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Women, Self-Harm, and the Moral Code of the Prison

Abstract

Discriminatory attitudes directed at women who non-fatally self-harm have been documented in psychiatric wards and medical settings, especially Accident and Emergency departments. Such attitudes constitute a “moral code”, which surrounds the act of self-harm and subjects it to negative comparison to accidents, to physical illness, and to completed suicide. What is less clear, however, are the characteristics of that moral code which governs self-harm in prisons – despite the fact that high rates of self-harm in women's prisons are well-known. Reporting the findings of a research project in one English prison, this article identifies the characteristics of that “moral code” and the way it affects the experiences of women in prison.

Keywords: Women, Self-Harm, Prison, Moral Code, Total Institution

Introduction

This article combines empirical and theoretical elements. Empirically, it reports the findings of a research project in one women's prison in England which sought to reduce rates of self-harm and to understand the experience of self-harm for imprisoned women. Self-harm is here defined as “acts of intentional self-poisoning or self-injury irrespective of type of motivation” (National Institute for Health Care Excellence [NICE], 2011, p. 5) and, statistically, its most frequent manifestations are acts of drug overdosing and self-cutting with sharp objects. In this article, women's prisons are understood as what Goffman called “total institutions”: institutions which have as their main characteristic the fact that “all aspects of life are conducted in the same place and under the same single authority” (Goffman, 1968, p. 11).

Theoretically, the article builds on our previous research published in *Ethical Human Psychology and Psychiatry* (EHPP) on medical attitudes to self-harm (Cresswell and Karimova, 2010). That research identified the existence of a “moral code” which discriminated against self-harmer’s in Accident and Emergency departments (A&E) in England.¹ “Medicine’s moral code” was defined as a group of “attitudes and practices in the context of which professional’s ‘treat’ self-harm” (Cresswell and Karimova, 2010, p. 159). It consisted of three parts: a) written and unwritten rules controlling professional and patient conduct, such as ethical codes of practice and moral attitudes; b) negative labeling applied to patient’s who self-harmed, such as calling them “manipulative” or “attention-seeking”; and c) practices of physical punishment such as being treated with inadequate pain relief following an episode of self-cutting. Historically, we found that patients who self-harmed were treated less sympathetically than some other patients in A&E such as accident victims, the physically ill and those considered suicidal. We theorized that this discrimination occurred because patients failed to conform to the rules of Parson’s (1951) “sick role”: instead of being seen as compliant patients, self-harmers were sometimes blamed by doctors and nurses for deliberately making themselves ill and then punished if they failed to co-operate with treatment. However, medicine’s moral code in A&E was not exclusively negative; we also found that it demonstrated some ethical and compassionate attitudes and that, gradually, from the late 1980s onwards, it began to incorporate progressive critiques emanating from the experiences of users and survivors of psychiatric and medical services (see Pembroke, [ed], 1994).

In this article, these empirical and theoretical elements are combined in understanding the specific moral code that is experienced by women who self-harmed in one prison in England rather than in the context of A&E. This new research is then compared and contrasted to the theory of self-harm

and medicine's moral code which we posited in EHPP in 2010 and the differences between the new research and the original theory are analyzed.

Background: Self-Harm in Women's Prisons in England

Research into self-harm in women's prisons in England is substantial. Using mainly Ministry of Justice (MoJ) statistics, we note the following findings. Statistical rates in women's prisons have been higher than in men's prisons, accounting for 25 per cent of total self-harm incidents although women comprise just 5 per cent of the prison population (MoJ, 2016). These rates show significant trends: overall numbers have fluctuated for women since 2006, rising to an all-time high in 2010 then subsiding until 2015 after which they rose again until June 2017, when they stood at a rate of 1914 incidents per 1000 prisoners compared to a rate of 3000 per 1000 prisoners in 2010 (MoJ, 2017). These figures indicate that repetition of self-harm is a significant problem amongst some individual self-harmers, amounting to an average of 6.5 incidents per female self-harmer in June 2017. Regarding methods of self-harm, of the 139, 135 incidents analyzed by Hawton et al (2014) the most common method was self-cutting; the second most common was self-strangulation by means of attaching a ligature to the neck within the prison cell. As with non-custodial settings, self-harm constitutes a well-established risk factor for prison suicides: in 2014 Hawton et al concluded that, for women, increased levels of risk were associated with serving a life sentence and multiple repeated episodes of self-harm.

