequency and severity of self-harm, her ability to care for her own wounds by healthcare staff will be promoted throughout as well as the use of the decision pathway outlined in section 5. Clinical judgement will be based upon an understanding of the individual woman and her needs, as recommended in the recent Royal College of Psychiatrists (RCP, 2010) report on self-harm, and as such no local risk assessments tool for the provision of dressings will be provided. The provision of dressings will not be a blanket policy for all women in prison or even for all who self-injure but as an option for professionals to use should they feel it beneficial for the individual. This accords with the clinician's duty of care.

4. Protocol for the pro-active provision of wound dressing

a) Dressings will not be provided for those whose self-injury is judged to represent a threat to their life or women who primarily use ligaturing, hanging or burning as their method of self-injury. Similarly if a woman is felt to be unable to adequately care for her own wounds due to mental health or learning difficulties dressings will not be provided.

b) Where clinicians are uncertain as to whether to pre-emptively provide dressings advice and supervision should be sought from line management before a decision is made. The woman will be informed of any decision in person.

c) Dressings will only be issued by appropriately trained healthcare staff.

d) Dressings will only be provided to allow the dressing of one 'act' of self-injury.

e) In possession dressings will only be replenished after the woman has sought medical attention for the injury she has dressed herself.

f) Usual procedure and policy will be followed is a woman is identified as having used self-injury or is considered at risk of doing so with the completion of ACCT, F213SH and other documentation as appropriate.

g) Dressings will only be provided along with activity and information packs and encouragement to engage with alternatives and distraction techniques.

h) If the recipient of dressings is already supervised under ACCT an entry will be made that she has received the pack. This will also be entered on to her Inmate Medical Record (IMR) and Part C of the Offender Management records.

i) The provision of dressings will be reviewed during ACCT case reviews during which multi-disciplinary input as to the appropriateness and continuation of the provision will be sought. It is important that appropriately trained healthcare staff attend case reviews.

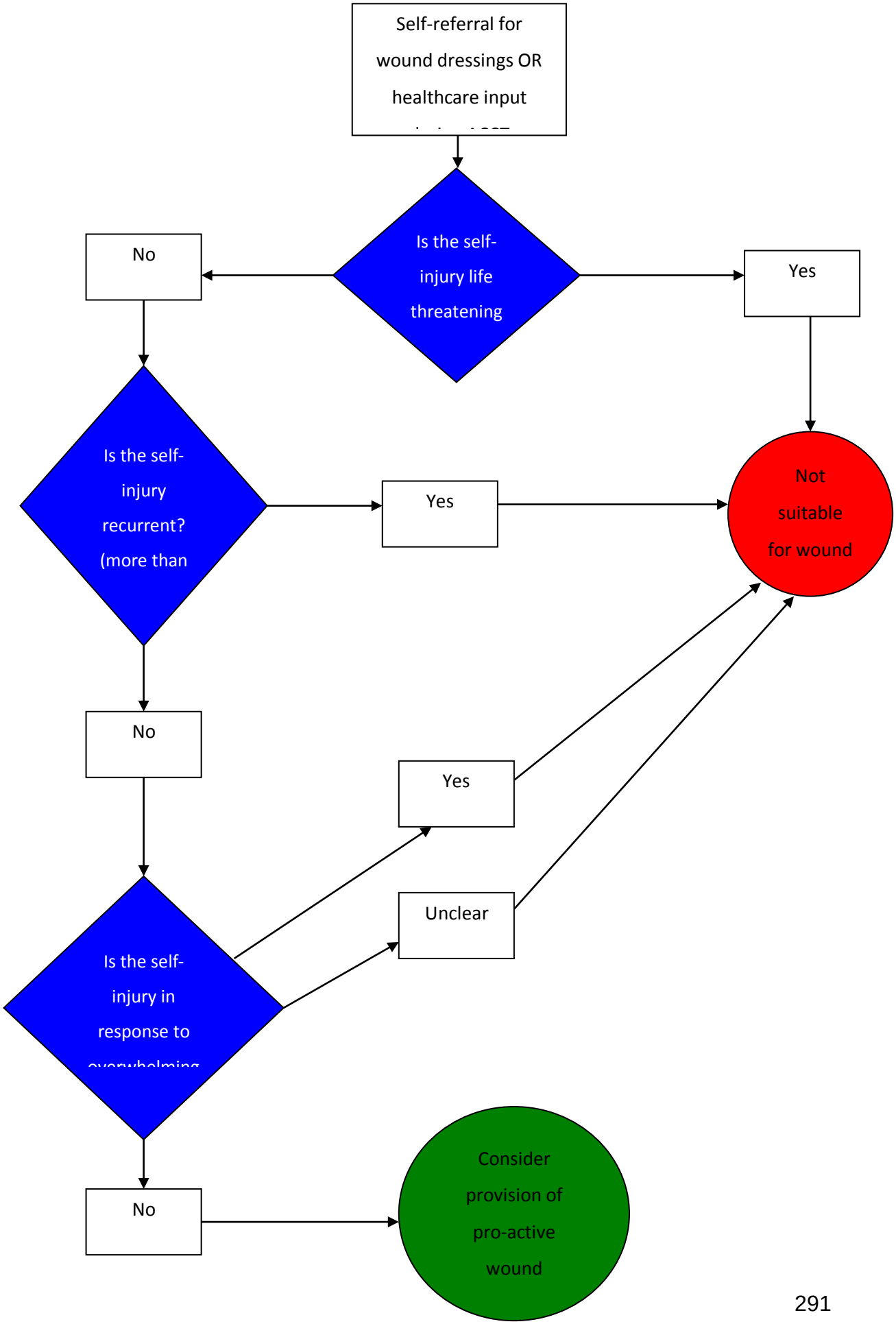
j) If dressings are removed before medical attention is received the women will be asked to dispose of the item in a clinical waste bag provided.

