Exploring the differences between self-harm and suicide in women with complex mental health needs.

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I dedicate this thesis to my Mother, my Grandfather, my Grandmother and the late great Rebecca Fox.

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"Who doesn't want to know that we notice them and value them? And who might respond to us better when they feel they matter? It probably cannot be overstated – it matters that people matter" (Steve Goodier).

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"The main thing for me is not to be lured into a false sense of security, these women are very very traumatized on a daily basis, they are literally the most distressed people we will ever nurse, and yet it becomes the norm to see them so distressed… we need to pay attention to it and for it not to be a normal thing for somebody to be so distressed, we need to not loose sight of people's distress and for it not to become a normal thing and that for me is the main learning point" (Rose, Clinical Nurse Practitioner).

Abstract

Self-harm and suicidal are major public health problems, which can contribute to many life-long adverse outcomes. The costs of self-harm and suicide are high on both an individual and societal level and have considerable financial implications for health services. Self-harm and suicide are known to be more prevalent amongst the forensic mental health population than in the general population and the wider mental health population. Whilst some claim that self-harm and suicide are distinctly different behaviours, recent literature advocates that the separation of self-harm and suicide may be more challenging than originally thought, as an additional type of self-harm behaviour has been noted. Life-threatening self-harm refers to self-harm that without medical intervention, is serious enough to bring about death.

As current literature situates life-threatening self-harm in the context of suicidal ideation, survivors of life-threatening self-harm are considered the best proxies to inform research and practice about suicide. It is however important to note that amongst the limited literature, there is a proportion of people who self-harm using highly lethal methods but do without suicidal intent. Consequentially, further investigation is warranted. Whilst a picture is forming for the general and prison population, to date there is yet to be a study that explores the reasons for life-threatening self-harm amongst women receiving forensic mental health services. The lack of literature is important, as currently literature from the prison and general population informs clinical practice, without understanding whether the findings are generalisable to the female forensic mental health population. This includes the use of self-harm and suicide prevention strategies, including restricting access to means. Therefore, the current research aimed to address the gap in literature, in a bid to better understand the functions of, and pathways to, life-threatening self-harm amongst women in forensic mental health services.

Sixteen members of staff and seven women from various levels of security were enlisted to take part in semi-structured interviews. The interviews aimed to hear the voices of women and staff and use them to provide a unique picture of life-threatening self-harm within a hard to access population; to determine the functions of, and pathways to life-threatening self-harm; and to explore the impacts of restricting access to means on life-threatening self-harm. The findings indicate that women in forensic mental health services do not enact life-threatening self-harm suicidal with intent. Instead, the women and staff who took part in the research posit there are seven functions of, and pathways to, life-threatening self-harm. The findings

also indicate that working with or living amongst women who enact life-threatening self-harm is emotionally taxing. Furthermore, the findings suggest that restricting access to means plays a contributory role in life-threatening self-harm. The findings of the research are discussed with reference to directions for future research, the clinical implications and the methodological limitations.

Thesis Overview

Self-harm is a major public health problem, which can contribute to many life-long adverse outcomes (Geulayov et al, 2016; Hawton et al, 2012; Bergen et al, 2014; NICE, 2013). The costs of self-harm are high at both an individual and societal level, and it has considerable financial implications for health services (Sinclair et al, 2011). Self-harm is a highly individualised phenomena, and the reasons for engaging in such behaviour vary (NICE, 2013). Determining the individual reasons for self-harm can be challenging, however it remains an important task to undertake, as for some people, self-harm can indicate some level of suicidality (Hawton et al, 2014; Oakes-Rogers & Slade, 2015). Whilst self-harm is a frequent event within community populations, self-harm within inpatient settings is far more common (James, 2012). Inpatients are thought to have a four-fold increased risk of self-harm compared to their community counterparts (Hargate et al, 2017), and approximately 264 incidents per 100 admissions occur each month (James et al, 2012). Across all inpatient settings, forensic patients account for the highest rates of self-harm, with a rate of 46 per 100 admissions. The rate is more than ten times that of acute wards, and three times that of PICU wards, (James et al, 2012). Those receiving forensic care are also far more likely to engage in self-harm repetitively, as despite only accounting for a small proportion, they are responsible for more than twice the number of incidents than those from any other inpatient service (James et al, 2012).