Despite these fluctuations in rates, women's self-harm in English prisons remains a "huge problem" (Corston, 2007, p. 3). One limitation to note is that most of the research cited above is conducted within a paradigm of quantitative methodologies which establish statistical rates and their correlations. Yet, as their practitioners admit (Marzano et al, 2016), these methodologies

provide only partial knowledge of self-harm for two reasons. First, correlations between self-harm and the quality of the prison environment are also strong and are not captured by quantitative methods alone. Second, quantitative methodologies are “largely atheoretical” (Slade et al, 2012, p. 1), failing to respond to the more qualitative dimensions of the experience of self-harm in prisons. As the criminologist Liebling (2004) has noted, prisons are moral environments with specific moral codes; and, as our previous research has suggested, self-harm in non-custodial settings is also surrounded by a specific moral code of its own. The rest of this article now addresses the subject of the moral code within one women’s prison with regard to self-harm and the experiences of women who self-harmed in that prison.

Researching Self-Harm in a Women's Prison, 2009-2013

The research which this article reports took place between 2009 and 2013 in one women's prison in England and aspects of it have been documented elsewhere (Ward and Bailey, 2011, 2012, 2013; Ward, 2012, 2014). The research confirmed the findings of the wider literature that the most frequent forms of self-harm in women’s prisons were self-cutting and self-strangulation by means of a ligature – these two methods accounted for 82 per cent of all recorded incident of self-harm during the life of the project (Ward, 2012). The project had two overall aims: a) to reduce rates of self-harm; and b) to explore the experiences of women who self-harmed in the prison. In the first it was successful with incidents falling from 960 in 2007 to 422 in 2011 whilst the overall prison population remained numerically stable throughout that period (Ward, 2013). The second aim is the primary theme of this article. Its goals were to identify the constituent parts of the moral code of the prison with regard to self-harm and to explore the interaction of this code with the experiences of women who self-harmed whilst imprisoned.

The project employed a mixed methods approach: it combined quantitative survey research (n =118), qualitative interviews (n =28) and documentary analysis (using four primary documents). For the qualitative aspects, women were purposively sampled (Bryman, 2012) being initially identified through prison health records and then approached individually for informed consent. Staff within the prison were also surveyed and interviewed to explore their attitudes to self-harm. In total, 15 women prisoners were interviewed and 13 members of staff; whilst 50 prisoners returned questionnaires and 68 members of staff. Four relevant policy documents related to self-harm – specifically, a Prison Service Order (PSO) (Her Majesty’s Prison Service [HMPS], 2007), a Government review (Corston, 2007) and two national clinical guidelines on self-harm (NICE, 2004, 2011) - were critically analyzed (see Atkinson and Coffey, 2011), primarily for the evidence they provided of the “written rules” element of the moral code of the prison.

In identifying this moral code, we began with the theory of the moral code and its categories formulated in EHPP in 2010 and which form part of a long-term research project which goes back to 2005 (see Cresswell, 2005). We then went through a two-stage codification process which involved descriptively breaking the data down into the three theoretical categories of “rules” (written and unwritten), “labeling” and “punishment”. A second codification stage then re-analyzed the descriptive results of the first codifications by comparing them to the theory of medicine’s moral code formulated in our 2010 research. The purpose of this second codification was to identify the similarities and differences experienced by self-harmers in two institutional settings both of which manifested high rates of self-harm and, therefore, to achieve a clear analysis of their institutional specificities. This codification process is not “grounded theory” (see Charmaz, 2008) but, rather, begins with established theoretical categories which are then used to generate a comparative analysis of a new institutional setting, in the course of which the theory itself is

revised. The affinities of this approach are with empirical sociological research which is theoretically informed (e.g. Connell, 2005; Bourdieu, 1984) rather than with “grounded theory”.

The codifications of written and unwritten rules, negative labeling, and punishment, structure our presentation of findings in the next section. A subsequent section explores the ways in which women in prison reacted to the rules imposed upon them by the moral code and the extent to which they complied with or resisted those rules. A final discussion analyzes what we have learnt about the moral code of the prison compared to the original theory of medicine’s moral code posited in 2010.

Self-Harm and the Moral Code of the Prison: Rules, Labeling and Punishment

Rules: Written

Given the status of self-harm as a public health issue, it is not surprising that there has been considerable national policy related to it in England. Of these the most significant have been the National Institute for Health Care Excellence’s (NICE) clinical guidelines (2004, 2011). But in terms of prison-specific policy relevant to women who self-harm the most significant interventions during the period in question have been the Corston Report (Corston, 2007) and a contemporaneous Prison Service Order (PSO) (HMPS, 2007).

