

Self-Harm amongst Female Offenders in Custody: Lessons from the Literature

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Summary: The prison population is extremely vulnerable to committing acts of self-harm and female prisoners are more likely to self-harm than their male counterparts. The National Suicide Research Foundation (2004) recorded that 22.2% of the cases of self-harm that occurred in Irish prisons in 2002 involved females, even though women comprised only 3.1% of the total prison population. This article examines international research and trends to consider why self-harm is so prevalent amongst female prisoners, how self-harm can be prevented and what the best response is to those who self-harm.

Keywords: Female offenders, self-harm, prison, personality disorders.

Introduction

The prison population is an extremely vulnerable one and is more likely to exhibit characteristics associated with self-harm than the general community. These characteristics include poor interpersonal relationships, inadequate problem-solving skills, low motivation, socioeconomic disadvantage, low self-esteem, poor education and employment history, substance misuse and involvement with the criminal justice system. The prison population has a higher rate of self-injurious behaviour than the general population (McArthur *et al.* 1999b). In general, female offenders experience more psychosocial problems than their male counterparts. Research has shown that female offenders are more likely to have personality disorders, psychosis, addiction problems, neurotic disorders and learning disabilities. In addition, more female than male offenders

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have experienced childhood abuse and have been in abusive relationships (Maden *et al.* 1994; McArthur *et al.* 1999b). Self-harm also occurs more frequently amongst the female prison population. The National Suicide Research Foundation (NSRF 2004) recorded that there were 144 parasuicide episodes (which they define as deliberate self-harm) involving 112 individuals in Irish prisons in 2002. Some 32 of these cases (22.2%) related to women. As only 3.1% of the Irish prison population of that year was female, women are clearly over represented in these figures. They may also under-represent the incidence of self-injury amongst prisoners as minor incidents often go undetected. As the ongoing trend shows that the female prison population is increasing, it is most likely that self-harm will become an even more prevalent problem in Irish prisons.

What is self-harm?

Isacsson and Rich (2001) argue that self-harm is not an illness but a behaviour. It is a physical act committed against oneself with the intention of inflicting harm. The severity of the act can vary from one that causes minor damage to one that threatens life. Some argue that self-harm and attempted suicide should be viewed as two separate categories; the former as a dysfunctional way of dealing with anxiety, tension, stress or guilt or of gaining control over aspects of one's life, and the latter as an intention to die. Self-harm is looked upon as a chronic problem that is more repetitive and less lethal than attempted suicide (McArthur *et al.* 1999b). Liebling (1996), however, believes that self-harm and attempted suicide are part of the same continuum, which begins with ideation, then self-injury, followed by suicide attempts and finally culminates in actual suicide. She goes on to say that people may enter or leave the continuum at various points.

Research indicates that prisoners who commit suicide have had a higher incidence of self-harm in the past and that those who self-harm are more likely to experience suicidal ideation (McArthur *et al.* 1999b). It follows, therefore, that regardless of which view is accepted self-harm should always be viewed as serious. McArthur *et al.* (1999b) state there is no correlation between intent and the seriousness of self-harm. This would certainly appear to be true in a custodial setting. In a prison situation there is limited access to less serious methods of self-harm such

as drug overdoses and more opportunities for more serious methods such as hanging and cutting. As a result there is an increased risk that any such attempts may turn out to be serious. Regardless of the seriousness of a specific incident, it should be noted that any level of self-harm indicates personal distress. For the purpose of this article I am using the term self-harm to encompass all types of deliberate self-injury regardless of intent.