Self-harm is more common amongst female forensic patients, compared to males, and approximately one in 20 women are detained because of their self-harm behaviour alone (Bartlett et al, 2014). Such literature is concerning as self-harm is one of the strongest predictors of suicide, and approximately 68% of all mental health service users who die by suicide have a history of self-harm (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2017). Like self-harm, suicide is an area of great importance on an individual, national and international level, (Bebbington et al, 2010). The suicide of a service user is one of the most serious events faced by mental health providers (Large et al, 2011), and the effects extend to relatives, peers and staff (Bowers et al, 2006). Between 2004 and 2014, 1207 suicides occurred on inpatient wards across England and Wales (NCISH, 2016). Despite a notable reduction in the number of inpatient suicides since major policy change removed all ligature points (Department of Health, 2003), forensic mental health patients continue to have an elevated risk of dying by suicide, in comparison to those within the general population (Preventing Suicide in England, 2012). Due to the on-going presence of staff, inpatient suicide and severe self-harm often appears to be more avoidable than incidents within the community

(Bowers et al, 2011). Nethertheless, the prediction and prevention of such behaviour is fraught with difficulty, in part due to the complexities of the people forensic services care for (Vollm et al, 2017), and because of unique environmental factors, which can in some cases exasperate these challenging behaviours (Powell et al, 2000).

A fundamental problem, which hinders our understanding of self-harm and suicidal behaviours, relates to definitional issues. Within the literature, there is heavy criticism regarding the use of inconsistent terminology, and there is a distinct lack of consensus as to which conceptual definitions best describe self-harm and suicide (Gratz, 2003; Silverman, 2007a). As a result, there are several terms used interchangeably to describe a single concept, whilst single, broader terms describe multiple behaviours, which can create issues for accurate assessment, and implementing appropriate treatment (Andover et al, 2012). Specifically, conflating terminology is of concern when discussing the motivations behind self-harm, and determining whether people do so with, or without suicidal intent, as it can significantly affect practical understanding. In an attempt to provide clarity, recently there has been a call for the separation of self-harm and suicidal behaviours, based on the frequency and severity of the self-harm, and the methods involved (DSM-5, 2013; American Psychiatric Association, 2013; Klonsky & Muehlenkamp, 2007; Nock et al, 2006; Whitlock et al, 2006). A fundamental assumption from this approach is that self-harm which occurs without suicidal intent, is inherently different to self-harm enacted with a degree of suicidal intent, meaning there will be distinct differences between the behaviours and the associated risk factors (May & Victor, 2018; Poon et al, 2019; Andover et al, 2012; Nock et al, 2008). Arguably, self-harm which occurs frequently, without suicidal intent, uses non-life-threatening methods, and results in minor to moderate self-injury, is non-suicidal self-injury (NSSI). Conversely, self-harm which uses potentially lethal methods, results in injuries requiring greater medical attention, and occurs with some level suicidal intent, ought to be termed suicidal behaviour (SB), or a suicide attempt (SA). There are however important underlying definitional flaws with the proposed differentiation between NSSI and SB, including a lack of best practice in relation to defining, and assessing a) the severity of self-harm, b) the frequency of self-harm, c) the potential lethality of methods and d) assessing suicidal intent. Whilst some guidance is emerging, these fundamental issues need addressing, and it is important for future research to introduce a standardised definition, and categorisation process for each element of distinction between NSSI and SB.

Despite the evidence base supporting the differences between NSSI and SB, the relationship between the behaviours is complex. There are risks associated with adopting a distinct bi-

directional approach, including introducing inappropriate treatment plans, and missing warning signs of increased risk of suicide. This is, in part, due to the distinct overlaps between NSSI, SA, and SB, and the fact that the behaviours do not always occur exclusively (Klonsky et al, 2013). Such a suggestion is widely evidenced and indicates a dichotomous approach to these behaviours may be to simplistic (VanOrden et al, 2010; Hawton et al, 2014; American Psychiatric Association, 2013; DSM-V, 2013).