Corston (2007) was a Government “review of women with particular vulnerabilities within the criminal justice system” in England. Its major recommendation endorsed the incorporation of prison health services into the National Health Service (NHS) and, what followed from that, “that management and care of self-harming women should be led by the NHS either in an NHS resource or shared multidisciplinary care in prison” (Corston, 2007, p. 13). Noting that high levels of self-

harm were accepted as the “norm”, Corston complained that prison staff were “insufficiently trained” to deal with the sorts of “complex life-experiences” (ibid, p. 12) which often accompanied self-harm. The UK government, however, only partially accepted Corston's recommendations with respect to NHS leadership; where self-harm was concerned they re-affirmed that “the day-to-day management of women who self-injure...is mainly through...Prison Service staff” (MoJ, 2007, p. 29).

Seven months after Corston reported, the Prison Service itself issued a Prison Service Order (PSO2700) (HMPS, 2007) entitled “Suicide Prevention and Self-Harm Management”.² PSOs did not have the force of law but they were “long-term mandatory instructions”³ and for our purposes have the status of powerful written rules. PSO2700 introduced a new multi-disciplinary system for the management of self-harm in prison called Assessment, Care in Custody and Teamwork (ACCT) for which training was compulsory. Staff were to open an “ACCT plan” whenever they believed a prisoner was at risk of self-harm; there were formal systems for recording incidents, including ligature making; special protocols were implemented for the provision of emergency response equipment for administering first aid; and the use of “Safer Cells” including furniture without points for attaching a ligature was authorized in defined circumstances. In accordance with the Government's response to Corston, ACCT was *not* under the leadership of prison health services although their involvement was mandated for the provision of specialist assessments, for medication reviews and for authorizing a regime of constant supervision where a prisoner was thought to be at high risk of suicide.

PSO2700 reflected some of Corston's progressive approach to staff attitudes, prison culture and therapeutic regimes: a non-judgmental approach was considered essential; negative labeling

criticized; whilst healthy prison environments including work, education, and exercise were promoted for their stress-reducing properties.

Rules – Unwritten

Placed in historical perspective, there were some progressive aspects expressed in the NICE guidelines, in PSO2700 and, especially, in the Corston Report. Yet, how rules were written down in official reports (Corston) and in the case of PSOs, national “orders”, was just one manifestation of rules in the prison – how rules were subsequently experienced at “street-level” by prisoners and staff was another. This difference formed a major theme of our staff and prisoner interviews. A gap between the written and unwritten rules was most obvious in the implementation of ACCT. Although PSO2700 mandated an ACCT whenever self-harm occurred, staff sometimes practiced “street-level bureaucracy” (Lipsky, 2010) in everyday situations on account of the paperwork that ACCT was perceived to entail. As one prison officer related:

“I went to open an ACCT document and the [senior] officer said, ‘what you doing that for?’ It's constantly like that. A real battle to open an ACCT”. (Staff [S]1)⁴

The prisoners’ experience of ACCT was ambivalent. In our survey research, 62 per cent of women “disagreed” or “strongly disagreed” with the statement, “ACCT helps me to feel safe”; on the other hand, 58 per cent “agreed” or “strongly agreed” with the statement, “I am listened to in my ACCT reviews”. But the most contentious issue was the *surveillance* associated with an ACCT. PSO2700 mandated a level of observation dependent upon an assessment of risk. This level varied from periodic to constant observation and its purpose was to “stop the individual from *wanting* to self-harm” (HMPS, 2007, paragraph 8.4.3, original emphasis). This was PSO2700's fundamental

written rule. Yet the effect could be contradictory both in terms of behavior and motivation, as one prisoner observed:

I have self-harmed quite a few times in jail and in my honest opinion ACCTs do not work. If someone wants to self-harm a few pieces of paper and an officer checking on you now and then isn't going to stop you. (Prisoner [P]1)

The women's collective suspicion – never openly admitted in the wording of PSO2700 – was that the purpose of surveillance was to protect the prison from litigation. But ACCT surveillance procedures were also experienced as “degrading” as many prisoners remarked as in, for example, the following:

I think constant observation is degrading. You feel dead uncomfortable. You're sat in your room but you can feel someone's eyes burning in your head, just watching you. You've got to be watched having a bath. I don't like them and it's not like they sit and talk to you about your problems. (P2)

