

**Female Offenders and Self-Harm: An Overview of
Prevalence and Evidence-Based Approaches**

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The occurrence of self-harm within a correctional setting is a significant problem that poses various risks and challenges for all involved (Fagan, Cox, Helfand, & Aufderheide, 2010). Self-harm behaviours threaten the mental and physical health of both offenders and staff, and consume significant amounts of resources, thus it is an important area to further investigate (Dehart, Smith, & Kaminski, 2009; Power & Brown, 2009). Due to the increasing rate of incarceration of female offenders relative to male offenders in Canada over the past twenty years (Kong & AuCoin, 2008; Sinclair & Boe, 2002), a focus on female self-injurious behaviour is particularly pertinent to explore. DeHart and colleagues (2009) indicate that there is limited research on self-injurious behaviour in correctional settings, and yet the reduction of such behaviours among female offenders in a federal correctional setting is a priority for the Correctional Service of Canada (CSC) (Power & Riley, 2010). The following summary paper will include a synopsis of the recent literature on the prevalence of self-injury among female offenders, and will follow with an overview of current intervention strategies/programs used to target and treat such behaviours.

Defining the Issue

There is no standard definition or classification system for identifying self-harm behaviours, and furthermore, even the appropriateness of the term *self-harm* has been debated in the literature (Daigle & Cote, 2006; Fagan et al., 2010; Power & Brown, 2009). Extensive overlap of definitions and conceptualizations exists among the numerous labels used to describe these behaviours, such as: self injury, para-suicide, deliberate self harm, self harm, self

mutilation, attempted suicide, non suicidal self injury and so on (Beasley, 2000; Daigle & Cote, 2006; Klonsky & Muehlenkamp, 2007; Mangnall & Yurkovich, 2008; Power, 2011).

In order to engage in a meaningful discussion about self-harming behaviour, it is important to first discuss and explicitly define terms that will be used to describe such behaviour. In a paper by Fillmore and Dell (2000), who took a female-centered approach to understanding self harm in Aboriginal women offenders, self-harm was holistically modeled and defined as: any behaviour (physical, emotional, or social) a woman commits with the intention to cause herself harm (p. 20). Klonsky and Muehlenkamp (2007) refer to non-suicidal self-injury (NSSI) as deliberate bodily disfigurement or harm without suicidal intent and for non-socially sanctioned reasons. NSSI is part of a broader category of behaviours: self-injurious behaviours (SIB). SIB is defined as any type of deliberate direct bodily harm not considered socially acceptable, that results in immediate unambiguous consequences and where suicidal intent is not known or is indeterminable (Favazza & Rosenthal, 1993; Power, 2011; Usher, Power, & Wilton, 2010). Self harm is a term used even more broadly to include SIB and behaviours excluded from the above SIB definition, for example: culturally sanctioned body modifications, health neglect, risk taking, eating disorders, and when harm is not immediate but a result of cumulative effects of certain behaviours (i.e. substance abuse) (Claes & Vandereycken, 2007; Power & Brown, 2009). The term suicide attempt is used to describe self injurious behaviour that has definite suicidal intent (Power, 2011). Suicide attempts may thus be included, along with NSSI, within the SIB category. Researchers suggest that there are clear distinctions between suicide attempts and self-harm behaviours and thus intent is an important aspect used to help distinguish and discuss these behaviours (Mangnall, & Yurkovich, 2008; Roth & Presse, 2003).

While this paper aims to focus on NSSI behaviours, SIB will be included in the discussion as well, because it was unclear/unknown whether suicidal intent was present in many of the included studies (Power, 2011). Suicide attempts and rates will be clearly distinguished and identified when discussed.

Function and Risk Factors of NSSI

NSSI is a complex set of behaviours with varying etiological factors. It is not uncommon for individuals who self-harm to present with mental health symptoms and diagnoses, however it is important to remember they are heterogeneous group (Klonsky, Oltmanns, & Turkheimer, 2003). There are particular pathologies that have been associated with self-harm behaviours such as Borderline Personality Disorder (BPD), bipolar disorder, obsessive-compulsive disorder, post-traumatic stress disorder, depression, anxiety, eating disorders, substance abuse, Antisocial Personality Disorder (ASPD), psychosis and others (Power & Brown, 2009; Power & Usher, 2011; Smith & Kaminski, 2010, Young, Justice & Erdberg, 2006). Risk factors for suicide among both general and offender populations include substance abuse, unemployment, interpersonal conflict, family mental health history, medication treatment, and mental illness (Daniel, 2006). According to Byrne and Howells (2002) self injury among adult female inmates has consistently been associated with substance abuse, anxiety, depression, personal stress and self esteem problems.