k) Misuse of dressings will result in immediate removal or refusal to replenish the pack and appropriate action through the Incentives and Earned Privileges (IEP) system.

l) If a woman in receipt of dressings is transferred to another establishment she will be unable to take these to the receiving prison. In this case the receiving prison will be informed that the woman has had this service withdrawn. If the woman has an ACCT open this will be communicated by an entry in the ACCT document. If no ACCT is open the appropriately trained healthcare member will telephone the receiving prison's

healthcare team and highlight the withdrawal of dressings in the IMR. If staff judge that the removal of dressings may increase risk of self-harm they should open an ACCT as a precautionary measure.

5. Decision pathway for use of wound dressing



6. Evaluation of self-care items

It is proposed that the provision of dressings is initially piloted for a period of 6 months with the possible extension to 12 months with agreement from the governance panel and the prison management board. The pilot can be stopped at any time due to unforeseen circumstances or any evidence of negative consequences of the pilot for those involved.

The evaluation of the provision of dressings will be in line with the overall KTP evaluation which seeks to monitor levels and severity of self-injury alongside staff and women's perceptions and experience of the pilot. In addition evaluation of self-care provision will specifically focus upon whether women and staff find this a protective or risk factor for self-injury through their experience of using or providing the resource. Findings will be disseminated with the overall KTP report and will be available to the clinical governance panel.

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Appendix K

A proposal for the provision of self-care items to some women for the purpose of re-dressing their wounds

1. Background

The proposal contained in this briefing has emerged from the ongoing Knowledge Transfer Partnership (KTP) project and has been developed in consultation with HMPS Safer Custody Policy Group (date) and the North East clinical governance steering group (25th January 2011).

The overall KTP project is a collaborative research programme between the North East Offender Health Commissioning Unit, Durham University and HMP YOI Low Newton. The project aims at increasing the understanding of self-injury and its use by women in custody, and utilising this knowledge to improve outcomes for both the women and staff in the prison.

Specific objectives of the KTP include:

IV. The reduction of self-injury in Low Newton and its associated costs.
V. Increased staff awareness of the issues around self-injury and increased confidence to manage such behaviour
VI. The promotion of service user involvement in the process of change in the prison.

It is suggested that if accepted this proposal will be piloted for an initial period of 6 months as a part of the KTP project and as such will be restricted to HMP YOI Low Newton because of the additional safeguarding procedures that are already in place as a result of the research programme having run for ??? months. These are ….

During this time ??? which time specific time for the pilot there will be close monitoring of the use of the proposed self-care items and associated protocols for their use in the jail . The pilot will be stopped immediately should any adverse consequences arise. This will be conveyed to the women??

Prison Service Order 2700 clearly emphasises the prison service's policy of not offering harm-minimisation in relation to self-injury and the service's duty of care in respect of??? . It is anticipated that the proposals set out here compliment these considerations by ensuring that the individual receives the necessary clinical and non-clinical care in the context of information provision and ACCT? whilst promoting an element of self-care and empowerment. Link this with women on prescription drugs being able to keep and administer their own meds if not deemed a risk?

The existing knowledge and experience of healthcare professionals supports a significant body of literature that differentiates between people who use self-injury intermittently and those who use self-injury repetitively (Yates 2008). As well as a difference in the frequency, the method and severity of self-injury

differs between these two groups. Yates' findings indicate that recurrent 'self-injurers' more frequently engage in more dangerous behaviour such as self-strangulation and ingesting harmful chemicals. They also need to receive outpatient medical attention more frequently than those who use self-injury intermittently. The proposal is therefore NOT suitable for these individuals

The difference in the use of self-injury is attributed to the difference in function of the self-injurious behaviour. Research reveals that intermittent self-injury is more commonly used as a means of communicating distress and the management of the individual's relationship with others. In contrast recurrent self-injury relates to the regulation of intrapersonal factors and an associated experiencing of overpowering emotion.

This proposal is rooted in the research that suggests that the degree of control an individual has over their self-injury will be greater for those who self injury more intermittently using less dangerous forms of behaviour.

As part of a Tier 1 stage of the pathway of care for women who self injure in custody the project is already making available an information pack that has been developed and in consultation with women, prison staff and a national expert group that includes self-help materials and workbooks that already exist in relation to self injury, Distraction focussed resources such as colouring books.
This proposal is to add to these packs one set of Self-care items (dressings)? to assist with the promotion of empowerment and self-worth for those who self-injure through an ability to re-dress their injury

Based on the evidence from Health Services Guidelines, a review of the literature and direct feedback from 17 women we suggest that there are compelling arguments for the empowerment of some women to become active in their self-care again link with meds .

1.1 Current Clinical Guidance and Evidence of Efficacy for 'Self-help' and empowering Provisions

NICE clinical practice guidelines (16, 2004) on the short term physical and psychological care of self-harm recommends Advice regarding *"self-management of superficial injuries, harm minimisation techniques, alternative coping strategies…for people who repeatedly self-injure."* (p.64); the use of tissue adhesive is also recommended. This is not currently available for women in prison in accordance with the prison services duty of care? what exactly does the duty of care say? .