The latter complaint was meant to be forestalled in PSO2700 where listening to prisoners was commended both as an aspect of the prison culture and specifically in the context of constant observation. The term “suicide watch” was considered “unhelpful” (HMPS, 2007, paragraph 8.7.1). However, women's experience was that surveillance, especially in the context of being kept in a Safer Cell, was harmful to staff-prisoner interactions:

It is wrong putting you in the safe cell because it can make you feel worse than you did at the start because they have taken everything away from you so that all you have to do is think about things. So the safe cell is like a form of punishment. (P3)

Both prisoners and staff had some positive comments to make about ACCT. For staff, its chief value, recommended by Corston and mandated by PSO2700, was its multidisciplinary status, especially the input of specialist mental health workers as one prison officer commented:

I think the ACCT process works pretty well when it's managed properly and there's a multidisciplinary approach and the woman herself is consulted. (S2)

However, against both Corston and PSO2700 recommendations, multidisciplinary attendance at ACCT case reviews was in fact poor. As part of our research we audited 63 case reviews in 2010 (Ward, 2014, p. 178): only 23 of these were attended by healthcare staff and just one by a member of the psychology team. This agreed with women's collective experience of the inadequacy of specialist mental health involvement, with the lack of access to counselling the main complaint voiced by many women:

[e]very one of my [ACCT] care plans has been "refer to counselling, refer to counselling" (P4);

[t]hey say I've got border split personality but I don't think I have. He hasn't even talked to me properly. He just came up with that – the psychiatrist – like he just gives me anything to shut me up. (P5)

Labeling

Corston had been sensitive to the negative labeling of women in prison and rejected the language of “poor copers”, or “inadequates”, even the “vulnerable” as it, “serves only to sustain the perception...that they are second-class citizens undeserving of care and compassion” (Corston, 2007, p. 15). Taking into account their many vulnerabilities, including histories of mental illness

and trauma, Corston perceived the women she reported on as “victims” as much as “offenders” (p. 3).

That sensitivity was absent in PSO2700, although it stressed the importance of non-judgmental staff attitudes, warning that, “attitudes that see some people who self-harm as ‘genuine’ and others as “‘manipulative’ are dangerous and should not be tolerated by management” (HMPS, 2007, paragraph 13.1.3). Prisoners certainly experienced some progressive practice from staff, although always from female rather than male officers. Simple listening was the most valued quality, as one prisoner commented:

[w]hen I told her [the prison officer] she didn't close the conversation down. She didn't dismiss it [a disclosure of childhood trauma]. She sat there and she cried with me. That was when I first started to say, ‘OK, I'll open up a bit here. (P6)

On the other hand, and despite PSO2700's warnings, staff were also experienced as distant, abusive and threatening, with numerous comments echoing the following views:

[she] spoke to [me] like a child. Staff judge by looking at the criminal not the person. Staff can be very blunt. [She] called [me] by [my] surname or number. [That] don't make me feel safe or human (P7);

[c]ertain people will shout at you and scream at you. “What the fuck have you done that for?” Some staff's way of stopping you self-harming is to come into your cell and scream and shout and threaten you with this and that. (P8)

Staff themselves recounted a range of attitudes to self-harm some of which reflected the progressiveness of PSO2700. But there were also emotional distancing maneuvers and the voicing of negative labels as in the following interview excerpts:

I thought that was good, to be detached from it [self-harm]. Some of them [prisoners] would cut to the bone to get a reaction. That didn't really bother me because I would think, "Well, I'm not related to you. You're not someone I know well" (S2);

I think some people do a little bit of copy-cat self-harming. They're quite impressionable some of them (S3);

[w]e have prolific self-harmers and others that just sometimes do it for attention. Some of the self-harm is because they're ill but a lot of it is because they're bad. (S4)

Our survey research registered the discrepancy between the ways in which staff and women interpreted the motivations that lay behind self-harm. Over 80 per cent of staff indicated that self-harm functioned primarily as a means of “gaining attention” compared to just 18 per cent of women; similarly, three quarters of staff felt that self-harm was used to “manipulate” - but only a fraction (4 per cent) of prisoners thought likewise.