Self-harm in a custodial setting

As already stated there is a higher rate of self-harm amongst prisoners than in the general population. McArthur *et al.* (1999b) put forward two theories as to why this situation should apply. The first is known as the 'importation theory', which states that the reason prisoners are more likely to self-harm is due to their personal attributes. Put into practice this means that suicide rates would be reduced if risk factors were identified and predictors for suicide were developed and implemented, such as the Suicide Risk Assessment and Management (S-RAMM) tool developed by the Cognitive Centre Foundation. This theory supports the view that a custodial setting plays little part in self-harm behaviour and that self-harm occurs more often in prison due to the vulnerability of this specific group to self-harm. McArthur *et al.*'s second theory is known as the 'derivational theory', which asserts that self-harm is caused by the stress and difficulties encountered through being incarcerated. These include the fact that prisoners' social support networks are broken: they no longer have on-demand access to their family and friends, they have lost control over their lives, they are denied membership of the wider society and they are part of a closed social system that contains violence, distrust and fear.

It might be that people in prison self-harm due to an interaction between the person and the environment. Holley and Arboleda-Florez (1988) argue that self-harm can be a way of gaining some control in an environment where rules and regulations apply such as prison. Those who are finding it difficult to tolerate the regime are more likely to use self-destructive behaviours. They put forward the view that punitive responses may increase the severity and frequency of these attempts. Additionally those who have lost their social support network may be more likely to turn to self-destructive behaviour in an attempt to deal

with feelings such as anger and frustration. Borhill *et al.* (2005) acknowledge that there is a link between self-harm and childhood abuse. They suggest prison may 'retraumatise women with histories of abuse because it replicates aspects of the traumatic experience, lack of privacy and autonomy, isolation from social support and dependence for basic needs on conformity to authority figures' (p. 68).

There are several points at which self-harming behaviour becomes increasingly prevalent in relation to people in custody. Dear *et al.* (1998) and Wool and Dooley (1987) note that prisoners on remand are overly represented in statistics of self-harm; this could be because they are subject to considerable stress as a result of the uncertainty regarding what lies ahead. Lloyd (1990) argues that many people who are on remand suffer from a mental disorder and are therefore considered to be at risk of suicidal behaviour. The *Report of the National Steering Group on Deaths in Prisons* (Department of Justice 1999) acknowledges that there is international evidence of suicide being increasingly likely during the remand stage, but found no clear pattern of this during their study in Ireland. Liebling (1995) puts forward the viewpoint that other precipitating factors for self-harm in prison include transfers, recent stressful prison events, refusal of parole, the start of a sentence and recent domestic events.

Several research studies have identified clusters of incidence of self-harm occurring within custodial settings. McArthur *et al.* (1999b) assert that prison subculture and the prison regime are factors in the level of self-harm within the prison. Ross and MacKay (1979) studied adolescent females in a custodial setting and found that 86% had cut themselves. They also found that the girls who self-harmed only once were more likely to be popular than those who had not self-harmed or who had self-harmed repeatedly. They conclude that this once-off self-harm occurred when girls realised that it would assist them in gaining acceptance. McArthur *et al.* (1999b) argue that this is a subculture that forms within the institutional setting and that is inherited from previous generations of prisoners.

Profile of those who self-harm in custody

Smyth *et al.* (1994) and Dear *et al.* (1998), amongst others, found that young people were more vulnerable to self-harm. This is also reflected in

the 2004 NSRF report, which found that the majority of the self-harm incidents in Irish prisons are committed by those aged between 15 and 39. This is indicative of the Irish prison population, where 86.4% of prisoners are under 40 years of age.

Prisoners most prone to self-harm are likely to have negative relationships with inmates and staff, have a history of mental disorder (including both mental illness and personality disorder), have a history of drug abuse, be victims of child sexual abuse, be impulsive and have poor problem-solving skills (McArthur *et al.* 1999a; Heney 1990).

Wichmann *et al.* (2002) argue that those who repeatedly self-harm not only commit self-directed acts of aggression, but are also more likely to be involved in institutional incidents of violence, drug and alcohol use and discipline problems. They also found that self-harmers were more likely to have adjustment difficulties to prison conditions, be victimised by their counterparts, have prior escape-related behaviour and have difficulty remaining crime free in the community. Their risk of reoffending was higher than those who did not self-harm.