There are many reasons that can account for NSSI behaviours, thus it is important to keep in mind that when persons repeatedly self-harm, they may not be doing so for the same reason (Horrocks et al., 2003). Persons who self-harm may do so in an attempt to end their life, however many episodes of self-harm are not linked to suicidal intent (National Institute of Clinical Excellence, 2004). Persons may self-harm in an attempt to obtain relief from an

emotional state or situation, to communicate with others, to influence or secure care from others, or paradoxically to preserve their life (Hjelmeland et al., 2002, National Institute of Clinical Excellence, 2004).

In one study, researchers used offender narratives as well as staff perceptions and accounts, to inform their understanding of self-harm in Aboriginal female offenders; they suggest that women self harm as a necessary mechanism to respond to distressing and oppressive conditions (Fillmore & Dell, 2000). These authors found that a history of abuse was noted to be a commonly identified antecedent to self-harm and that self-harm served as a means of coping and to serve several functions: self-punishment, provide an opportunity to feel, release of painful emotion, response to an abusive partner, gaining life control, and as a cry for attention (Fillmore & Dell, 2000). Another study, which included a sample of 89 female prisoners, found that there were significant relationships between anger, body related shame, and child sexual abuse and self-harming and suicidal behaviour (Milligan & Andrews, 2005).

Doty, Smith, and Rojek (2012) found that self-injury among offenders was used as a response to perceived stress of both inside and outside the prison setting. A secondary motive of some inmates in this study was to engage in self-injury as a form of rebellion, as they understood the link between engaging in these acts and the impact it had on the prison environment and staff. According to a recent systematic review of NSSI within offender populations, the main functions of NSSI behaviours found in the available literature were: to regulate or relieve unwanted emotions; to self-punish, and/or for social reinforcement (often considered a 'manipulative' motive in correctional settings) (Dixon-Gordon, Harrison, & Roesch, 2012). Gordon (2010) found that the majority of self-injurious incidents reported resulted in very minor injury and concluded that most of these acts are not intended to end one's life.

Weekes and Morrison (as cited in Power & Brown, 2009) proposed three theoretically identified types of self-injury found within incarcerated populations: (a) suicidal behaviours – those with genuine intent, (b) self mutilation, and (c) malingering. Self-mutilation is undertaken as means of self-preservation, or as a way to cope, and often these individuals are at low risk for suicide. NSSI is considered malingering when it is not internally induced and when it lacks true suicidal intent. Power and Brown suggest that NSSI in a correctional setting may also be used as a manipulation technique, because in this setting it has the potential to result in unique rewards, for example, removal from the larger group. For example, women in the Fillmore and Dell study (2000) reportedly used self-harm as a means to gain attention, medication, and relocation to a more desirable institution. Given that there are many reasons for NSSI behaviour, it is important to assess each act separately and to avoid making assumptions about intent based on prior acts (Appelbaum, Savageau, Trestman, Metzner, & Baillargeon, 2011; National Institute of Clinical Excellence, 2004). Currently there is no universally agreed upon classification system for NSSI, however it has been suggested that classifications used for the general population must be modified to suit incarcerated self-injurers (Power & Brown, 2009).

NSSI behaviours can take many forms such as biting, head banging, hitting, ligature use, burning, swallowing sharp/indigestible objects, and inserting and removing objects (Power & Brown, 2009; Power & Riley, 2010). Gratz (2001) notes that most individuals who engage in self-injury use more than one method of NSSI. Smith and Kaminsky (2011) conducted a national survey of SIB across prison facilities in the US. Results indicated that the most concerning SIB identified by prison staff and mental health professionals was cutting with an object, followed by lower ranking of concern for behaviours involving inserting objects, ingesting objects, head banging, and opening old wounds. The most common form of NSSI

found was scratching (95.7%), followed closely by cutting (94.3%), and headbanging (84.8%) (Smith & Kaminsky, 2011).

Prevalence/Incidence Rates

It has been challenging to collect accurate prevalence rates for NSSI in correctional settings for a variety of reasons. First, the lack of agreement and inconsistencies in defining NSSI and SIB can lead to overestimations when definitions are too broad, and underestimates when they are too constrained (Power & Brown, 2009). Second, because much of the data collected via self-report, it is likely that underreporting occurs, due to the shame and unacceptability associated with NSSI. Finally, due to the high turnover rate of offenders in institutions as well as variable methods of measurement (e.g., number of admissions, average length of stay, etc.), that lack consistency and accuracy, prevalence estimates have been difficult to obtain (Gallagher & Dobrin, 2007; Power, Brown, & Usher, 2013).