There are also issues regarding the transferability of a bi-directional approach to inpatient populations, due to self-harm and suicide prevention strategies, which restrict the availability of self-harm methods. It is generally accepted that method selection is unlikely to be random, and is instead influenced by a range of cultural, social, psychological, and environmental factors (Cantor & Baurne, 1998). Typically, individuals select methods based on the motivation behind their self-harm behaviour, and research suggests the use of more lethal methods as the desire to die increases (Haw et al, 2015). It also accepted that the physical availability of self-harm means affects method selection, therefore within community samples, restricting access to potentially lethal methods can be a successful suicide prevention strategy (Hawton et al, 2001). There is, however, evidence to suggest that things may be different for individuals cared for by forensic services and restricting access to means could increase the severity of an incident, without the presence of suicidal intent (Sarkar, 2011; Dyke et al, 2014;). Method substitution (changing methods in light of impeded access to another) has been noted in a number of population wide studies (Rich et al, 1990; Lester, 1990), evidencing that whilst restricting access to potentially lethal methods is able to hinder a specific incident, it does little to prevent self-harm and suicidal behaviour in the longer term (Florentine & Crane, 2010). Method substitution is likely to be more pronounced for forensic patients, whereby access to methods that cause mild to moderate harm are restricted, such as means to enact cutting, scratching or burning. As a result, a much broader range of self-harm methods are utilised by forensic patients, including the use of ligaturing (using everyday items such as clothing), and occluding the airways (Tromans et al, 2018; Dyke et al, 2014; James et al, 2012). Sadly, these methods are common, and they pose high-risk to life, however it is unclear whether such methods are indicative of suicidal intent amongst forensic patients, as they often are within community populations. It is therefore important for future research to explore the impact of restricting access to means further, and establish whether frequently used, near-lethal methods are indicative of suicidal intent, or the result of restricted access to means. Understanding the complex decision-making process better has important implications, as current approaches to assessing, treating and managing such behaviours are based largely on

our understanding of community samples. Arguably, such an approach lacks specificity for the forensic population (Oakes-Rogers & Slade, 2015). Therefore, the current study collected the lived experience of women service users who had enacted life-threatening self-harm and suicidal behaviours and members of staff from three forensic mental health hospitals. Their expert opinions were used to enrich our understanding of life-threatening self-harm. To the authors knowledge, this is the first time life-threatening self-harm has been explored specifically within women's forensic mental health services, and the first to incorporate the testimonies of both staff and women service users.

To achieve the thesis aims, the following questions were explored

- What are staff and women's experiences of living amongst, or working with, women who enact life-threatening self-harm?
- Why do women enact life-threatening self-harm?
- Is life-threatening self-harm enacted with suicidal intent?
- What are the pathways to life-threatening self-harm?
- Does restricting access to means of self-harm play a contributory role in the development of life-threatening self-harm?

To do so, this research thesis enlisted individual semi-structured interviews and focus group to collate the experiential knowledge of women and staff from across one forensic pathway in England (see Chapter 1, Overview of Forensic Services).

To present the findings of this doctoral research, the first chapter of this thesis will contextualise the research by presenting data relating to the prevalence of self-harm and suicide within both community and forensic settings. To provide a clear description of the population that were studied within this thesis, an overview of forensic services within the UK will be provided. Chapter two will define self-harm and suicidal behaviours and outline the associated risk and protective factors. It will critically discuss the current academic standpoint as to whether self-harm and suicide can be separated and explore near-lethal self-harm. In doing so, an argument is presented that currently there is a distinct lack of understanding surrounding the motivations underpinning such behaviour. Chapter two will also present literature relating to method selection, method substitution and restricting access to means, and review whether evidence from the general population can be generalised to forensic mental health patients. The third chapter will present an overview of the widely accepted

theoretical models that attempt to explain why people engage in self-harm behaviours in a bid to clarify whether a theory exists that can appropriately explain near-lethal self-harm.

Chapter four will provide details of the methodological framework that underpinned the research within the thesis, followed by chapter five, which details the methods that were employed.

Chapters six, seven and eight contain the findings from the thesis. The first findings chapter, The Experience of Life-Threatening Self-Harm aimed to provide overview of life-threatening self-harm within women's forensic mental health services. Unlike before, the findings offer a rarely unseen perspective of a relatively unexplored behaviour, in a hard to access population. Chapter seven, the functions of, and pathways to, life-threatening self-harm, contains the findings that describe the reasons why women in forensic mental health services enact life-threatening self-harm. The chapter contains novel findings in that the women and staff who took part in the research understood life-threatening self-harm to occur without suicidal intent, which is distinctly different to other literature. Instead, seven sub-types of life-threatening self-harm are outlined, which provide an explanatory framework as to why women enact life-threatening self-harm and how the behaviour develops. Chapter eight presents the findings, which explored the impact of restricting access to means on life-threatening self-harm. Whilst the research did not directly test whether restricting access to means predicts or contributes to life-threatening self-harm, as the impacts have scarcely been explored within forensic mental health services, the chapter offers an important insight. In doing so, the findings raise questions as to the effectiveness of restricting access to means, which have important implications for practice.