Punishment

The idea of punishment was far from the intention of Corston (2007, p. 11), whose optimism extended to the opinion “that the public is not as punitive in outlook” towards criminals as social surveys suggest. At the same time, the reality of punishment for Corston pervaded the whole

experience of prison considered as what Goffman (1968) called a “total institution”: “loss of liberty...the effect of cramped living conditions...located in a small cell for long hours...deprivation of human contact. This is the reality of the "custody" we impose on women” (Corston, 2007, pp. 15 and 26).

Corston's advocacy, therefore, (2007, p.18) was not just for a “human rights approach” to women's prison management but for a general diversion from custody for women with vulnerabilities including all but the most dangerous offenders. In the specific case of self-harm, PSO2700 was also aware of the problem of punishment, expressly forbidding the use of reward-and-punishment strategies for managing self-harm. More problematic, however, was the use of Safer Cells and the removal of clothing and personal possessions in cases of high suicide risk where the following approach was ordered:

[w]here it is necessary to remove a prisoners clothing...this should be done by persuasion...and not by force. This is particularly important where it is known...that the prisoner has previously been raped...where it is considered that there is no other way...then C&R⁵ techniques may be used to forcibly undress the prisoner (HMPS, 2007, paragraph 8.10.5).

However, despite the careful language, these written rules were amongst the most feared by women, who experienced them simply as punishment. Two prisoners summed up the collective sentiment powerfully:

[m]ost of us are so scared we'll get stuck in a safe cell (P9);

[t]he safe cell is like a form of punishment”. (P3)

Reacting to the Moral Code

One consequence of identifying the functions of rules, labelling and punishment can be the impression of the all-powerful nature of the moral code of the prison. Indeed, to a much greater extent than in our previous work in A&E, we were aware that the “total institution” constituted a powerful regime which severely controlled the emotions and bodies of women. Nevertheless, there was evidence that the women we interviewed did not just passively experience the power of the moral code but, rather, reacted to and sometimes resisted it in various ways. The questions to be asked, then, in this section, are to what extent prisoners complied with the code and to what extent they resisted it?

Unlike the experience of A&E, which is relatively brief, women in prison experienced prolonged incarceration in the context of a “total institution” in which “all aspects of life are conducted in the same place and under the same single authority” (Goffman, 1968, p. 11). That experience included not only physical acts of self-harm, such as cutting or ligaturing, but also two contrasting emotions: anger and boredom. In our survey research, anger was the most commonly reported (58 per cent) emotion prior to the act of self-harm and it had a biographical dimension: anger was linked to previous traumatic experience and “thinking of the past” was the most frequent (66 per cent) antecedent of self-harm. During interviews women often reached for a “pressure-cooker” metaphor as in the following example:

[y]our body just gets so angry. And when you're angry you just can't get it out. So, the way to get it out is to cut up. You try something else like the PlayStation but it doesn't work. Then your only option is to cut up. (P10)

Prolonged boredom was the contrasting emotion in the lives of these women as one prisoner described it:

[b]ored. Alone in your room. Your mind works overtime and you find it hard not to do what your head is telling you: self-harm. (P11)

This emotional dynamic of anger and boredom was frequently described as an antecedent to specific acts of self-harm, especially self-cutting; it seemed to relieve prolonged boredom or to pacify intense anger. In this sense, the experiences of women who self-harmed in the prison corresponded closely to the “motif of control and release” and the necessity of “emotional regulation” often described in non-custodial settings (see Chandler, 2012, pp. 444-448). But the presence of intense distress and biographical trauma complicated matters for women in prison. Of the women surveyed, half (50 per cent) used self-harm to cope with their psychological symptoms, including flashbacks (36 per cent) to previous traumatic experiences. In such circumstances self-harm also functioned as what Chandler (2012, p. 450) called a “non-pharmaceutical, non-clinical method” of “working on” traumatic experience. So, in addition to the immediate challenge of coping with anger and boredom, past trauma was an additional biographical dimension that kept on intruding into the experiences of imprisoned women.

The prison exercised considerable control over women’s emotions and bodies. Whereas in A&E, the moral code was policed by doctors and nurses, in prison, power took on the more continuous form of a twenty-four-hour-seven-day-a-week regime. It was a “total institution”. Its everyday face was the prison officer but its power extended beyond them. Its main written rule was paragraph 8.4.3 of PSO2700 – “the goal is to stop the individual from *wanting* to self-harm” (original emphasis) - and its main method of achieving this was to place women who self-harmed under

surveillance. However, this was not the type of surveillance associated with advanced digital technologies or even older technologies such as closed circuit television. The constant supervision of women who self-harmed in prison was mostly direct observation by prison officers. As the women were fully aware, it involved surveillance (“eyes burning in your head” as one prisoner described it [P2]) that was not technologically aided because it did not need to be. Moreover, PSO2700s wording was very precise: the goal was not just to *stop* the prisoner from self-harming, but to stop her from *wanting* to self-harm. Confronted with such a precise rule and such direct forms of implementation, the prisoner under surveillance had little choice but to either comply or resist.