Research has indicated that NSSI is more prevalent among psychiatric and offender populations compared with the public, where best estimates suggest about 4% of the general adult population have engaged in NSSI during their lives (Briere & Gill, 1998; Klonsky et al., 2003; Young et al., 2006). The high rate of self-harm among offender populations is due to the high rate of factors associated with self-harm prevalent in this population, such as the higher likelihood of mental health issues (including personality disorders and alcohol/substance abuse dependence) as well as of a history of abuse (National Institute for Clinical Excellence, 2004). Self-injury is also typically associated with younger offenders (Cutter, Jaffe, & Segal, 2008). Smith and Kaminsky (2011) reported a point prevalence of 2.4% of SIB across US prisons surveyed, with 0.7% prevalence for serious SIB. The prevalence of SIB in offenders receiving psychiatric care, in a study involving male offenders in a California state prison, was

substantially higher, at 18% (Young et al., 2006). According to Metzner (2002) suicide is the second and third leading cause of death in US jails and prisons, respectively. Approximately half of inmates who commit suicide have had a previous attempt (Daniels, 2006).

Establishing prevalence rates for women in custody has been somewhat challenging due to the small sample sizes of females in past studies (Howard League, 1999). Blanchette and Brown (2006) indicated that women in custody are more likely than men in custody, and than both genders in the general population, to engage in self-harming behaviour. A UK study found that 23% of women imprisoned for a period of two or more years had engaged in NSSI behaviours during their incarceration. This same study indicated that female offenders might be over five times more likely than males, to engage in NSSI (Howard League, 1999). Another study found that half of female offenders had a history of one or more episodes of self-injury (Borril et al., 2003). A study that investigated the amount of self-injury incident across Correctional Service of Canada (CSC) between April 2006 and September 2008 was found that women offenders were more likely than men to self-injure and to do so more than one time (Gordon, 2010).

A recent national survey of mental health directors of US prison systems (39 of 51 nationally representative systems contacted participated), found that between approximately 0.5-9% of the prison census engaged in self-injury during the previous calendar year (Appelbaum et al., 2011). Most systems experienced SIB events at least weekly or several times a week. Appelbaum and colleagues also found that inmates who were in lockdown or segregation cells were found to have the highest rate of SIB in the majority of systems surveyed. Although this study included statewide correctional directors, their responses were mostly impressionistic as there was a lack of tracked data related to SIB. The ONS Survey of Psychiatric Morbidity

among Prisoners in England and Wales was conducted in 1997 and results indicated that approximately 10% of the 771 female offenders surveyed reported engaging in deliberate, nonsuicidal self harm or NSSI (O'Brien, Mortimer, Singleton, & Meltzer, 2003).

McDonagh, Noël, and Wichmann (2002) conducted a Needs Analysis to assist in developing a strategy to target the risk and needs of women classified as maximum security in facilities across Canada. Of the 74 female offenders who completed their survey (19 Aboriginal), approximately half of the total sample was identified at risk for suicide and one third had previously attempted suicide within the past two years. SIB was reported more often for women classified at maximum security (58% vs. 35%) however was a currently identified concern related to self-harm for 25% of the total sample (regardless risk level).

Barrett, Allenby, and Taylor (2010) conducted an update on the 1989 Survey of Federally Sentenced Women and attempted to survey all federally incarcerated women across Canada between October 2007 and January 2008. Of approximately 520 eligible participants, 178 (or 34% of the incarcerated population) completed the survey. Results of their study indicated that 43.6% of the sample had engaged in self-harm behaviours, which included attempted suicide, burning, hitting/slapping, cutting/slashing, and an 'other' category (i.e. drug use, pills etc). The most common form of self-harm was attempted suicide (76.4%), followed by cutting/slashing (52.8%) and hitting/slapping (29.2%). 43.6% of the women surveyed reported they had previously engaged in self-harm throughout their life and approximately 27% of the women had self-harmed both prior to and during their incarceration periods. Of those who reported engaging in self-harm, 9% reported engaging in self-harm only during their incarceration. Women incarcerated for a violent offence were significantly more likely to engage in self-harm than those with non-violent index offences. It is of note that their results suggest an

overrepresentation of Aboriginal peoples within the correctional system: approximately 32% of their sample self identified as Aboriginal, which is in line with other correctional data that found 31% of incarcerated women in Canada identify as Aboriginal (Public Safety and Emergency Preparedness, 2009). This suggests that the results of this study are representative of the female prisoner population in Canada, and this is an important characteristic of the population to keep in mind when considering treatment approaches for SIB.

Gordon (2010) found that within a 30 month period (2006-2008) the incidents of self-harm as reported in the CSC Offender Management System (OMS) increased by over 70%. In this study, ligature and slashing were reported the most common methods of self-injury among female offenders and the majority of self-injuring offenders were classified as maximum security. It was concluded that the results of the report did not provide an accurate measure of self-injurious incidence within CSC facilities. The observed increase may potentially have been a result of the population of offenders in CSC shifting over time to include younger offenders serving shorter sentences (who are more prone to engage in such behaviours), however more likely the apparent increase may be related to greater staff awareness and changes in reporting patterns within CSC that occurring during the two year span of the study (Gordon, 2010).