Reasons for self-injury are varied and individual. However experiencing a lack of control or using self-injury to exercise control is a common theme (Sane, 2008; Sinclair & Green, 2005; Wichmann et al, 2002; Burstow, 1992). This theme was echoed by the current research project with women discussing both the negative effect of the removal of control by the prison environment and the positives of feeling they had a sense of autonomy. Promoting control is also a key theme in existing self-help materials for self-injury (Arnold 1998, Leader

1995). The negative effect of the removal of power is highlighted by the women who are required to seek medical attention for minor injuries that would not require medical attention in the community due to their free access to plasters/dressings for minor wounds. Based on the evidence we would suggest that allowing a woman who self-injures a degree of control over her wound care and distress management will have an empowering effect that may provide a protective factor against the exacerbated use of self-injury in custody.

2. Proposed provision:

It is suggested that one set of dressings such as steri-strips and/or Mepore dressings would be provided . This would allow the women to be able to re-dress? the injury having initially received the appropriate clinical assessment of the wound for the wound.

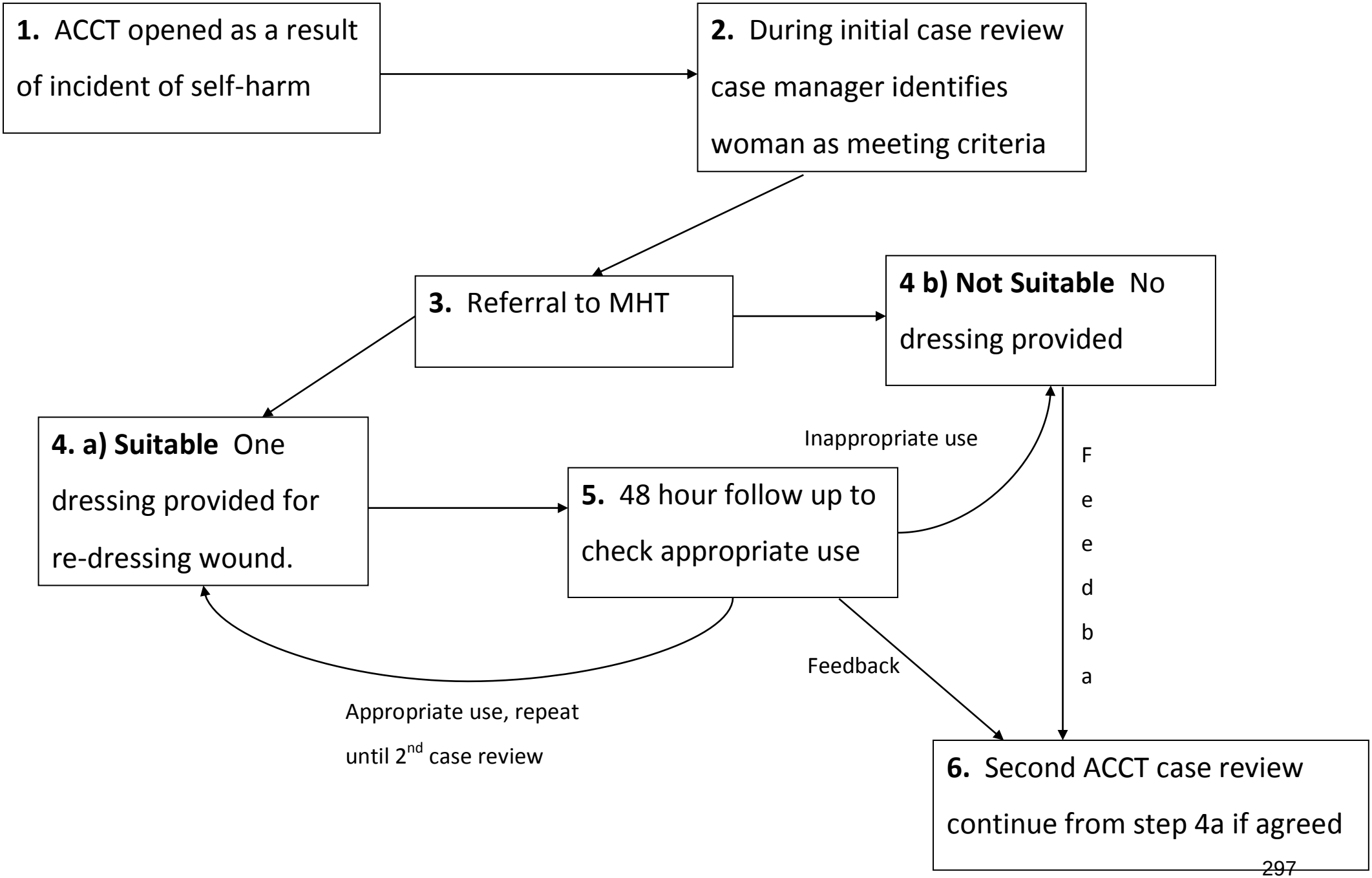
I'm a bit unclear what we are saying here. Are we saying women cuts goes to nurse and the nurse gives the women the dressing to administer herself there and then or is the nurse dressing it the first time and then having assessed the wound as low risk giving the women the dressings to reapply

The dressings will be included in the 'pack' which is already available and provides a woman with information and alternatives to self-injury and the means to prepare their own care plan for sharing with staff and appropriate peers. Items to distract from thoughts of self-injury such as puzzles or art equipment and items to encourage the woman to express herself in alternative ways including a diary and workbook would also be included.

The provision of items to the woman re-dress the injury will be written into the ACCT process how? We need to say if a woman is not on ACCT giving the dressings will trigger this and monitored through the case review procedures. Potential candidates will be identified by case managers during the first case review and assessed for suitability by members of the mental health team. Suitable candidates who receive any self-care items will be required to attend a 48 hour follow-up to ensure the correct use of the dressing. Non-compliance or incorrect use will result in the provisions being withdrawn. This will be made clear in information supplied with the dressings. (we need a simple flow chart for the women to reflect the protocol) the one in Figure 1 is fine for staff but ??? to complicated for the womenContinued provision will be reviewed in subsequent ACCT case reviews. The proposed system of identification, assessment, provision and review is laid out in Figure 1.