Whilst the majority of the thesis is written in the third person, because of the methodological framework (Participatory Action Research), and its requirement to critically reflect over each stage of the research, where a critical reflection is included, aspects of the thesis will be written in the first person.

It is important to note that whilst the findings detailed within the thesis are indeed explicit and highly emotive, at no stage of the research did the author detect that the way in which the staff express themselves posed any safeguarding risk to the women in their care. Similarly, the women did not express any stories or plans that caused the researcher to believe any of the participants, or the staff were at immanent risk of harm. Instead, their stories reflect the experiences of staff who work in highly emotive environments, and women who are clearly vulnerable.

Thesis Definitions

Definitions

For the purpose of this thesis, when discussing self-harm, the following definitions apply

'Self-harm'

Adopting the definition offered by The National Institute for Health and Care Excellence (NICE) (2013), the term 'self-harm' will be used to broadly encompass

"Any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation".

The definition excludes "harm arising from overeating, body piercing, body tattooing, and excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa, or accidental harm to oneself". When used within this thesis, the term 'self-harm' will not make specific reference to the intent or motivation behind the act, and encompasses intentional harm, which occurs both in the presence, and absence of suicidal intent.

'Non-suicidal self-injury'

Adopting the definition widely used within academic literature, within this thesis, NSSI will be defined as:

"The intentional destruction of one's own body tissue *without suicidal intent*, and for purposes not socially sanctioned".

Behaviours that cause unintentional harm (such as smoking), and culturally sanctioned body modifications included tattoos and piercings are excluded from this definition (Nock et al, 2009).

'Near-Lethal Self-Harm'

Considering the evidence base that disputes the relationship between near-lethal self-harm and suicidal intent, this thesis will adopt suggestions from both Douglas et al (2004) and Marzano et al (2010) and define near-lethal self-harm as:

- "Any act of self-harm using a method that would usually lead to death, e.g. hanging, drowning, self-poisoning with car exhaust fumes, jumping from a high place or in front of a moving vehicle" OR
- Acts which would be fatal without a fast medical response and/or intervention

- "Self-injury to a 'vital' body area (e.g. throat, chest or abdomen, not wrists, legs or arms)" OR
- "Self-poisoning that requires admission to an intensive care unit or is judged to be potentially lethal by an accident and emergency doctor".

'Life-Threatening Self-Harm'

When referring to the term life-threatening self-harm, the following definition will apply:

'An act of self-harm that has the potential to be lethal, which was enacted without suicidal intent including: any behaviour that restricts breathing; blood-letting and vein-popping; cutting near main arteries; and any behaviour that makes a pre-existing vulnerability more likely to be lethal'.

'Non-Life-threatening Self-Harm'

When referring to the term non-life-threatening self-harm, the following definition will apply:

'All self-harm that is not dangerous enough to cause death or pose a high risk to life'.

'Suicide Attempt'

Adopting suggestions from Nock et al, (2008), when referring to a suicide attempt, the following definition will apply:

"Engagement in potentially self-injurious behaviour in which there is at least *some intent* to die"

'Suicide'

Adopting the definition employed by the National Health Service, for the purposes of the thesis, the term suicide is defined as:

'The act of *deliberately* taking one's own life'

The definition excludes any other definition of suicide and phrases that relate to other types of intentional death including 'suicide bomber', and 'assisted suicide' (NHS England, 2018).