A recent study conducted by Power and colleagues (2013) examined the prevalence and incidence rates of NSSI and SIB in federally sentenced woman in Canada using both an archival and a field study. Both the field and archival samples had a similar ethnic breakdown with over 50% of Caucasian, and over 30% of Aboriginal ethnicity. Power and colleagues' (2013) field study included surveying and interviewing 150 women incarcerated across all federal Canadian women's correctional institutions, regarding their SIB. The lifetime prevalence rate of NSSI for women in the sample was 38% and 60% of the sample reported at least one suicide attempt or

NSSI incident during their lifetime. 41% of the women had engaged in NSSI while in a federal institution, although the overwhelming majority (86%) of women had a prior history of NSSI in the community. The most common type of NSSI engaged in was cutting (77%), followed by head banging (19%) and burning and hitting inanimate objects (12% each) (Power et al., 2013).

The archival study included the use of 400 randomly selected federally sentenced women incarcerated between April 2008 and March 2009, stratified across Canada's five regions (Power et al., 2013). The lifetime prevalence for SIB in the sample was 24% with 80% of women having engaged in NSSI prior to their admission to a federal institution. This lower rate found in the archival study may be a result of underreporting. The most commonly reported SIB was cutting or scratching (55%), followed by ligature use (18%) and head banging (9%). The 1-year incidence rate of engaging in at least 1 act of SIB was 3.8% for this sample or 3.6 incidents per 27.4 person-years (ie. number of years incarcerated). Their results indicated that NSSI behaviours did not manifest in response to the incarceration environment but rather were more likely a continuation of a pattern of behaviours initiated prior to entering the correctional facility, which may be an important characteristic to remember for treatment of such behaviours (Power et al., 2013).

Intervention

Assessment and Screening

Given the high prevalence of self-harming behaviours among female offenders, it is imperative that institutions have effective methods of managing and preventing these behaviours. Regardless of the population in which these behaviours manifest, treatment of self-harm requires an assessment of the function that these behaviours serve for the individual (Bloom & Holly, 2011; Dixon-Gordon, et al., 2012). It has been suggested that all inmates undergo a screening for

NSSI and suicidal behaviour upon their admission to an institution (Ivanoff & Hayes, 2001).

Although some instruments have been developed in order to screen offenders for risk of suicide, there are currently no standardized instruments used to determine NSSI risk, and given that base rates and risk factors vary by context, it is difficult to construct such a measure (Dixon-Gordon et al., 2012). Assessment tools should assess the function of and type of NSSI as well as consider risk factors of NSSI (Dixon-Gordon et al., 2012; Walsh, 2007). See Dixon-Gordon et al. (2012) for a more comprehensive summary of available assessment tools.

Fagan and colleagues (2010) suggested that when screening for suicide risk factors it is important to understand the impact that incarceration can have on these risk factors as it may represent a difficult life event and stressor that can increase vulnerability to suicide. These authors suggest that the final step in an effective risk assessment involves identify immediate safety needs and protective factors which reduce the short and long term risk. Protective factors include: effective clinical care, easy access to various clinical interventions and support for help seeking behavior, restricted access to lethal methods, family and community support, cultural and religious beliefs that discourage suicide, support from medical and mental health relationships, and learning skills in problem solving and conflict resolution (Fagan et al., 2010). Although there is significant overlap, it is important to keep in mind that there are differences in risk factors associated with NSSI behaviours compared to suicide, and there currently does not appear to be a clear consensus within the literature as to what risk factors are associated with non-lethal self-injury.

Currently Available Interventions

Although NSSI behaviours are very problematic in correctional settings, according to Dixon-Gordon and colleagues (2012) there have been few treatments developed specifically to

target NSSI and there are currently no efficacious treatments for NSSI. According to these authors, treatments that currently show promise in reducing rates of NSSI, are not widely implemented in correctional settings in North America (Dixon-Gordon et al., 2012). The most common response to NSSI of correctional officers is therapeutic seclusion and restraint yet there is not much support for the effectiveness of these responses and they pose an increased demand on correctional workers and available resources (Dixon-Gordon et al., 2012).

One study which involved a content analysis of approximately 352 critical incidents of self-injury of offenders from a South Carolina prison found that offenders who self injured were more likely to receive disciplinary charges as a means of punishment for their behaviour (Doty et al., 2012). This study found that punitive responses to SIB by correctional staff were used almost three times as often as therapeutic approaches. Offenders who self injured were also provided with crisis intervention services/suicide protocols (i.e. seclusion), but although these programs help prevent immediate self-harm risk they only serve to temporarily prevent symptoms rather than treating the cause (Doty et al., 2012).