Consequently, self-harm sometimes became a struggle over the control of self-harm. Both prisoners and prison officers were in agreement on this. Over four-fifths of the staff surveyed cited this as a reason for women's self-harm, as one of them told us:

[s]ome women self-harm for control. They'll say, “I've got nothing outside. I've got you telling me what to eat. You telling me when to sleep. This is the one control mechanism I've got.” (S5).

Similarly, many women were clear that the surveillance mechanisms of PSO2700 could be resisted, as one prisoner narrated:

[w]hen you're suddenly stripped of every bit of control and you're feeling vulnerable and they take away something like a telly or a radio and all you've got in the head is self-harm, that is a dangerous point. I've done it in my safe cell. I've used my fingernails and I've cut quite deep because if you're in that

mind you will. You've had all the control taken away so you want some control back for yourself. (P11)

It was from such acts of resistance as these that an ethical dilemma emerged which revealed a central feature of the moral code of the prison. PSO2700's main written rule was to stop women self-harming. Everyone knew this – prison officers, mental health workers, prisoners – yet everyone knew that this was hard to achieve simply through the existence of a written rule. One prison officer admitted that the removal of glass from the wing accommodating women serving life sentences had no impact on rates of self-harm. She observed that she had, “seen women self-harm with false teeth and with shards of toenails which are thick and sharp” (S6); whilst prisoners were also clear about the significance they placed upon keeping control of the act of self-cutting. “That bit of glass” one woman told us, “is the most important thing to you in your life”. (P12)

Yet the written rule, PSO2700, remained a fact of prison life. The dilemma was of ethical concern as we – the research team - were aware from our interviews that: a) most women self-harmed in secret; and b) where sharp objects had been removed from cells, several women had resorted to self-strangulation by means of ligaturing – a potentially lethal substitution of method. Self-cutting was sometimes, as one prisoner remarked, a “safety mechanism” (P12), a form of suicide prevention rather than attempted suicide.

This general idea – that, in some circumstances, self-harm might be a “safety mechanism” rather than a suicide attempt – is by now well-known from the psychiatric user/survivor literature (for example, Pembroke [ed], 1994). As a research team, we tried to engage the prison management in a discussion about it and the possibility of using “harm-minimization” strategies for women experiencing repetitive patterns of self-harm. These strategies, which are well known in English prisons for dealing with substance abuse (see Ward, 2014), involved educating prisoners who self-

harmful about basic anatomy and wound care so that, in certain carefully assessed cases, women might learn to manage their own self-harm. We had experience of the implementation of harm-minimization strategies for self-harm in other institutional settings (see Cresswell (ed), 2010). However, although the idea received some support from NHS healthcare management, it was rejected by the prison management who argued that such strategies compromised their legal duty to care for prisoners. Their rejection was understandable because allowing some degree of harm-minimization for self-harm in the prison explicitly acknowledged that some level of self-harm could not be prevented. This would have entailed rejecting the primary written rule for dealing with self-harm in the prison: the rule that there should be no self-harm and that prisoners should not even want to self-harm. This rule, together with the surveillance strategies that accompanied it, was one of the most powerful manifestations of the moral code of the prison.

Medicine's Moral Code and the Moral Code of the Prison

At the start of this article, we reiterated the theory of our EHPP research in 2010 – that there was a moral code that discriminated against individuals who self-harmed and came to A&E and that this was a specifically medical code in that the power of doctors and nurses policed it. This is what we called with regard to self-harm, “medicine’s moral code”, which we defined as a group of “attitudes and practices in the context of which professional’s “treat” self-harm” (Cresswell and Karimova, 2010, p. 159). We have kept that definition in mind so that we can now contrast it to the particular moral code that our research has encountered in one women’s prison in England. So, our concluding questions are these: what are the similarities and differences between A&E and the prison with regard to the experience of self-harm? What are the similarities and differences between these moral codes? We understand that comparison in terms of two similarities and two differences.