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Glossary

Term	Definition
Ambivalence	A state of co-occurring, conflicting feelings and/or uncertainty about how an individual is feeling.
Acquired Capacity	The ability to engage in behaviour dangerous enough to bring about death
Burdensomeness	The feeling that you are a burden to other people
Forensic Mental Health Population	Individuals cared for by secure forensic mental health services.
Frequency	The number of occurrences of self-harm incidents
High Secure Services	Secure forensic mental health services that provide care to individuals who are detained under the Mental Health Act and who "require treatment under conditions of high security on account of their dangerous, violent or criminal propensities" (NHS Standard Contract, C03/S/A, 2014).
Inpatient services	Mental health services providing care to people who are experiencing, or who are at risk of experiencing, or are recovering from a mental health crisis and who can not longer be safety cared for by community mental health teams (Joint Commissioning Panel for Mental Health, 2013).
Lethality	The extent to which an incident of self-harm poses a risk to life.
Life threatening self-harm	An act of self-harm that has the potential to be lethal, which was enacted without suicidal intent including; any behaviour that restricts breathing, blood-letting and vein-popping, cutting near main arteries, and any behaviour that makes a pre-existing vulnerability more likely to be lethal.
Low Secure Services	Secure mental health services that provide mental health care to individuals who require a hospital admission, present a risk to others,

	present a risk of absconding but do not require a category B or above security perimeter, and have progressed or show evidence of being able to integrate back into the community.
Means Restrictions	The restriction, or removal of items that can be used to inflict harm on oneself.
Medium Secure Services	Secure mental health services that provide mental health care to individuals who require a hospital admission, present a risk to others, present a risk of absconding and do not require a category B or above security perimeter.
Method Substitution	Replacing one method of self-harm with an alternative method of higher, lower or equal lethality.
Near-lethal self-harm	Acts of self-harm using a method that would usually lead to death **OR** Acts which require fast medical response, which without emergency, or medical intervention, could prove fatal **AND** Self-harm to a vital body area (e.g. throat, chest or abdomen, not wrists, legs or arms)
Non-life-threatening self-harm	All self-harm that is not dangerous enough to cause death or pose a high risk to life.
Non-suicidal self-injury	The intentional destruction of one's own body tissue without suicidal intent and for purposes not socially sanctioned. Behaviours that cause unintentional harm (such as smoking) and culturally sanctioned body modifications including tattoos and piercings are excluded from this definition (Nock & Prinstein, 2009).
Psychiatric Intensive Care Units	Specialised mental health inpatient services for adult patients who are experiencing an acutely disturbed phase of a serious mental health disorder (The National Association of Psychiatric Intensive Care & Low Secure Units, 2016; Department of Health, 2002).

Risk Factor	Any attribute, characteristic, vulnerability or exposure of an individual that increases the likelihood of an event, disease or injury.
Restricting access to means	The restriction, or removal of items that can be used to inflict harm on oneself.
Secure Forensic Mental Health Services	Secure mental health hospitals designed to offer mental health care for individuals who have a history of offending behaviour and/or a history of irresponsible behaviour that cannot be safely managed by community mental health teams.
Self-harm	'Self-poisoning or self-injury, carried out by a person, irrespective of their motivation" (National Institute for Clinical Excellence Self-harm Quality Standard QS34, 2013). Behaviours which may be considered self-harm as a result of physical or psychological damage, such as smoking, recreational drug use, excessive alcohol consumption, over-eating or dieting, and excess exercising, and self-harm which occurs as part of religious practise, political or social protest or as an act of 'body enhancement' are also excluded.
Self inflicted death	Deaths arising from non-natural causes that appeared to be directly caused by the actions of the individual concerned.
Severity	The seriousness of self-harm incidents
Suicide attempt	Engagement in potentially self-injurious behaviour in which there is at least some intent to die (British Psychological Society, 2016).
Suicide	The act of deliberately taking one's own life (NHS England, 2018).
The Forensic Pathway	A mental health care pathway designed to provide secure, step down forensic mental health care to adults who have come into contact with the criminal justice system. Individuals are assessed and referred to the forensic pathway via several routes including; court referral, referral from prison, referral from another secure forensic service, or referral from generic mental health inpatient services (NHS Standard Contract, C03/S/A, 2014).

Thwarted belongingness	An extreme disconnection to other people and society
Women's Enhances Medium Secure Services (WEMSS)	Enhanced medium secure services offered to women currently receiving forensic mental health services in medium secure settings but who require additional security measures.