2.1 It is anticipated that for some women provided with self-care items an element of education in attending to and re-dressing wounds may be required. In these cases the healthcare professional will provide instruction following best practice guidelines. Written information for wound care will also be included in the packs.

3. Figure 1. Process for identification, assessment and possible provision of resources to re-dress injuries.


1. ACCT opened as a result of incident of self-harm
2. During initial case review case manager identifies woman as meeting criteria
3. Referral to MHT
4 b) Not Suitable No dressing provided
4. a) Suitable One dressing provided for re-dressing wound.
Inappropriate use
5. 48 hour follow up to check appropriate use
Feedback
Appropriate use, repeat until 2nd case review
Feedback
6. Second ACCT case review continue from step 4a if agreed

4. Protocol for the provision of items to re-dress injuries

m) Upon discovering or being made aware of an incident of self-harm staff will follow all existing procedures in relation to medical attention and documentation. There is no variance to this stage of the process

n) During the initial case review with 24 hours of the incident the case manager will judge whether the person might benefit from the ability to re-dress her injuries and is so whether they want to access such a service. If appropriate a referral will be made to the mental health team for assessment of suitability. The process illustrated in Figure 1 will be followed.

o) Dressings will not be provided for those whose self-injury is judged to represent a threat to their life or women who primarily use ligaturing, hanging or burning as their method of self-injury. Similarly if a woman is felt to be unable to adequately care for her own wounds due to mental health or learning difficulties dressings will not be provided.

p) Dressings will only be issued to suitable women after an incident of self-harm and after the injury has been appropriately treated by healthcare staff. Dressing WILL NOT be issued pre-emptive of an act of self-harm.

q) Where clinicians are uncertain as to whether to provide dressings advice and supervision should be sought from line management before a decision is made. The woman will be informed of any decision in person.

r) Dressings will only be issued by appropriately trained healthcare staff.

s) Dressings will only be provided to allow the re-dressing of one ‘act’ of self-injury.

t) In possession dressings will only be replenished after the woman has attended a 48 hour follow up to ensure she has used the provision appropriately. Failure to use the dressing in the correct manner or misuse of the dressing will result in withdrawal of the service

u) Dressings will only be provided along with activity and information packs and encouragement to engage with alternatives and distraction techniques.

v) Provision of a dressing and pack will be recorded in the ACCT document and the woman’s Inmate Medical Record (IMR).

w) The provision of dressings will be reviewed during ACCT case reviews during which multi-disciplinary input as to the appropriateness and continuation of the provision will be sought. It is important that appropriately trained healthcare staff attend case reviews.

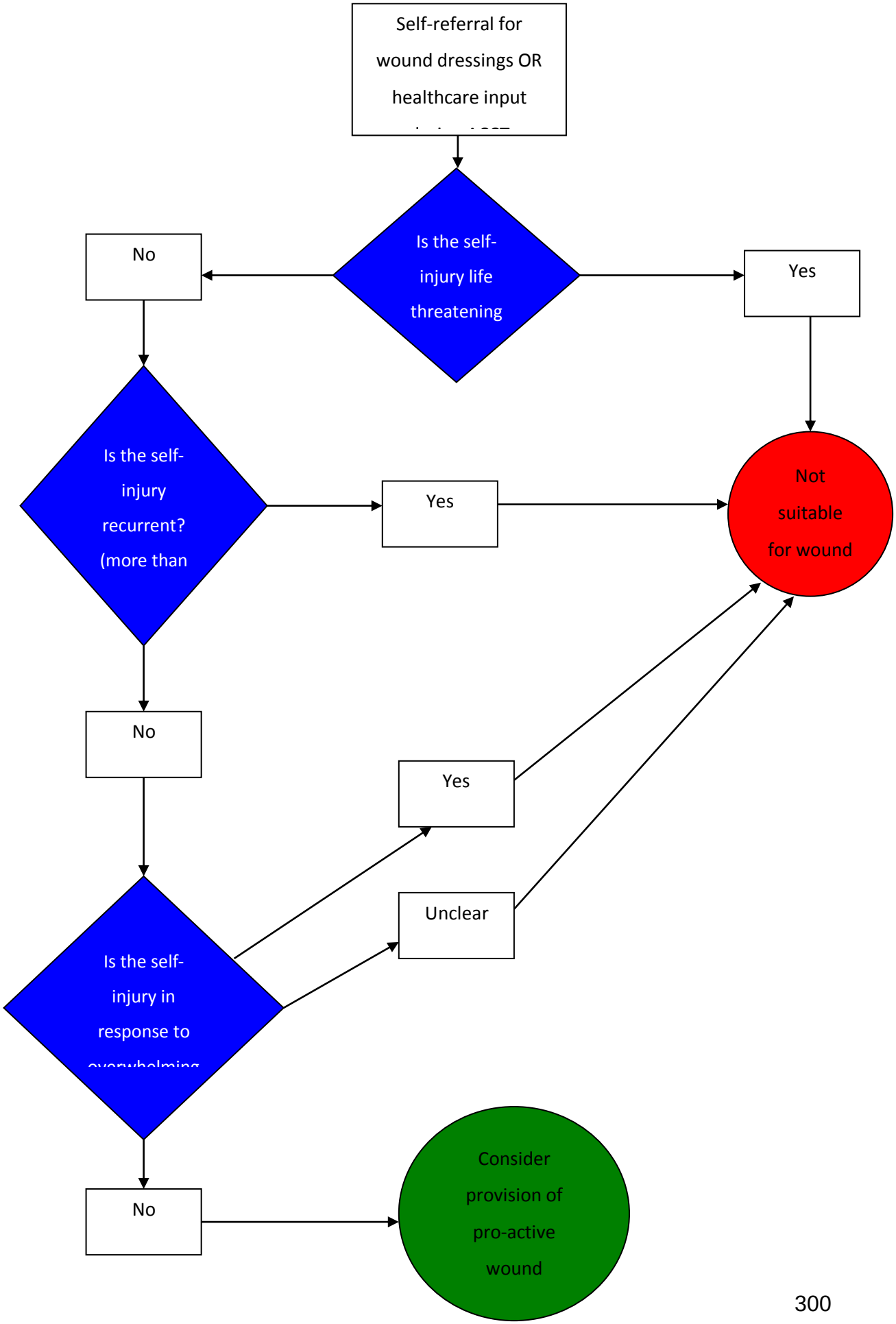
x) Misuse of dressings will result in immediate removal or refusal to replenish the pack and appropriate action through the Incentives and Earned Privileges (IEP) system.