Kilty (2006) indicated that the practice of segregation in response to self injury should not be used as it is perceived as a punitive reaction, and other research has shown segregation to exacerbate future SIB and suicide risk (Daniel, 2006; Walsh, 2006). Barrett and colleagues (2010) note that self-harm must be regarded as a mental health issue rather than just one of security. The incarcerated women they surveyed indicated that speaking to someone, rather than entering segregation would be more helpful in preventing their future self-harm. Thus, mental health services should be made immediately available to offenders who have self-harmed (Barrett et al., 2010) because confinement alone does not facilitate any improvement in mental health (Berzins & Trestman, 2004).

According to Powis (2002) the following measures have been identified that reduce the risk of self-harm and suicide among offenders: providing adequate staff training and support, ensuring continuity of care and communication between staff working with these offenders, conducting detailed risk assessment on all prisoners, regular observation and monitoring, encouraging regular contact with families, employing a multi-disciplinary response, and ensuring the institutional regime includes regular social activities. Ellis, Gromley, Ellis and Sower (2002) suggested that once an offender is judged to be at risk for self-harm she should be taught stress and anger management and relaxation, and should be helped to develop a plan to put in place if she experiences heightened emotional distress.

Dialectical Behavioural Therapy (DBT). It has been well established that there is a high incidence of personality disorders, such as BPD and ASPD, among offender populations (McCann, Ball, & Ivanoff, 2000). Thus, treatments that target behaviours relevant to such disorders are particularly important to investigate. One of the only well established treatments of NSSI behaviour is within the context of BPD (Dixon-Gordon et al., 2012). Dialectical Behavioural Therapy (DBT) was developed by Linehan (1993) in order to treat chronically parasuicidal women (i.e. those with a pattern of intentional self-damaging acts and suicide attempts) with a diagnosis of BPD. DBT focuses in the interrelatedness of skills deficits and therapy aims to teach clients to become comfortable with change rather than trying to focus on maintaining a stable environment. Central to DBT is the targeting of the four problem areas of BPD with four corresponding skill modules: (a) mindfulness skills, (b) distress tolerance skills, (c) emotional regulation skills and (d) interpersonal effectiveness skills. These modules are designed to decrease maladaptive behaviours and thought patterns, while at the same time increase adaptive behaviours and corresponding cognitions (Linehan, 1993).

DBT has been widely accepted and research has been conducted that supports its usefulness for a variety of populations (Dimeff & Koerner, 2007). Research has consistently shown that DBT is more effective than treatment as usual (TAU) in terms of reductions in parasuicidal behaviour (Rizvi & Linehan, 2005). DBT has been adapted and is used in correctional settings across North America and the UK (McCann et al., 2000). Given the high incidence of borderline personality disorder among offender populations, and female offenders in particular, DBT is a particularly relevant treatment option. McCann and colleagues (2000) indicated that the structured nature of DBT is advantageous in a forensic setting as research has indicated structured programs are more effective in reducing recidivism than are less structured approaches. Female patients in a high security hospital who engaged in deliberate self-harm participated in a year long DBT treatment program and a significant reduction of deliberate self-harm behaviours was maintained during therapy and after a six-month follow up (Low, Jones, Dugan, Power, & Macleod, 2001). According to Trupin, Stewart, Beach and Boesky (2002) DBT effectiveness is enhanced when treatment is matched to appropriate behaviour.

In Australia a DBT based program called RUSH (or Real Understanding of Self Help) was adapted to work for offenders exhibiting borderline traits, particularly those who engaged in self-harm behaviour. This program aimed to validate offenders' past and current cognitive, behavioural and emotional responses to stressful life experiences and encourage self-help and life enhancement skills (Eccleston & Sorbello, 2002). RUSH involved twice-weekly two hour group skills training for 20 weeks and individual therapy on a needs-only basis, used warm up and closure exercises to engage participants in group, and modified certain content from Linehan's original DBT program, to better suit an offender population (see Eccleston & Sorbello for a more detailed description). Preliminary program evaluation of the RUSH program that was

conducted on two units (N=20) revealed a decline in symptomatology post-treatment, which included self-harming behavior.

The CSC offers DBT for female offenders in three different forensic settings and inmates are selected based on behaviours consistent with BPD rather than the diagnosis itself (Berzins & Trestman, 2004). DBT initiatives designed for women with behavioural dysregulation problems and mental health needs were offered within Structured Living Environment units in five Canadian regional women's facilities (Blanchette, Flight, Verbrugge, Gobeil, & Taylor, 2011). Researchers found that women who participated attained moderate to high magnitude improvements on a variety of measures of well-being and psychological symptoms. The DBT intervention was able to help women increase coping skills and institutional functioning, results suggested a strong treatment effect, and there is some preliminary support that participation may have contributed to lowered self-injury rates (Blanchette et al., 2011). Overall, DBT programs have been found to be the most efficacious in reducing self-harm behaviours. However, this course of therapy is very time consuming and intensive and there has been a need for briefer interventions (Dixon-Gordon et al., 2012).

