DELIBERATE SELF-HARM AMONG ADULTS IN PRISONS

Laura Bennett and Judith Dyson review the literature to find out how this issue has become such a problem among inmates and why policies to reduce it are not being implemented successfully.

Abstract

This article explores barriers that prevent or interfere with the implementation of policies for reducing deliberate self-harm in adults in prisons and the levers that aid implementation. An integrative literature review was conducted of 12 studies of deliberate self-harm in the prison service between 2000 and 2012. Data were analysed thematically. Six themes were identified: knowledge; attitudes; emotion; staff skills; environment; and resisting treatment. The authors argue that having identified barriers and levers, the next stage is to address them so that the high levels of self-harm in prison can be reduced.

Keywords

Attitudes, depression, emotion, injury, inmates, mental health, prison, self-harm, suicide

SELF-HARM AND suicide have become increasing public concerns in recent years, but an aspect that is less frequently reported is the number of incidents that occur within Her Majesty’s Prison Service. There are numerous policy documents identifying this problem and suggesting measures to address it (Home Office 1984, 1986, Scottish Home and Health Department 1985, Phillips 1986, Backett 1987), but these have not been implemented (Her Majesty’s Inspectorate of Prisons (HMIP) 1996, 1997, 1999, 2000, Health Advisory Committee for the Prison Service 1997, Prison Service and NHS Executive Working Group 1999a, 1999b).

This article reviews the literature on self-harm and suicide in prisons, as well as barriers to implementing strategies, and levers that could help address them.

Self-harm is: ‘Self-poisoning or injury, irrespective of the apparent purpose of the act’ (National Institute for Health and Care Excellence (NICE) 2004); and suicide is: ‘Death caused by self-directed injurious behaviour with any intent to die as a result of the behaviour’ (Wenzel et al 2009).

There are many reasons why incidents of self-harm occur in prisons. For example, inmates diagnosed with depression (Klonsky and Muehlenkamp 2007) and mental health issues (Hawton et al 2001) are more likely to self-harm. A history of drug misuse (Beasley 2000, Cuellar and Curry 2007) and the presence of certain feelings such as cynicism, resentment, hopelessness, self-doubt, guilt and self-criticism are reported by inmates to precipitate incidents of self-harm (Herpertz et al 1997). This is also true of those who have suffered abuse as a child or who have been in an abusive relationship as an adult (Kenning et al 2010), and of inmates who suffer a bereavement or who have children removed during their prison stay (Kenning et al 2010). The stress of prison may also influence the likelihood of self-harm: inmates report that being placed in ‘isolation’ may precipitate such behaviour (Edwards 2000), as can ‘boredom’ (Borrill et al 2005).

The number of individuals reported to have self-harmed in 2010 was 6,639 in England and Wales (Ministry of Justice 2012). Reasons cited for the high number of prison episodes of self-harm include ineffective procedures to reduce incidents (Rickford 2003, Shaw et al 2003). Historically, investigations into prison suicides are rare. However, in 1982 the...
death of an 18-year-old prisoner following an episode of self-harm resulted in a verdict of 'lack of care' on the part of the prison (Smith 1984).

A wave of political, media and public concern, and a spate of prisoner deaths, caused the Home Office to instigate an official inquiry into the practices of suicide prevention in prisons (HMIP 1990, Tumim 1990). Year after year, recommendations have been made to prevent self-harm but have not been implemented (HMIP 1996, 1997, 1999, 2000, Health Advisory Committee for the Prison Service 1997, Prison Service and NHS Executive Working Group 1999a, 1999b). A literature review was therefore conducted to identify barriers to and levers for implementing suicide and self-harm prevention policies in the prison service for adult inmates.

Search strategy
The databases searched included CINAHL, Medline, and PsycINFO. Key author searches were conducted and reports from the Ministry of Justice and the Department of Health were examined. Search terms were 'adult', 'deliberate self-harm', 'depression', 'incarcerat*', 'mental health', 'offend*', 'prison', 'inmate', 'psychiatr*' and 'suicid*' in various combinations.

Due to the lack of literature on this subject, search inclusion criteria were broad. Papers were taken from peer-reviewed journals and although quality levels varied, they were appraised with quality at the forefront of the criteria. They were all considered to be at a more-than-satisfactory level of quality. Peer-reviewed papers had to report, investigate or contain information related to the barriers and levers to implementing self-harm and suicide prevention policies in prisons. They also had to include participants aged 18 years and over who were considered to be adult offenders. Figure 1 identifies the numbers of papers found and discarded at each stage of the review. Because of varied methodologies in the literature that was included, a thematic analysis was used following the six-step framework identified by Braun and Clarke (2006).