y) If a woman in receipt of dressings is transferred to another establishment she will be unable to take these to the receiving prison. In this case the receiving prison will be informed that the woman has had this service withdrawn. If the woman has an ACCT open this will be communicated by an entry in the ACCT document. If the ACCT is open only in respect of giving dressings will this not then need to be closed if she can't take them with her? Ethically it seems unfair to go on an ACCT?

If no ACCT is open the appropriately trained healthcare member will telephone the receiving prison's healthcare team and highlight the withdrawal of dressings in the IMR. If staff judge that the removal of dressings may increase risk of self-harm they should open an ACCT as a precautionary measure.

I think it's box 4 in the flow chart that needs expanding into a version for the women.

5. Decision pathway for issuing a dressing



6. Evaluation of self-care items

It is proposed that the provision of dressings is initially piloted for a period of 6 months. The pilot can be stopped at any time due to unforeseen circumstances or any evidence of negative consequences of the pilot for those involved.

The evaluation of the provision of dressings will be in line with the overall KTP evaluation which seeks to monitor levels and severity of self-injury alongside staff and women's perceptions and experience of the pilot. In addition evaluation of self-care provision will specifically focus upon whether women and staff find this a protective or risk factor for self-injury through their experience of using or providing the resource. Findings will be disseminated with the overall KTP report.

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Endnotes

[1] Lather (1991) described praxis as *"philosophy becoming practical"* (P.11). Later in the thesis I argue how more philosophical, less practical, objectives such as consciousness raising may not be immediately desirable for women in prison (see p.33). Thus an emphasis is placed upon the practicalities of transformative research (e.g. products). A focus upon the tangible may not only be of more benefit to women in prison but also make it easier to ascertain whether praxis has been achieved.

[2] These figures are arrived at when comparing the rate of self-harm as being 4% of the general population as calculated by Briers & Gill (2003) with the rate in custody of 16% provided by Corston (2007)

[3] Knowledge Transfer Partnerships are a UK wide initiative primarily with the aim of pairing businesses with academic institutions to drive innovation and research within the private sector. The KTP which ran alongside this thesis was unique in that in the business partner was a primary care trust.

[4] The final report of the KTP project is available at http://www.cdd.nhs.uk/media/314927/ktp-final_report-31512.pdf

[5] Ligaturing in prison is predominately the restriction of blood and oxygen to the brain through tying a tourniquet around the neck. Most commonly the tourniquet is either a piece of underwear or a piece of material such as a 'jay cloth'.

[6] Although the literature reviewed was not restricted by gender invariably the majority of the research focussed upon women. Men are particularly absent from the cultural and research representations of self-harm (Cresswell, lecture Men, Masculinity and Self-Harm) which Smith (In Pembroke, 1994) suggests is a result of emotional expression through self-harm being typified as female and not male. This thesis does little to challenge this by focussing upon women's self-harm as a necessity due to the research site being a women's prison. Whilst I will almost exclusively discuss women this is not to imply that self-harm for men is fundamentally different as men often use similar means for similar reasons as women (Cresswell, 1996) nor that men's self-harm should not be afforded the same emancipatory research priorities that I advocate here. Instead I hope it is clear that the omission of men's in this thesis is a conscious and unfortunate one and not an oversight or dismissal.

[7] Given the size of the medical literature a colleague was enlisted to help with this aspect of the review (see Ward, de Motte & Bailey, 2012). To attempt to be as consistent as possible a systematic approach, which is often a characteristic of medical literature reviews, was employed. Subsequent searches of the feminist and service user literature did not yield nearly as much and I was therefore able to tackle this myself. These different approaches I also felt mirrored the work that was being reviewed. A rigid, systematic approach felt more apt for the medical literature whilst a more intuitive and subjective approach to the feminist works also 'fitted'.

[8] I have used the phrase A-B design to denote a single subjects experiment in which efficacy of an intervention is determined through pre-treatment measurement (A) of, in this case self-harm, and then post-treatment measurement (B) of self-harm. Measurement is usually the number of acts of self-harm or the number of presentations to medical staff following self-harm. Efficacy is determined through the statistical analysis of the pre and post (A & B) information.

[9] RCTs evaluate treatment efficacy by randomly assigning participants to a specific group, usually either the intervention being evaluated or a control group (placebo or treatment as usual). Efficacy is determined through statistical comparison of the measured variable (e.g. repetition of self-harm) between the two groups.