Isacson and Rich (2001) assert that between 90% and 99% of those prisoners who self-harm have one or more psychiatric disorders, under which heading they include personality disorder and substance misuse. Research also indicates that self-harm is more prominent amongst those who have personality disorders than it is amongst those with a mental illness. Rutherford and Taylor (2004) compared the self-harm rate amongst these two groups and found that 73% of those with personality disorders self-harm as opposed to only 19% of those with a mental illness. Gorsuch (1998) studied 44 women who were referred to a psychiatrist working in London's Holloway Prison and compared those who were 'difficult to place' in psychiatric services with those who never had a problem getting a bed in a secure NHS facility. The research found that the members of the group that was difficult to place in psychiatric services were more likely to have experienced abuse, be homeless, be guilty of more violent offences, have had arson convictions and have addiction problems. Most were diagnosed with a personality disorder as opposed to an acute psychiatric illness and were considered a management problem by the prison. The study showed that these women were also more likely to self-harm, with 95% of them engaging in such acts compared to 36% of those with psychiatric illness.

Such women find it difficult to survive in the community and in Ireland there are only a limited number of hostels and transitional

housing projects available for women. It is my opinion that women who have a variety of social and psychological problems struggle to deal with the rules in these services and as a result they can become excluded from them. Feeling even more marginalised, they then continue in the perpetual cycle of offending and prison.

Wilkins and Coid (1991) state that 'the containment of such disturbed and damaged women has now shifted from the psychiatric to the penal system'. Coid *et al.* (2003) assert that prisoners are being increasingly removed from the psychiatric system by re-diagnosing them as having personality or criminal behaviour problems, or by 'reorganising the gate keeping processes leading to admission to the disadvantage of offender patients and lack of resources, specifically secure beds' (p. 337).

Prevention of self-harm in custody

Initial screening of prisoners for risk of self-harm is common practice internationally, however it is widely accepted that this in itself is not sufficient in preventing suicide. Dooley (1990) asserts that self-harm should be seen in terms of the morale of the institution and not in terms of an individual's problems. One should be wary of disregarding the individual in the equation, however, as not every prisoner self-harms. Therefore the act may be most likely to result from the interaction between a prisoner's characteristics and the institution. In order to address the issues relating to self-harm, preventative strategies within the prison and appropriate responses to those who self-harm should be utilised. I will first look at the positive protective strategies that the prison can take to reduce the level of self-harm amongst all prisoners.

Liebling (1995) argues that prevention of self-harm is often better placed in the mainstream prison than in the healthcare unit and that the focus should be on strengthening protective factors. She asserts that constructive activity within the prison is important in the prevention of self-harm. Although female prisons, for example the Dóchas Centre in Dublin, often provide a wide range of educational, recreational and work-related activities, many prisoners do not partake in these activities due to poor motivation. The Dóchas Centre previously operated a scheme to encourage women to participate in education and work within the prison by awarding points for partaking in these activities. These points could be traded in for extra privileges. The Dóchas Centre is also

reintroducing regular house meetings within the prison, which provide the prisoners with a forum for voicing their opinions on the way their house is functioning. Projects such as these assist women in gaining some level of control over their environment, which Liebling (1995) argues is necessary for them to recover from self-harm.

Liebling (1995) also identifies the need for these women to have hopes and plans in order to prevent self-harm in prisons. She argues it is essential that a positive sentence-management service is in place (including a comprehensive plan for each prisoner) in which needs are assessed and appropriate programmes developed. These programmes would equip prisoners with skills and capabilities to protect them from self-harming as well as assisting them to improve their behaviour in prison and reducing their offending behaviour on release.