Results
Thematic analysis of the papers revealed 23 codes; these were amalgamated into six themes and 16 sub-themes that were relevant to the research question (Figure 2). Details of included papers are summarised in Table 1 (page 18).

Themes
The themes identified were:
- Knowledge.
- Attitudes.

Knowledge
Lack of knowledge about the issue of self-harm and lack of training in how to deal with such incidents were barriers to implementing prevention strategies (Maden et al 2000, Borrill et al 2003, Pannell et al 2003, Ireland and Quinn 2007, Kenning et al 2010). Kenning et al (2010) also found that lack of motivation was often associated with lack of training and knowledge of self-harm in prisons, which meant prison staff were less willing to want to help. Nurses working in prisons identified a lack of support in dealing with self-harm, and staff believed their lack of knowledge was linked with poor confidence when dealing with prisoners who self-harm (Ireland and Quinn 2007, Kenning et al 2010).

Recommendations to improve the implementation of self-harm prevention policies included more training for all staff members who deal with self-harming inmates (Pannell et al 2003).

Attitudes
Attitude was identified as something that could either enhance or prevent the implementation of suicide and self-harm prevention procedures. Some officers believed self-harming behaviour was used to manipulate the staff and/or rules so that the inmate could get what they want or require, rather than something that required care (Ireland and Quinn 2007). Ireland and Quinn (2007) found
that although attitudes towards the general prisoner population were generally positive, attitudes towards self-harming inmates were not. Officers often refused to refer inmates for treatment and did not keep episodes of harm confidential, frequently sharing information with other inmates.

Although it was acknowledged that positive attitudes could be helpful in supporting the implementation of recommended care, the literature suggests positive attitudes are rare (Borrill et al. 2005, Ireland and Quinn 2007, Kenning et al. 2010, Marzano et al. 2012). A clear link was found between a lack of training and negative attitudes towards inmates who self-harm (Borrill et al. 2005, Ireland and Quinn 2007, Kenning et al. 2010). Training was identified in some prisons, but the focus of such training tended to be more on filling in forms than treating inmates (Pannell et al. 2003). When training did include reasons why prisoners engage in self-harming behaviour, it influenced attitudes positively (Pannell et al. 2003). Kenning et al. (2010) investigated the opinions of prison officers and healthcare staff, and whether their attitudes and opinions could affect service delivery. Officers believed self-harming behaviour was used to manipulate officers and rules for the inmate’s own benefit, whereas healthcare staff believed it to be self-punishment.

Officers believed that many inmates with mental illnesses were beyond help; an opinion not shared by the nurses who were surveyed. Officers considered that this difference in attitudes might be due to being desensitised to self-harm because it happens so frequently. Borrill et al. (2005) reported the experiences of survivors of severe self-harm incidents. Many inmates thought they had received positive reactions from healthcare staff, who listened and offered support. However, the time that healthcare staff spent with inmates was brief.

**Emotions** The emotions of staff can influence the implementation of policy towards the care and treatment that inmates who self-harm should receive. Marzano et al. (2012) questioned inmates about staff responses. Inmates reported that officers did not care about or understand their behaviour. Officers were seen to be unsympathetic and did not take inmates’ actions seriously. Inmates accused healthcare staff of being rude, judgemental and patronising, reporting that they accused them of being attention-seekers and time-wasters. Nurses were said to demonstrate anger and annoyance.