[10] The Delphi process is one by which a panel of experts anonymously answer questions about a particular subject. This is done over a period of rounds in which the panel members can

change their perspective based upon the contributions of others if they wish. The outcome is a consensus amongst the experts as to a correct answer to the question in hand (Linstone & Turoff, 2002).

[11] http://www.grassrootsfeminism.net/cms/

[12] This is the label that Elliott herself attaches to her actions.

[13] Brickman (2004) described a 'delicate cutter' as *"the white, suburban, attractive teenage girl"* (p.87) and evidences this myth from the medical discourse of the 1960's and more recent media portrayals (Girl Interrupted). The extent to which this, obviously damaging, portrayal is actually a problem is perhaps questionable. The term delicate cutter is not one that has appeared in any other article I have read suggesting that this is perhaps language that is consigned to the 1960's (Pao, 1969). Brickman's use of contemporary media portrayals of young attractive women who self-harm is probably greater evidence of the underlying sexism and objectification of women that exists within the media than a widely held stereotype of women who self-harm. That this is a problem of Brickman's own making, I would suggest, is evidenced by the phrase not appearing in Shaw's (2002) comprehensive examination of the historic clinical discourse of self-harm.

[14] The Bristol Crisis Service for Women is a voluntary service established in 1988 for women in crisis generally and particularly self-harm. It was founded by three notable activists in the survivor movement Tamsin Wilton, Maggy Ross and Diane Harrison.

[15] The dates that these initiatives are reference to are taken from Andrew Robert's notes and research of both SSO and the NSHN. This is available at http://studymore.org.uk/ssohist.doc

[16] As well as ending the routine strip searching of women prisoners the Corston review was also responsible for re-considering women's pathways in to offending. This however did not extend to a total re-working but the addition of two extra pathways for women, domestic violence and sex work. Whilst these do reflect the experiences of women in prison the simple addition of two avenues for women seems like a missed opportunity to fully and more holistically consider women's offending behaviour.

[17] Women In Prison is a campaign and support group for women who are affected by the Criminal Justice System. See http://www.womeninprison.org.uk/aboutus.php. The group was established by Chris Tchaikovsky and Pat Carlen as an organisation for political activism and individual support of women in prison.

[18] Stanley & Wise (1983) described objectivity as "an excuse for a power relationship" arguing that the removal of experience from epistemology is akin to subjugation.

[19] The positivistic position also includes the values of validity and reliability. However where some argue that these are key features of empiricism, many qualitative researchers (whether feminist or not) would argue that such terms have been improperly appropriated by quantitative researchers and that qualitative research can be equally valid and reliable (see Merrick, 1999; Lather, 1993).

[20] The distinction between feminist research and feminist *action* research may also result out of traditionally held assumptions as to the purpose of research and whether this is solely the objective gathering of information, or whether change is the intention. Silverman (1993) takes a hard line (and mirrors Hammersley's argument without reference) against the later objective, suggesting that emancipation muddies the waters between fact and values. As such Silverman claims that 'valid' knowledge cannot come from emancipatory research. To exemplify the point Silverman refers to the Aryan sciences under the Nazi regime as research being driven by a political agenda. Such unequivocal rejection of an agenda in research however is surely naïve and short-sighted given the often reported and unreported interests of 'scientists' including those who conduct the gold standard of empiricism the randomised control trial (see

http://www.guardian.co.uk/commentisfree/2009/oct/03/bad-science-verdict-drug-trials about the failing of the clinical trials register).

[21] Tickner (2001) described patriarchy as a social construct by men for the purpose of maintaining control and power over women.

[22] Martel (2004) wrote of her experience of researching the segregation of women in Canadian Federal prisons. Although the article outlines the interesting findings of this research it is the 'policing' of the information produced from this that is of interest. This included having to compromise her research design at the request of the CSC to include quantitative information in order to ensure 'representative' sampling and then denying the study a 'scientific status' (despite appearing in a peer reviewed journal) and leading to pillorying in press for the research's anecdotal nature.

[24] Whether this is actual gender neutrality or, as is often the case in the prison system that the focus of research is predominately upon the significantly larger male population is unclear.

[25] It is of interest to note that in preparing this review the Sainsbury Centre themselves undertook consultation with *"Key experts"* (p.3) yet none of these experts were identified as being service users themselves but all described as 'professionals'. This lack of SUI in the report, rather ironically, provides further evidence of the lack of SUI in prisons.

[26] Brier & Gill (1998) reported that 4% of the general population self-harm. The SANE report (2008) states that 80% of all Accident and Emergency presentations are a result of self-harm but only 36% of people who self-harm receive medical attention.

[27] NICE is the independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health now called the National Institute of Health and Clinical Guidance although the acronym remains the same.

[28] The Truth Hurts inquiry set out to examine the nature, extent and methods of prevention and ways to respond to young people who use self-harm. The report is written by The Mental Health Foundation (2006) a charity that aims to improve services for those affected by mental health problems.

[29] The Cortson Report was commissioned following six self-inflicted deaths within 13 month at HMP Styal, a women's prison in the North West of England. The original term of reference was to independently review services for "vulnerable" women who come in to contact with the CJS and specifically how to define "particularly vulnerable" women. Thus the original terms were not encompassing of all women in the CJS. Baroness Corston however rejected the labelling of women with multifaceted needs as vulnerable and instead widened the remit of the review to include all women who, in her opinion, we inappropriately placed in prisons or for whom the CJS did not have the resources to meet their needs.