There are no open prisons for female offenders in Ireland. It is arguable that the lack of such facilities may have a bearing on the women prisoners' motivation to become involved in educational activities and to partake in programmes aimed at helping to reduce their offending behaviour; the opportunity of progression to an open facility may have offered an incentive to participation. Due to the ongoing rise in the numbers of females being incarcerated, increasing pressure is being placed on the two existing prisons: the Dóchas Centre and Limerick. In view of the plans to move Dublin's Mountjoy complex (incorporating the Dóchas Centre) to a new site at Thornton Hall, it is an appropriate time for the Department of Justice to examine the concept of providing a low security or open prison for females.

McArthur *et al.* (1999a) argue that those who are at risk of self-harm should be regularly assessed and receive counselling from members of a multi-disciplinary team consisting of psychiatrists, psychologists, psychiatric nurses and probation officers. It is important that cases of those who are at risk or who have self-harmed are regularly reviewed. Regular weekly healthcare meetings are held in the Dóchas Centre to review cases of prisoners that fall into this category.

McArthur *et al.* (1999a) also assert that the Victorian model for unit management divides the prison into small manageable units which allow for greater interaction between prisoners and staff and have the additional benefit of reducing isolation. The Dóchas Centre operates under this model and is subdivided into seven houses with staff assigned to a panel for each one. Prison officers have more contact hours with prisoners than any other profession within the prison and are more likely

to be in the vicinity when a crisis occurs. Selected prison officers could be given additional specialised training to enable them to play a key working role with long-term prisoners and repeat offenders.

Visits from family members can reduce feelings of stress and isolation. Keeping up regular contact with family can also help in reintegrating prisoners into society. The *Report of the National Steering Group on Deaths in Prison* (1999) recommends regular telephone contact and visits for families. Prisoners in the Dóchas Centre are able to make daily telephone calls to their families and receive weekly visits. Those on remand are able to receive visits on a more regular basis, which is most desirable because, as already stated, being on remand can cause particular personal distress and can increase the risk of self-harm. McArthur *et al.* (1999a) argue that to reduce the stress of the prison environment, new prisoners should receive an induction programme. They give an example of one such programme in Australia where prisoners receive basic information on prison routine, support services and safety issues. Additionally it is widely acknowledged that the provision of a television reduces incidences of self-harm as it decreases feelings of boredom and isolation (McArthur *et al.* 1999a; Department of Justice 1999). Each cell in the Dóchas Centre has a television. Schemes such as the Befriender Scheme, which is run in the Dóchas Centre, where volunteers visit those who have few visitors are beneficial in reducing feelings of isolation and allowing prisoners to feel they belong to the wider community.

Heney (1990) reports that many female prisoners support each other informally following self-harm, which includes taking care of wounds to avoid detection by prison management. Some prisons in Britain, Australia and the US have placed this arrangement on a more formal basis through a peer support programme. In Britain and Northern Ireland a listening scheme is operated in some prisons by the Samaritans. At least 10 to 12 long-term prisoners, who have no substance-use issues, are trained as listeners. They listen and provide support to other prisoners in crisis and may also share their cell with them if required. The Samaritans run weekly group sessions for the listeners. Davies (1994) found that the listener scheme in Swansea reduced self-harm by 50%. It would undoubtedly be difficult to implement such a scheme amongst female offenders in Ireland because both of the prisons catering for women have an insufficient pool of long-term prisoners at any one time. Nevertheless, it might be possible to introduce a modified version of the scheme.

Best practice when self-harm occurs

Kapur (2005) argues that when self-harm occurs there should be a move from a risk assessment of further self-harm to a needs assessment, which would identify psychosocial factors that might explain the act of self-harm and help develop a plan to counteract the problem. Some prisons in New South Wales, Australia investigate and address each case of self-harm using a number of treatment options, including immediate referral to counselling, increased family visits and special accommodation such as shared cells and peer support.