Abbreviated Terminology

NSSI	Non-suicidal self-harm
NLSH	Near-lethal self-harm
LTSH	Life-threatening self-harm
NLTSH	Non-life-threatening self-harm
PICU	Psychiatric Intensive Care Unit
IPMS	The Interpersonal-Psychological Model of Suicide
IMV	The Integrated Motivational-Volitional Model of Suicidal Behaviour
PAR	Participatory Action Research
HRA	Health Research Authority

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Chapter 1 - Contextualising the Research
The Prevalence of Self-Harm and Suicide

1. Introduction

To contextualise the research for this doctoral thesis, the following chapter aims to provide an overview of self-harm and suicide amongst the general population and those in receipt of forensic mental health care. The impact of self-harm and suicide will be addressed for both populations and the current literature pertaining to risk factors is presented and its limitations discussed. When discussing the risk factors for self-harm and suicide amongst the forensic mental health population, a short summary of the risk factors amongst the prison population and the wider psychiatric inpatient population will also be presented. This is due to the limited evidence base specifically for the forensic mental health population meaning it is appropriate to consider literature pertaining to the prison and wider psychiatric inpatient population as they are the most similar counterparts for forensic mental health population. Finally, a synopsis of the forensic mental healthcare system within the UK is presented to help inform the reader of the population under study. It will include a summary of whom and why people receive forensic mental health care and explain how people are referred to forensic services. It also outlines the legal responsibilities forensic mental health services have, to protect their patients from harm; highlighting the impact self-harm and suicidal behaviours has on their legal responsibilities.

1.1 Prevalence of self-harm and suicide

Across the United Kingdom, statistics relating to self-harm and suicide are routinely collected and held on public databases. Not only do these statistics serve to provide information regarding the occurrence of self-harm, suicide attempts, and deaths by suicide, they also help to profile people who may be at increased risk of suicide (WHO, 2014). It is however important to recognise that statistics do not attempt to explain the complicated relationships between suicidal thoughts, self-harm and suicide, nor do they provide information that may explain why people enact such behaviour. They are however, particularly useful in identifying

trends and changes to incident rates across different populations (McManus et al, 2016). This is useful as it allows government initiatives and health policies to appropriately target those at risk. Due to the often secretive nature of self-harm and suicidal behaviour, it is however important to approach the prevalence rates with caution, as not all incidents that occur are reported (McManus et al, 2016). Not all people who self-harm seek help for their injuries, meaning public records such as the Office of National Statistics, (which are informed by primary (GP) and secondary (hospital) healthcare databases), will underestimate the true prevalence of self-harm and suicide attempts.

1.2 Self-harm

Within the UK currently, the rate of self-harm is estimated at 363 per 100,00 males, and 4441 per 100,000 females (Guelayov et al, 2016), making it the highest within Europe (Royal Institute of Psychiatry, 2017). Sadly, the rates of self-harm continue to rise (Griffin et al, 2018; Carr et al, 2016), and between 2000 and 2014, self-harm increased by 13.2% in females and 3.8% in men (Adult Morbidity Survey, 2014). It is therefore no surprise that within the general population self-harm remains one of the most common causes for hospital attendance (Bergen et al, 2010), and over the last decade hospital attendances as a consequence of self-harm rose by over 18% (Health and Social Care Information Centre, 2017). Literature shows that among those who do seek medical treatment in hospital, almost three-quarters will attend following an incident of self-poisoning (Geulayov et al, 2016). Cutting is the second most common method of self-harm within the general population, followed by asphyxiation/ hanging, jumping from heights and drowning (Geulayov et al, 2016). Those who self-harm and seek medical treatment within secondary settings are often to known to attend emergency healthcare services frequently, and it is estimated that approximately 20% will present to the same hospital for self-harm within one year (Bergen et al, 2010). This has significant implications and adds to the already challenging social and financial impact of self-harm, which is estimated to cost the NHS £162 million per year (Tsiachristas et al, 2017).