[30] Safer Custody and Women and Young People's Groups are Prison Service headquarters teams responsible for the development of policy and audit of adherence to policy in the areas of suicide prevention and self-harm management and women and young people in prisons respectively. As maybe expected there is substantial overlap in the remit of both teams in policy relating to self-harm, and similarly to policy between the MOJ and DH can be inconsistent or contradictory. This is particularly highlighted by the guidance around harm-minimisation information in relation to self-harm as discussed in Chapter 7.

[31] http://www.hmprisonservice.gov.uk/adviceandsupport/prison_life/selfharm/

[32] The Listener scheme is a volunteer peer supporters system by which prisoners are trained and supported by Samaritans to listen to and offer emotional support to their fellow prisoners The objectives of such a scheme are to assist in preventing suicide, reducing self-harm and generally to help alleviate the feelings of those in distress. The Listeners adhere to the same guidelines as the Samaritans in that they offer total confidence to their 'client'.

[33] The Fawcett Society is an organisation campaigning for gender equality and women's representation in areas such as politics, pensions, poverty and the criminal justice system.

[34] It is acknowledged that in some areas there continues to be resistance to harm minimisation approaches for substance use (States, Reuter & MacCoun, 1995). However given that prescription of methadone, needle exchanges and public educational initiatives are common place I would argue that the approach is much more successful than its counterpart for self-harm.

[35] By incorrect I mean a recording that does not concord with the deceased's intention, which is generally unknowable.

[36] The use of the phrase 'desire' by Gutridge could be in of itself an example of the negative moral code and stereotype Cresswell and Karimova (2010) identify in relation to 'celebrating' self-harm. I have heard people describe a need, necessity and impulse or even a craving to self-harm. I have never heard or read of anyone describing the antecedent of self-harm as being a desire however.

[37] The Bolam test as described by Hewitt (2004) relates to a court case *Bolam v Friern Hospital Management Committee, 1957* and which now stands as the test for medical negligence. Hewitt describes this as *"a particular clinical intervention will be lawful where it is consistent with a 'standard of practice accepted as proper by a responsible body of medical opinion skilled in the art'"* (p.156).

[38] St. Georges Hospital, Stafford for some in-patients will include the use of self-harm on the person's care plan if agreed by a multidisciplinary team. This has inevitably proved controversial and attracted media interest, see http://news.bbc.co.uk/1/hi/health/4830448.stm.

[39] Schramme wrote more broadly about 'self-mutilation' including procedures done for cosmetic or cultural reasons such as tongue splitting and scarification. Regardless the point of a general discomfort around any form of injury that is not medically or accidentally inflicted hold equally true for the concept of self-harm used in this these i.e. that of harm inflicted as a result of mental ill health or distress.

[40] In personal correspondence

[41] Kant's duty to oneself is supposes that humans have a special in 'creation' and therefore are duty bound to adhere to imperatives that include a moral duty of self-preservation.

[42] based upon 4% of the general population of approximately 60 million

[43] Whilst I hold the NICE guidelines as an example of 'mainstream success' I do so in full recognition of the criticisms of the lack of SUI in the process of preparing the document and the treatment that those who took part were subjected too (Pembroke, 2005).

[44] Sterilising tablets were piloted for a short time before being withdrawn due to concerns about possible toxic effects and their flammability. These risks were reviewed and deemed safe by the prison service, hence being reintroduced. Although the Prison Service Instruction is clear that the aim of the sterilising tablets is to reduce the risk to prisoners and staff of infection of blood born viruses through shared usage of needle stick accidents/assaults, the planned "marketing" (p. 1) of the tablets is to promote sterilisation of other equipment such as toothbrushes and razors. This indicates a lack of ingenuity, or at least openness, of the prison service to openly accept that the use of injecting paraphernalia in the prison, especially given that the limit set on in-cell possession of the tablets is 34!

[45] The PCT claimed partial ownership of the research site and required that their ethical governance procedures were followed. Whilst this was argued against on the grounds that the women and staff were in a prison and not a healthcare setting this was rejected and the PCT claimed that although prisoners the women in the prison were still healthcare service users.

Whilst this is undoubtedly true it raises the question of whether all research in the field of health involving NHS service users (which will amount to the majority of the population in the UK) should require PCT R&D approval.

[46] These complex and multifaceted needs are often described as 'vulnerabilities' for people in prison, however the label of 'vulnerable' has been criticised for being further stigmatising and unhelpful (Corston, 2007) and does not reflect the culture of respect for women and staff that this research is trying to abide by.

[47] Adjudications are hearings conducted by either a prison governor, or in more serious cases an external magistrate, following the reported breach of prison security regulations. The purpose of the hearing is to determine whether the person reported is guilty of a breach of the rules and if so to set an appropriate punishment for the incident. Sanctions can range from loss of earning, association time or privileges such as use of a television in their cell to segregation and additional days added to a sentence. PSO 2000 (2005) states adjudications have has two purposes, i) To help maintain order, control, discipline and a safe environment by investigating offences and punishing those responsible and ii) To ensure that the use of authority in the establishment is lawful, reasonable and fair.

[48] A Sentence Plan is a set of targets the prisoner is expected to complete in order to reduce their risk of re-offending. Often these will include educational, therapeutic and offending behaviour interventions. For prisoners on life sentence and indeterminate sentences their progression through the prison system, and their eventual release is dependent upon them completing their sentence plan. That therapeutic and psychological based interventions are often included is much discussed and whether this constitutes and anti-therapeutic level of coercion is debated (see Day, Tucker & Howells, 2004)

[49] The 'canteen' is a service provided by a contracted company through which people in prison can buy additional items such as toiletries, confectionary, stamps, clothes telephone credit etc. Prices are often inflated from those on the high street to represent the additional resources required for delivery and distribution to the prison. This results in people in prison being further restricted in what they can purchase due to high prices, low wages and restrictions on expenditure.