Borrill et al. (2005) identified that, from an inmate’s point of view, tension that derives from relationships with prison officers can affect the implementation of policies. The emotion demonstrated by staff, combined with the negative attitudes reported, may go some way to explain the limitations on therapeutic relationships. Examples of such limitations are lack of trust, which could lead officers to think inmates are being ignorant or ungrateful and therefore cancelling treatments or activities, or inmates feeling unable to talk to officers because previously when they had spoken with them confidentially, the information had been shared with other officers and inmates.
<table>
<thead>
<tr>
<th>Author, date and country</th>
<th>Type of study</th>
<th>Focus</th>
<th>Participants</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maden et al 2000, UK</td>
<td>Interviews</td>
<td>Risk factors for deliberate self-harm in prison populations.</td>
<td>n=1,741 male inmates</td>
<td>White prisoners are more likely to self-harm than other ethnicities. Lack of training means deliberate self-harm is not always identified. More communication is needed.</td>
</tr>
<tr>
<td>Dear et al 2001, Australia</td>
<td>Interviews</td>
<td>Differences between prisoners who have and have not self-harmed.</td>
<td>n=71 male inmates</td>
<td>Staff need to develop more effective methods for identifying distress.</td>
</tr>
<tr>
<td>Borrill et al 2003, UK</td>
<td>Interviews</td>
<td>Patterns of self-harm and attempted suicide among white and black/mixed race female prisoners.</td>
<td>n=301 female inmates</td>
<td>More methods of individual and group communication needed for inmates, staff and outside services.</td>
</tr>
<tr>
<td>Pannell et al 2003, Australia</td>
<td>Questionnaire and interviews</td>
<td>Prison officers’ beliefs regarding prisoners who self-harm.</td>
<td>n=76 male inmates and male/female officers</td>
<td>Training is needed for all staff. Current training is too focused on form-filling and not enough on the care and treatment of inmates.</td>
</tr>
<tr>
<td>Roth and Presse 2003, Canada</td>
<td>Case report</td>
<td>Nursing interventions for self-harming.</td>
<td>N/A Female inmates</td>
<td>Care for prisoners who self-harm is demanding. Prisoners often resist care and treatment.</td>
</tr>
<tr>
<td>Borrill et al 2005, UK</td>
<td>Interviews</td>
<td>Learning from ‘near misses’. Women who survived an incident of severe self-harm in prison.</td>
<td>n=15 female inmates</td>
<td>Improvements to the general prison regime needed, including training and support for staff.</td>
</tr>
<tr>
<td>Palmer and Connelly 2005, UK</td>
<td>Randomised controlled trial</td>
<td>Depression, hopelessness and suicide ideation among prisoners.</td>
<td>n=24 males inmates</td>
<td>Patients resist treatment due to fear that care will be withdrawn. Treatment by counselling, medical intervention and occupational activities is the most successful.</td>
</tr>
<tr>
<td>Young et al 2006, US</td>
<td>Interviews</td>
<td>Risk of harm: inmates who harm in prison psychiatric treatment.</td>
<td>n=242 males inmates</td>
<td>Patients resist treatment when forced to take part in something they were coerced into doing, rather than accessing treatment by choice.</td>
</tr>
<tr>
<td>Ireland and Quinn 2007, UK</td>
<td>Case control study</td>
<td>Officers’ attitudes toward prisoners who self-harm.</td>
<td>n=162 male (100) and female (62) officers</td>
<td>Women more likely than men to report positive attitudes towards prisoners who self-harm. Attitudes more negative than towards other prisoners.</td>
</tr>
<tr>
<td>Kenning et al 2010, UK</td>
<td>Randomised controlled trial and interviewing</td>
<td>Prison staff and female prisoners’ views on self-harm.</td>
<td>n=30 male (6)/female (24) inmates, governors, healthcare staff and officers</td>
<td>Officers attribute harm motives as ‘manipulation’ and ‘attention-seeking’. Differences between staff understanding of self-harm may lie in training.</td>
</tr>
<tr>
<td>Suto and Arnaut 2010, US</td>
<td>Interviews</td>
<td>Suicide in prison: a qualitative study.</td>
<td>n=24 male inmates; mean age=31.83</td>
<td>Causes include depressive thoughts, feelings of hopelessness, loneliness, guilt and/or shame related to crime, anxiety, paranoid ideation, impulsivity, relationship issues with family, inmates or staff.</td>
</tr>
<tr>
<td>Marzano et al 2012, UK</td>
<td>Interviews</td>
<td>Prisoners’ perspectives: impact of staff responses on self-harming behaviours.</td>
<td>n=20 male inmates; ethnicity=18 white, 2 other</td>
<td>Prison officers, nurses, and doctors said to be ill-prepared to deal with deliberate self-harm and often display hostile attitudes and behaviours.</td>
</tr>
</tbody>
</table>
Limitations on the implementation of psychological interventions are, for instance, a lack of trust or not having someone to communicate, which can leave an inmate feeling vulnerable, leaving them open to being bullied and therefore increasing the risk of self-harm (Borrill et al 2005).