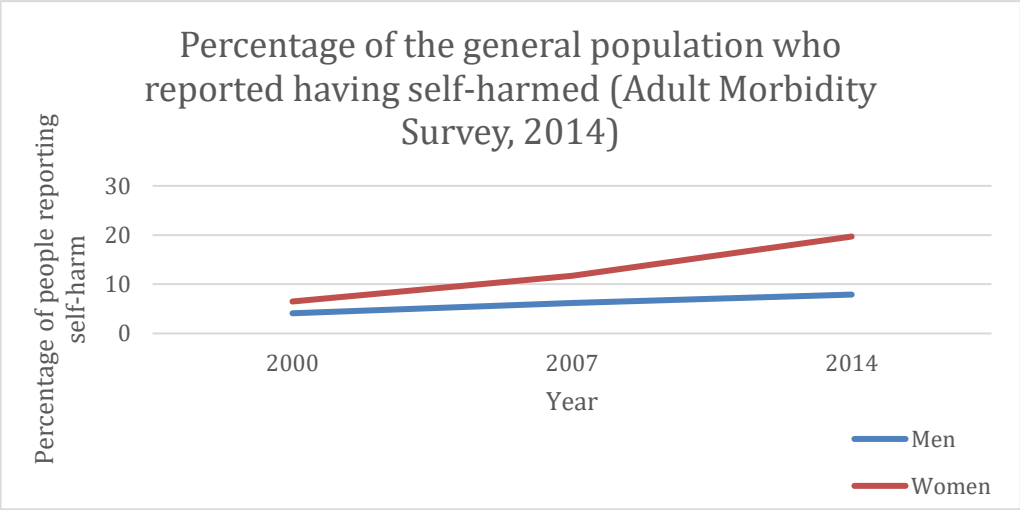
It is well known that the prevalence of self-harm is far greater within female populations compared to males (Carr et al, 2016; Clements et al, 2016; Hawton et al, 2014). With one in five young women reporting they had self-harmed at least once in their lives, women are twice as likely than men to self-harm (NHS England, 2018; Stanford et al, 2017; Clements et al, 2016; Carr et al, 2016). In particular girls aged between 15 and 24, have consistently been identified as those accounting for the most incidents of self-harm (NHS Episode Statistics, 2018). NHS England (2018) has quantified this, estimating almost a quarter of 14 year old girls (22%) have

self-harmed. Of additional concern, recent statistics indicate an increase in self-harm in female children between the ages of 8-15 (HSCIC, 2016). These findings suggest young girls are engaging in self-harm earlier than before, extending the period during which they self-harm (Griffin et al, 2018; Nakar et al, 2016). This has important implications considering evidence that demonstrates poorer long-term outcomes when the onset of self-harm occurs at a young age (Stanford et al, 2017). Although self-harm is particularly pronounced amongst adolescence and young adulthood (Griffin et al, 2017), research suggests within community samples, there is a direct correlation between increased age and a decrease in self-harm incidents in women (Stanford et al, 2017).

Despite self-harm being more prevalent in girls and women, self-harm among males is still an important national issue. Unlike women, among males in the general population, self-harm appears to manifest slightly later in life and often begins during early adulthood between the ages of 20 and 24 (Griffin et al, 2018). Self-harm amongst males continues to rise with age and the number of self-harm incidents is greatest in later years. This is particularly true for males of working age (Townsend et al, 2016; Hawton et al, 2012), and those between the ages of 46 and 65 (Carr et al, 2016). Whilst many young men self-harm during young adulthood (Madge et al, 2008), national statistics have shown that after the age of 50, for the first time in across the time span males are responsible for more self-harm incidents than women (Hawton & Harriss, 2005).

As self-harm presents a significant issue amongst community populations, to comprehensively understand the statistics, it is helpful to acknowledge other factors that may influence trends in the prevalence of the behaviour. Some argue that instead of an increase in the prevalence of self-harm, the recent rise in the number of self-harm incidents may be a result of increased reporting of self-harm (McManus et al, 2014). Literature indicates more people now disclose minor acts of self-harm, based partly on the reduced stigmatisation around the behaviour, and more people seek medical attention for their self-harm (McManus et al, 2014). Additionally, improved administrative coding of self-harm within general hospitals may have improved, meaning more incidents are recorded than before (McGill et al, 2018). Whilst these suggestions are valid, it is most likely that the increased rates indicate a combination of factors, including a real increase in the behaviour (Clements, 2016).

Figure 1: Self-report self-harm rates within UK adults within the general population



Although self-harm among the general population is undoubtedly a pressing public health issue, it is well evidenced that individuals cared for by mental health services are responsible for a far greater proportion of self-harm incidents (O'Connor, 2008). Among mental health service users, those receiving care within inpatient mental health hospitals are at even greater risk of self-harm compared to members of the general population, and community mental health service users (James et al, 2012). Sadly, self-harm within inpatient mental health settings is common, with approximately 264 incidents occurring per month, per 100 admissions (James et al, 2012). It is thought that approximately 19 in every 100 admitted patients self-harm, of whom 32% are known to enact self-harm repetitively (James et al, 2012).