[50] Card goes on to suggest that the term pro-feminist also avoids the mockery that ensues when a man is called a feminist and believes that the term instils more a "tinge of fear" (p.26) than a male feminist might . This however undermines her argument that the original reason for the distinction between 'feminists' and 'pro-feminists' was due to the "legacies of sexual politics" (p.4). I am sure women have been, and continue to be, mocked for identifying themselves as feminists. This manifestation of a hegemonic masculinity surely requires challenging and not avoiding by rebranding and that such challenges will instil the fear if that is the desired effect.

[51] The Senior Management Team (SMT) consists of various Governors and other functional heads from around the prison representing each department within the prison. The SMT at the prison is surprisingly large, consisting at times of up to 17 members at one point of whom eight were female.

[52] Although Oakley described interviewing women as a contradiction in terms.

[53] HMIP is an independent inspectorate which examines the conditions and treatment of prisoners in prisons, immigration removal and detention facilities and young offender institutions in England and Wales. The inspectorate reports directly to the Ministry of Justice and Home Office. Whilst the inspectorate have no statutory powers to enforce compliance with its recommendations a degree of influence is exerted through placing reports in the public domain sometimes resulting in negative media attention for prison's whose standards are found to be inadequate (for example see http://www.guardian.co.uk/society/2001/mar/12/penal.comment?INTCMP=SRCH)

[54] SURGE was the service user 'hub' of the Mental Health Research Network (www.mhrn.info). This now appears to have been replaced by the Service Users in Research Network still hosted by the MHRN.

[55] Liebling ,in the development of the MQPL tool, was well resourced receiving funding from the Home Office and, in addition, considerable institutional support from the prison in which the tool was developed. This included the opportunity to spend entire days with groups of staff and prisoners, which is very different from the experience of the author of having to negotiate a 45 minute window for an officer to be released from the detail to be interviewed as was the case with this research.

[56] Unfortunately the design of the questionnaires and interview schedules were required by the REC before the process of engaging with potential participants could begin. This made it impossible to involve the women and the staff in the design of these and adhere to the ethical guidelines at the time. Current guidelines allow for the active involvement of potential research participants in planning process before ethical approval (Involve, 2009). The REC submission for this project however pre-dated this publication by a matter of months.

[57] All known acts of self-harm are required to be recorded by the member of prison staff who discovers or are told of the act on an incident reporting form. This information is collated by the prison's Safer Custody Department and it was this that formed the baseline for incidence rates of self-harm.

[58] This was largely borne out by the findings of the research in which women generally reported feeling isolated in their self-harm and mental health difficulties.

[59] CARATS stands for **C**ounselling, **A**ssessment, **R**eferral, **A**dvice, and **T**hroughcare **S**ervices, provides low intensity, low threshold, multi-disciplinary, drug misuse intervention services (PSO 3630). This is a mandatory service for all poly drug users (including alcohol) in prisons in England and Wales. CARAT workers are generally specialist drug workers contracted to work in the prison from drug agencies.

[60] Offender Management aims to provide the integrated management of offenders between probation and prison services. Offender managers are usually probation officers seconded to work in the prisons but also include specially trained prison staff including officers.

[61] There are very few women from Black or Minority Ethnic backgrounds within the prison with typically around 91% of the population in the research site identify themselves as White British.

[62] Arguably the process of PAR in this research has therefore been more akin to Planning – Critical Reflection – Action – Critical Reflection as illustrated in Figure 3. This is probably true of most action research, however, and reflection upon even a daily basis is necessary to continuously improve, develop and learn from mistakes. To describe this process, however, would be cumbersome and unnecessary and therefore I shall stick to the three stages outlined even if these are not truly linear in nature.

[63] It is worth highlighting that the quantitative information presented is taken from records that are often completed immediately after an incident of self-harm and in addition to other duties the member of staff is required to fulfil. As such records are often incomplete and therefore totals reported may not be consistent. The records also do not provide a full picture of self-harm within the prison as they are only those incidents which are discovered by or reported to staff.

[64] Safer Cells are special accommodation designed to reduce the means available with which to self-harm, primarily by reducing ligature points within the room. Safer cells however also do not have televisions or radios in, often removed for fear of the glass or cables being used to self-harm or attempt suicide. For similar reasons women are not allowed to take personal possessions in to the rooms and often not even reading material as such are very impersonal spaces with little distraction or opportunity to engage in meaningful activity.

[65] Services provided by mental health staff (RMN's, CPN's, OT's etc) only run Monday to Friday 9am – 7pm. I make the point that mental health services are only *perceived* to be during these hours as a key aspect of all staff roles, including officers who are there 24 hours a day, is the care for the individual's mental wellbeing.

[66] Care First is an independent organisation offering "Employee Assistance Programmes" (www.care-first.co.uk). Care First is contracted by the prison service to provide telephone counselling services to directly and non-directly employed prison staff. Referral for staff is via their line manager which for many is an obstacle to access as is being released from the detail and finding a private and quiet place in which to call during work hours.

[67] The 'packs' are care planning action packs designed with the aim of empowering women to develop their own care plans and consider what actions they can take, and what they can ask of others, to help maintain mental wellbeing.

[68] Activity boxes contain activities for distraction such as puzzles, colouring sheets etc.

[69] Largely the proposal as to who was suitable to receive self-care items was common sense couched in the medical discourse of assessment with which we had to engage. Women who would not be 'assessed as suitable' for the scheme were those whose self-harm was potentially life threatening or who used practises in which harm could not be minimised such as overdosing or ligaturing. This criteria was largely informed by the survivor literature such as the Hurt Yourself Less Workbook.