The first similarity is that they are both *moral* codes. This may sound obvious but we mean it in a specific way. We agree with Tucker (2013, p. 71) that “it is helpful to differentiate between morals and ethics” and also with Andrade and Ugalde (2011, p. 29) that in a significant sense moral codes are “pre-ethical”. This is what we meant in our original theory when we pointed to the fact that even seasoned clinicians faced with an individual who had self-harmed in A&E experienced feelings of “revulsion” (Cresswell and Karimova, 2010, p. 159). Such a reaction is simultaneously an emotional feeling, a cognitive attitude and a negative judgment – in short, what we defined as a group of “attitudes and practices”. There is nothing particularly “clinical” about it; and it has no necessary connection to the written rules of professional ethical codes because, as Andrade and Ugalde (2011: 30) also stressed, moral codes “establish guidelines *before* the truly ethical question even arises”. In other words, those feelings of revulsion in A&E and the prison officer thinking to himself that it “was good to be detached from it [self-harm]” because “[y]ou’re [the prisoner] not someone I know well” (S2) form parts of a moral code that existed *before* any institution in England wrote down a NICE clinical guideline or a Prison Service Order. What is similar about A&E and the prison is that they are powerful institutions with moral codes about self-harm which are sometimes written rules (NICE guidelines, PSOs) but are just as often unwritten (feelings of revulsion, the attitude that “you’re not someone I know”). Sometimes, they are pre-ethical moral codes.

The second similarity relates to the risk of suicide. As institutions, both A&E and the prison are what Szasz (2011) called “suicide prohibitionists”. Again, the point is well-known: modern medicine and psychiatry have taken upon themselves the moral function of suicide prevention, one historically discharged by the institutions of religion and the law. As we remarked in 2010, the act of self-harm in A&E has often been seen, not on its own terms, but in relation to suicide. This is

usually expressed in the language of “risk” as in the NICE clinical guideline (2004, p. 6): “all people who have self-harmed should be assessed for risk...in particular, depression, hopelessness and continuing suicidal intent”. The same holds true for the prison where the relevant Prison Service Order (PSO2700) is itself entitled “Suicide Prevention and Self-Harm Management”. Hence, the emphasis in PSO2700 upon the function of surveillance to prevent further self-harm but also, in the process of surveillance, to prevent suicide. The attitudes and practices which assess self-harm and which place the woman who self-harms under surveillance in prison form part of a wider group of attitudes and practices which prohibit suicide. They are expressed in written rules such as PSO2700; but they also express a general unwritten moral attitude about suicide prevention. As in the case of A&E, however, this attitude contains an ethical dilemma: the psychiatric user/survivor critique of the professional treatment of self-harm and some specific evidence drawn from interview data here, suggests that not only has self-harm in some cases little connection with suicide, it may in fact function as a form of suicide prevention, as a “safety mechanism”. Yet despite this now well-known observation, the prison remained opposed to strategies of harm-minimization. That situation was and remains an ethical dilemma in custodial settings where the management of self-harm is concerned.

A major difference between A&E and the prison is the extent of surveillance. Nothing in the experience of self-harm in A&E corresponds to the extent of surveillance mandated by PSO2700. Constant observation, being watched having a bath, the removal of clothes and possessions, being placed in a Safer Cell – these have no equivalents in the experience of the individual who self-harms and goes to A&E. Of course, this is obvious too: Accident and Emergency departments in general hospitals are open and transient environments, whilst prisons are closed and continuous ones. But here Goffman’s (1968) concept of the “total institution” is specifically connected to the

moral code of the prison. Only in an institution where “all aspects of life are conducted in the same place and under the same single authority” (Goffman, 1968, p. 11) can constant observation effectively occur; and only in the total institution can the rule that there should not only be no self-harm but that the prisoner should not even *want* to self-harm, be potentially enforced. This, though, is not the same as saying that the prison code was all-powerful. The moral code of the prison was that of a total institution not that of total domination and the evidence from our interview data was that despite the prison exercising considerable control over their emotions and bodies, women sometimes did find ways of resisting its power. This is why the question of who controlled self-harm – the prison officers or the prisoners – was such a point of contention and struggle.