International practice is moving away from the use of strip cells for those exhibiting self-harm behaviour, as research indicates self-harm is more likely to occur when alone. Being placed alone in a cell can increase feelings of isolation and therefore, if circumstances allow, it is preferable to let the prisoner share a cell with someone else. However, Coid *et al.* (2003) acknowledge that if the individual also poses a management problem there may be few alternatives to the strip cell. The *Report of the National Steering Group on Deaths in Prison* (1999) states that the strip cell allows a person to overcome an immediate crisis but does not solve the problem of self-harm. In circumstances where there is no alternative but to use a strip cell, every effort should be made to resolve the issues facing the prisoner so as to end the time spent there as soon as possible. The report also argues that high-support units for those exhibiting self-harm behaviour would be more suitable. These units would have the advantage of being staffed by dedicated personnel with specialist training, however, it could be argued that such units might cause a cluster of self-harming incidents to occur. Liebling (1994) argues:

. . . prison staff and other specialists on the other hand, may be better placed to resolve some of the immediate problems precipitating the crisis. Access to social service agencies, legal aid, probation officer or other sources of advice and practical assistance may be a more effective and humane response to distress than referral to a psychiatrist or isolation in a prison hospital. Prison staff and other prisoners may also be able to offer the support, company and diversion that is required (p. 7).

It is essential, therefore, that a multi-disciplinary approach is adopted in dealing with crisis situations. The team should include a nurse,

psychologist, probation officer, psychiatrist, a member of prison management and a prison officer who has a lot of contact with the prisoner (McArthur *et al.* 1999a). Prisoners who are considered at risk of self-harm in Ireland are placed on a special observation list and are checked every 15 minutes. In the case of the Dóchas Centre, these lists are reviewed on a regular basis.

Problem-solving skills

Biggam and Power (2005) express support for the use of problem-solving interventions for mental health issues and self-harm. They assert that:

. . . from a mental health perspective, problem solving serves as a general coping strategy that allows an individual to generate, select and implement a whole host of effective behaviours which will enhance general well-being in psychological and social terms and protect the individual from possible maladaptation (p. 147).

Biggam and Power argue that such interventions could be offered to vulnerable prisoners who have difficulties in adjusting to prison. These should be integrated with other programmes such as drug rehabilitation programmes. They say that the problem-solving intervention for mental health is a brief form of intervention and therefore can be offered to those with short sentences. Problem-solving interventions for mental health can be used to prepare individuals for other programmes aimed at reducing recidivism. The goal of the problem-solving training should be to equip prisoners with generalised skills that they can use in any context and not just in prison. More research is needed to establish whether problem-solving skills reduce self-harm amongst female offenders in both the short and long terms.

Conclusion

Self-harm is a serious problem amongst female prisoners and will most likely worsen because of the ongoing rise in the number of females imprisoned. In order to address the problem, general self-harm prevention policies are indicated, utilising existing support networks. Every prisoner should be the subject of a risk and needs assessment with

multi-disciplinary case management and should be encouraged to partake in the pro-social activities in the prison and to maintain family contacts. Additionally, those who feel isolated should be referred to a Befriender Scheme. As prison officers are most likely to be in the vicinity when a crisis occurs, it might be appropriate for certain prison officers with extra training to provide a key worker role to long-term prisoners and repeat offenders. Those who self-harm should receive appropriate counselling and every attempt should be made to alleviate their personal distress and other underlying problems so as to help counteract their self-destructive tendencies. It might also be beneficial to provide problem-solving interventions for mental health issues and self-harm within the prisons. These can also be used to prepare prisoners for programmes aimed at reducing recidivism.

Coid *et al.* (1993) highlight the increasing number of people who were previously treated in the psychiatric services and who are now coming into contact with prison services. In this regard it is likely that there will be more people with personality disorders being incarcerated. In view of the fact that this particular group has a high incidence of self-harm and present management problems in custody, it is imperative that priority is given to putting the necessary services in place. If protective factors against self-harm are strengthened in the prisons, it is likely that it will lead to an improvement of the behaviour of the prisoners involved and a reduction in their levels of offending on release.

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