Emotional tension between staff and inmates can make implementation of self-harm prevention policies difficult (Borrill et al 2005). Tension can lead to resentment and reluctance among prison officers to implement guidelines that essentially demonstrate caring (Borrill et al 2005, Marzano et al 2012). At the same time, inmates do not want to receive treatment because of their anger towards officers at the poor way they consider they are treated (Borrill et al 2005, Kenning et al 2010, Suto and Arnaut 2010, Marzano et al 2012). All papers cited here rely on prisoners’ perspectives; no paper was found that considered emotional barriers to the implementation of self-harm policy from the perspective of staff.

**Skills** Ireland and Quinn (2007) and Kenning et al (2010) identify an absence of the skills necessary to implement self-harm policies. To follow such guidelines staff need to be skilled in communication, in particular in active listening. Only one quarter of participants in the study by Ireland and Quinn (2007) recall being given training related to self-harm. In prisons that offered more extensive self-harm training, staff demonstrated greater awareness and skills (Dear et al 2001, Kenning et al 2010). Pannell et al (2003) found that where training was offered it was focused on attempted suicide after the act, rather than prevention, and was centred on form-filling rather than people.

Despite acknowledging that training would improve skills in terms of recognising changes in inmates’ behaviour, such as distress, anger and stress, such training was still rare (Dear et al 2001, Ireland and Quinn 2007).

**Environment** Environmental factors can be considered a barrier or lever when implementing policies. Inmates report that staffing levels are low and staff time is not always used effectively (Dear et al 2001, Borrill et al 2005, Suto and Arnaut 2010). In a study where inmates who survived incidents of severe self-harm were interviewed, one of the measures identified to be useful was occupational activity to reduce anxiety and distract from intrusive thoughts. There are, however, few out-of-cell activities (Borrill et al 2005).

Co-operation with other services is important when maintaining care for inmates who self-harm (Marzano et al 2012) yet services do not always work in a multidisciplinary manner (Kenning et al 2010). There is disagreement about whether healthcare staff or officers should take responsibility for inmates who self-harm (Liebling 1994, Borrill et al 2005).

**Resisting treatment** Inmates’ resistance to treatment is another barrier to implementing policies in prison (Roth and Presse 2003, Palmer and Connelly 2005, Young et al 2006, Kenning et al 2010). Patients refuse treatments for a number of reasons. Roth and Presse (2003) found that inmates in a vulnerable state resist treatment because of a lack of trust. Counselling is the treatment most resisted. Inmates reported that it is easier to reject help than to trust prison and/or medical staff, depending on previous experiences (Kenning et al 2010).

One reason for this is that inmates are wary that treatment could be withdrawn; it is not uncommon for people who should be receiving treatment for drug and mental health issues to refuse help because they do not want to have treatment withdrawn if they harm themselves or have a break in their care due to relocation within the prison (Palmer and Connelly 2005, Kenning et al 2010). Treatment is also resisted when inmates are forced to take part in it, rather than accessing treatment by choice. In these instances, inmates fail to comply to protest against a lack of autonomy and choice (Palmer and Connelly 2005, Young et al 2006).

**Conclusion**

The aim of this study was to identify what helps and what hinders the implementation of policies for reducing self-harm among adults in prisons. The barriers and levers identified include knowledge, attitudes, emotion, skills, environmental factors and inmates resisting treatment.

Despite a dearth of literature on this subject, there is consistency in the research about what can be seen as a barrier or lever to implementation of appropriate policies, even if this is not the specific hypothesis of the literature. Cooper (1998) and Pope et al (2007) believe that having literature with diverse methodology could affect the quality of the overall study, whereas Dixon-Woods et al (2004) consider a mix of literature types to be a positive reaction within a study because of the ‘triangulation’ and the ability to cross-examine ideas to find the most relevant recommendations.

Another limitation was the age of the studies used. Although it can be seen that self-harm reduction policies had not been implemented at the time of the study, prison service policies are being updated constantly and it is possible that previous
recommendations may have been implemented since the publication of the included studies.


Implications for practice

There is a need for training to:

- Enhance understanding of self-harm.
- Positively influence attitudes (Pannell et al 2003).
- Improve self-harm prevention skills (Ireland and Quinn 2007).
- Address emotional coping skills.
- Improve staff coping (Marzano et al 2012).
- Address environmental factors, such as staffing levels, occupational activity (Borrill et al 2005) and interdisciplinary working.

References