Brief Interventions. Manual-assisted cognitive behavioural therapy or MACT for the treatment of NSSI is a short term structured group therapy that involves cognitive restructuring, problem solving skills, and emotional regulation skills (Evans, 2000). This therapy includes bibliotherapy in the form of six booklets, which incorporate DBT elements, and the work booklets are the basis of individual therapy that lasts usually between 2-6 sessions (Robins & Chapman, 2004). When compared to TAU in an outpatient setting, it was superior in reducing severity of para-suicidal behaviour. In a larger randomized control study using outpatients,

MACT was not significantly different from TAU, however the frequency of self-harm episodes was fewer in the MACT group (Tryer et al., 2003).

Emotion Regulation Group Therapy (ERGT) was developed for patients with DBT and co-occurring NSSI and is a 14-week acceptance based group treatment program (Gratz & Gunderson, 2006). ERGT draws from DBT and Acceptance and Commitment Therapy (Hayes, Stosahl, & Wilson, 1999) and is an emotion-focused behaviour therapy that emphasizes consequences and teaches emotion regulation. A pilot study which included female outpatients found significant reductions in both NSSI and BPD symptoms post-treatment, compared to TAU, but there is no data on the efficacy of such treatment with offenders (Gratz & Gunderson, 2006).

STEPPS or Systems Training for Emotional Predictability and Problem Solving is a manual based group therapy for persons with borderline personality disorder (Black, Blum, McCormick, & Allen, 2013). This program combines skills training and cognitive behavioural elements, consists of 20 two-hour weekly sessions with detailed lesson plans, and is usually co-facilitated. This program is not intended to replace, but rather to supplement other treatments such as individual therapy and/or medication. Elements include BPD psychoeducation, behavioural management skills training, emotion management skills training, and a unique systems component, which involves a one time session for group participants, and their family and friends. Detailed descriptions of STEPPS can be found at www.stepsforbpd.com. Research has shown that participants report clinical significant improvement in mood and behaviour and it has also been effective in a correctional setting (Black et al., 2008). A recent study conducted in Iowa prisons with both male and women offenders with BPD found a significant reduction in the number of self-harm/suicidal behaviours and disciplinary infractions occurring among the STEPPS participants (Black et al., 2013). This finding was consistent with a UK study that also

found a reduction in suicidal behaviours among participants, although it is important to note that this was not an offender population (Harvey, Black, & Blum, 2010).

Offender Led Programming. Although the training of staff is the most common approach to suicide prevention and intervention, often inmates are not likely to trust correctional staff and staff are not able to identify all offenders at risk for suicide. Thus engaging other inmates in leading peer suicide prevention programs may be an alternative approach (Hall & Gabor, 2004). The SAMS in the Pen program, which was implemented in an Alberta medium security Institution for three years, involved volunteer inmates trained in suicide prevention that responded to other inmates who were at risk to self-harm. Due to low base rates of completed suicides in the institution, which had a small population (~610 inmates), evidence for the impact of the SAMS program could not be conclusively demonstrated, however it was perceived as a useful and promising service model by various stakeholders. The general inmate population viewed the service as accessible and helpful and professional staff were relatively (compared with correctional workers) satisfied with the service model (Hall & Gabor, 2004). Although there is still much research to be conducted in this area, it is worth considering the impact that inmates have on one another, how they can learn and support each, and how this connection among them could be used to help prevent and treat persons who self harm. According to national clinical practice guidelines in the U.K. (NICE, 2004), people who have engaged in self-harm should be involved in the planning and delivery of training for staff who are in contact with such persons.

Treatment and Staff Training

In order to effectively assist and prevent self-harm behaviours, staff working with persons who engage in these behaviours must be successfully educated and supported. High stress is commonly experienced in correctional settings and it is likely exacerbated by the higher

rate of assault and aggression on staff by offenders with a suicidal and NSSI histories (Young et al., 2006). For example, Young and colleagues (2006) found that offenders who harmed themselves were over 8 times more likely than comparable cohorts, to harm treatment staff.

Findings from the NICE (2004) research initiative indicated that both staff attitude and staff knowledge about self-harm are important to treatment and experiences of persons who self harm. Much of the existing literature on staff attitudes towards self-harmers indicates that they have negative and often punitive attitudes towards this population, which likely impacts quality of care and treatment efficacy. It was found that correctional staff resented offenders who they perceived to engage in self harm for manipulation purposes and viewed them as less in need of support and help (Short et al., 2009). If correctional staff are provided adequate training to deal with and recognize motives behind suicidal behaviour, they are less likely to assume that inmates are being manipulative (Daniel, 2006) and this may improve effectiveness of treatment.