Finally, it could be objected that everything we have said about the prison as a total institution could also be applied to the psychiatric in-patient ward and the psychiatric hospital in agreement with Goffman’s (1968) theory in *Asylums*. As total institutions, prisons and psychiatric wards are both different from A&E. Indeed, the research reported by Hagen and Nixon (2011) in EHPP concerning women’s experiences of Canadian in-patient psychiatric units, largely concurred with our own. The systematic invalidation of women’s experiences and the violence and violations that they describe were also ever-present in the lives of the women who self-harmed in the English prison we researched. But here we would make two specific geographical and historical points. After the 2008 economic recession and especially post-2010 and the UK government’s policy of systematic “austerity”, psychiatric in-patient facilities in England have been reduced in number (Crisp et al, 2016). England has arguably transitioned into an era characterized by what Spandler (2016) has called “psychiatric neglect”. At the same time there has been a doubling of the women’s prison population from 1995 onwards.⁶

This has implications for the moral code of the prison in comparison to medicine's moral code. The fact is that though the NHS has been present in English prisons since 2003, (H.M. Prison Service and NHS Executive Working Group, 1999) the policing of the moral code of the prison remains firmly in the hands of prison officers and prison management, not doctors and nurses. Corston wanted NHS clinicians to take the lead where self-harm was concerned but the UK government rejected her recommendation. Reviewing the progress of the Corston recommendations in 2017, ten years on from its publication, the pressure group Women in Prison (2017, pp. 25-26) had this to say:

levels of self-harm by women in prison have remained extremely high and 2016 saw the highest number on record of deaths of women in prison in England...Self-harm in prison is managed through Assessment, Care in Custody and Teamwork (ACCT)...ACCT reviews are largely set up, monitored and managed by the Safer Custody teams in prison, not by the NHS.

There are theoretical and practical ramifications to this situation. Theoretically, what impressed us during our research upon self-harm and medicine's moral code in A&E was the ongoing usefulness of Parsons' theory of the sick role: self-harmers in A&E sometimes broke its unwritten rules and were sometimes punished for their transgressions. Yet, the sick role itself also implies a doctor-role and a nurse-role. This is precisely why medicine's moral code in A&E is a *medical* code. It is policed by doctors and nurses. But in the relative absence of such clinicians in the prison, women who self-harm cannot really be breaking the rules of the sick role. Rather, they are breaking the rules attached to the role of the prisoner, in which case prison officers construct a simple dichotomy between "good" and "bad" prisoners. "Sickness", in the form of mental illness or trauma, could enter the equation as could the clinicians – in which case mental illness tended to speak on the side

of the “good” prisoner. But in those cases the sick role was secondary to an original attribution of “goodness” and “badness”. “Good” prisoners self-harmed once and were appropriately treated via ACCT; “bad” prisoners were “repeaters”, continued to find ways to commit acts self-harm, and continued to “want” to. As one prison officer told us: “some of the self-harm is because they're ill but a lot of it is because they're bad.” (S4) The theory of Parsons’ sick role, therefore, is not wholly appropriate to understanding the experience of women who self-harmed in prison; it needs to be supplemented by a more institutionally specific theory of the prison’s own moral code . Regarding self-harm in one women’s prison, we conclude that there was a moral code but it was not primarily a medical code policed by doctors and nurses. It was a penal code. It consisted of specific rules, labeling, and punishments and it was primarily policed by prison officers.

In practical terms, medicine’s moral code in A&E was usually experienced transiently although the experience could be repeated. By contrast, the moral code of the prison was prolonged and continuous in the context of the total institution. This is not to deny that the experience of the individual who self-harms and goes to A&E may be traumatic. But in the prison, trauma (institutional) was piled upon trauma (biographical) and the punishment of the prison experience itself was a constant traumatic intrusion. That is why the moral code of the prison was always experienced in the context of the total institution.

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¹ This article uses the term Accident and Emergency department (abbreviated to A&E) to refer to the provision of 24-hour emergency medicine within the UK National Health Service (NHS). Such services in other countries are often referred to as “emergency medicine” or the “emergency room”.

² Available from the UK Government Web Archive. URL:

<http://webarchive.nationalarchives.gov.uk/20110602060704/http://pso.hmprisonservice.gov.uk/pso2700/PSO%202700-front-index-and-PSO-itself.htm>.

³ URL: <https://www.justice.gov.uk/offenders/psos>

⁴ To preserve anonymity in the interview data which follows we refer to staff members as “S” and prisoners as “P” together with the number they were randomly allocated during the research process.

⁵ C&R = Control and Restraint. It refers to the institutionally sanctioned techniques of physical force allowed to be used by prison officers on prisoners.

⁶ ‘Women in Prison: Key Facts’: URL: <http://www.womeninprison.org.uk/research/key-facts.php>