Although self injury is often a maladaptive means of communicating and viewed as manipulative, this should be addressed in treatment and not been seen as a reason to not engage in treatment (Appelbaum et al., 2011). Clinical practice recommendations indicate that providing treatment for this population requires a high level of communication skills and support. Staff should also be provided with clinical supervision during which they can discuss the emotional impact of their line of work, for example in dealing with disclosures of abuse (Byrne & Howells, 2002; NICE, 2004). CSC has a well-established Critical Incident Stress Management (CISM) program that is intended to help staff deal with a variety of stressful incidents however Gordon (2010) found that only in 4% of reported incidents of self-injury was there a clear indication that CISM was offered to staff. Although this result does not necessarily imply that this service was not offered in the rest of cases, it is possible that because self-injury is seen as a common

occurrence in these institutions, it may not been seen as requiring CISM intervention (Gordon, 2010).

According to Daniel (2006) staff training must occur regularly and training topics should include: identification of high risk to harm offenders, how to identify symptoms of mental illness, and how to handle communication of intent. Around 60% of offenders may communicate their suicide intent either verbally or nonverbally, to officers, staff, other inmates, or family/visitors. Although it is challenging to keep track of such communications and encourage others to report it, a confidential system for reporting (preferably written) should be put in place in order to safeguard those offenders making a report (Daniel, 2006). Officers and clinicians are expected to report to one another and administration and the report should be added to the offender's file and steps taken to ensure there is no imminent self-harm risk. It is also imperative that good communication exists between correctional officers, mental health staff, and administrators, and that all groups participate in the training. Finally, Daniel noted that programming must be continually evaluated in a timely manner and systematic program evaluation and a quality assurance plan should be developed and used.

Doty and colleagues (2012) indicated that by addressing specific institutional stressors and the presence of social control, the risk of self-injury in prisons may be reduced. For repeat self-injurers, reducing idle time can help to reduce recidivism rates of SIB. These authors also indicated that attempts by staff to engage in dialogue with vulnerable offenders (those who are at high risk due to environmental triggers) will produce positive results.

Behaviour management plans that use positive reinforces and/or restrictions to increase desired behaviours may be used to target SIB in correctional settings. Plans that are short term and operationally defined are more likely to be effective. Plans should be flexible, individually

tailored, and jointly authored by staff and offender; a joint approach is very important (Fagan et al., 2010). For example offenders could be provided with incentives for appropriate behaviour, which included for example reductions in their segregation treatment plans (Cahill-Masching & Ray, 2003).

Cahill-Masching and Ray (2003) suggested that when defining a treatment team to treat BPD offenders, all decisions related to their treatment should be divided among only a limited number of individuals in order to prevent “splitting” of staff- or the tendency of BPD individuals to pin staff against each other. These authors designed a treatment plan (which included a DBT influenced group) focused on preventing crises, rewarding appropriate behaviour (vs. only reprimanding inappropriate behaviour) and providing consistent treatment to severely behaviourally disordered female offenders. In order to provide reliable and consistent treatment, physical modifications were made to tables and restraining mechanisms in order for offenders to continue to attend group therapy. They noted that shifting the focus to preventative rather than solely reactive measures was worth the effort, and both staff and offenders were satisfied with the change in treatment planning. In a sample case they provided, following the implementation of the treatment plan, the self-harming behaviours of a female offender were significantly reduced (Cahill-Masching & Ray, 2003).

DBT is unique in that it not only targets client behaviour but also focuses on staff behaviours that may interfere with successful therapy such as: poor interpersonal boundaries, favoritism, extreme irreverence, and extreme rigidity or flexibility (Linehan, 1993). Trupin and colleagues (2002) in attempting to adapt and institute DBT for juvenile female offenders in a juvenile rehabilitation facility found that mean staff punitive action and youth behavioural problems were reduced compared to the year prior. These authors concluded that DBT which

was targeted at reducing aggressive and parasuicidal behaviours was successful in reducing these problematic behaviours and as a result the females who were usually segregated, were able to gain more access to rehabilitative services such as substance abuse treatment and employment opportunities. Although the study overall generated mixed results, it was found that important to the success of the DBT intervention is intensive staff training (minimum 16 hour training in DBT from Linehan's associates plus weekly instruction and case consultation for approximately one year) and motivated staff (Trupin et al., 2002).

In McCann and colleagues (2000) adapted DBT for forensic inpatients they noted that both patients and staff were to model DBT skills and staff were encouraged to use these skills both during group sessions and on the ward. These authors suggested that every environment is different and when implementing DBT on particular forensic wards it is imperative to assess the unique needs of the institution and staff. It is important to validate staff and reinforce what is validating for staff to work in such an environment. Finally McCann and colleagues (2000) suggest that by linking staff training to their work evaluation and linking administrative goals (such as accreditation standards or political agendas) to DBT implementation and effective outcomes, obstacles that are bound to occur will be easier to face and deal with.

There are significant barriers in developing programming to effectively manage offender self-injury and these must be considered and addressed. Barriers may include: staff resistance to treatment strategies, lack of uniformity in training, clinician burnout, and a lack of classification system and standardized language to describe SIB (Fagan et al., 2010). Fagan and colleagues (2010) suggest that first it is important to promote awareness that self-injury in correctional settings is a public safety problem and is preventable as this will dispel myths and reduce the stigma associated with such behaviours.

Gendered Programming

Correctional programming for females should be gender specific, that is, it should be rooted in everyday experiences of females and take into account their needs, development, and social realities (Berman, 2005). Wright, Van Voorhis, Salisbury and Bauman (2012) suggested that more generally the mission of women's prisons should align with a rehabilitative, rather than a punitive, orientation as research suggests that women require a different management style than male offenders.

When the unique needs of female offenders are considered, long term and positive changes can take place (Franklin, 2008). This includes differences in experience that bring women into the criminal justice system, such as the high rates of victimization and abuse among female offenders relative to males, and catering practices to respond accordingly (Berman, 2005). Gender responsive treatment includes several key principles as outlined in Bloom, Owen and Covington's (2004) influential report. It is important to identify and accept that gender does make a difference in correctional practice and create an environment that is based on respect, dignity and safety for women. Administrators may want to consider the settings in which male staff are appropriate, and if it is deemed that the presence of male staff (in treatment settings) may cause further anxiety or impair disclosure of past sexual abuse, their role in such situations could be minimized (Ellis et al., 2002).

Women respond more favorably to an environment that recognizes their worth and that is positive and supportive (Batchelor & Burman, 2004). Working with women creates different conditions and to ensure best practice staff require specific training in empathic listening and counselling (Byrne & Howells, 2002). Policies should reflect healthy relationships within the

institution and promote healthy relationships with family and prosocial others (Bloom et al., 2004).

According to Batchelor and Burman (2004) successful programming with young women offenders employ holistic strategies that address multiple needs at the same time. These authors also suggest that it is important to help women feel empowered and to develop their self-efficacy in order to help them make informed decisions about their lives. Additionally, it has been suggested that a strength based approach to treatment will be more beneficial in the treatment of women offenders than the traditional problem focused approach (Bloom & Covington, 2009).

Conclusion

Due to the multiple costs associated with female offender self-harming behaviour in correctional settings, not only for the offender but for the institution itself, female offender self-harm is an important issue that cannot be ignored. Unfortunately there is currently no agreed upon or systematic assessment program that defines NSSI behaviours and there is still much variation and debate in the literature as to how to define and discriminate self-harm and related behaviours. There are many reasons that persons engage in self-harming behaviour such as emotional regulation, to communicate with others, and to influence their environment. Often, SIB of offenders is considered manipulative in correctional settings.

Although in general it has been difficult to collect accurate rates of NSSI for a variety of reasons, the evidence above outlines the rate of self-harm is higher among female versus males, and is substantially higher in correctional settings. Research has found that the lifetime rate of incarcerated women SIB ranges substantially with reported lifetime rates between 24-80%. A recent Canadian study involving female offenders found the lifetime rate to be 38%. The most

common forms of NSSI methods used among incarcerated women were cutting or scratching and ligature use.

Typically, restraint and segregation with close observation are the most common reactions and approaches to self-harm behaviours in correctional settings, yet there is inconclusive evidence to suggest these approaches are helpful. In fact some researchers have found that if these approaches alone are used, they may cause more harm.

A significant part of the intervention process relies on the discovery of the motive behind the self-harm behaviour. Currently there are no standardized instruments used to assess NSSI however there are several available instruments that have been recently developed.

Although there are no currently established evidence based treatments to specifically target NSSI in isolation, efficacious treatments are available that target these behaviours under the umbrella of relevant personality disorders, particularly BPD. Specifically Linehan's (1993) DBT has been found to be a well established treatment to treat BPD and related symptoms such as NSSI behaviours. DBT has been adapted and used in various forensic settings with success in reducing NSSI behaviours. As well, brief interventions based in cognitive behaviour therapy and which include a focus on problem solving and emotional regulation, have been created and there is preliminary evidence to suggest they are successful in reducing suicidal and para-suicidal behaviours.

Important to the successful treatment and management of persons who engage in NSSI and suicidal behaviour, is that staff working with these persons must be successfully educated and supported. Research consistently suggests that it is imperative that correctional staff have adequate training and knowledge about self-harm behaviours, and that a gendered approach is important to successful treatment with female offenders. It is essential that administrators, staff,

and mental health professionals all work together and agree upon a united approach to the prevention and treatment of NSSI behaviours in correctional settings. Overall there is still much research yet to be conducted involving efficacious treatments of NSSI behaviours in offenders beyond the use of DBT and related therapies, however, there are recently developed treatments available that have shown promising results in reducing NSSI.

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