Recent evidence now suggests that the rate of self-harm also differs between types of inpatient provision. Notably, service users receiving care within forensic mental health services account for the highest rates of self-harm when compared to those in any other inpatient settings, with a rate of 46 per 100 admissions (James et al, 2012). This equates to 29% of all inpatient self-harm incidents, making it more than ten times the rate of acute mental health wards, and three times the rate of Psychiatric Intensive Care Units (PICU) (James et al, 2012). Whilst the forensic mental health pathway is discussed in depth later in this chapter, (see section 1.6), to summarise, forensic mental health services provide care to those who have a history of contact with the criminal justice system, or individuals whose behaviour cannot be adequately managed within alternative mental health services (Vollm et al, 2017).

The risk of self-harm amongst forensic mental health patients is far greater than in those within the general population (Oddie, 2015). Compared to the general population, recent evidence estimates there is a four-fold increase in the prevalence of self-harm across the

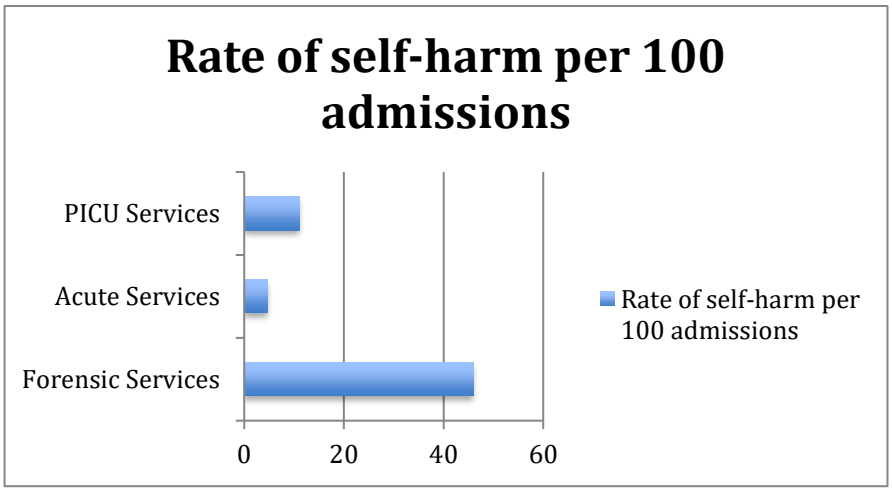
forensic population (Hargate et al, 2017). Despite the differences in incident prevalence, like within the general population, self-harm amongst women in forensic mental health services is more common than in males (Bartlett et al, 2014). In fact, it is estimated that one in 20 women receiving care within the forensic pathway are detained because of their self-harm behaviour alone (Bartlett et al, 2014). Whilst self-harm amongst detained populations is known to feature heavily during the adolescent years, a recent study indicated the behaviour tends to peak around the age of 17, which is somewhat older than the trends shown amongst the general population (Casiano et al, 2016). Most notably, Casiano et al, (2016) found that girls aged between 12 and 15 accounted for the lowest rates of self-harm within a detained population, which is distinctly different to the general population. Sadly, self-harm amongst women forensic mental health patients appears in many cases to be life-long, and unlike the trajectory within community samples, self-harm does not always desist with age (Haagsma et al, 2016).

Despite literature that references the extent and impact of self-harm within the forensic mental health population, in comparison to general or other inpatient populations, the volume of research on forensic mental health populations is scant. Instead, typically research explores self-harm amongst inpatient populations and include a small sample of forensic patients (James, Stewart & Bowers, 2012a). Arguably, therefore our understanding of self-harm amongst the forensic mental health population is limited. The dearth of research is likely to be in part due to forensic mental health population being a particularly hard population to access, on account of the increased security measures afforded to this population (Livingston et al, 2018).

It is however important to address the lack of research, as there are unique issues associated with forensic mental health services that may distort our understanding. Firstly, clarification is needed surrounding the definitions used when quantifying the prevalence of self-harm incidents. Unlike the general population where incidents of self-harm are recorded when individuals present to medical professionals (Haw et al, 2005), within forensic mental health services, self-harm is reported as it occurs, regardless of medical severity. Consequentially, it is likely that a much broader range of behaviours are recorded as self-harm within forensic mental health services than would be within general population settings (Slade, 2011). This highlights a definitional issue between populations, which is explored in depth in Chapter 2, and may in part explain why the rates of self-harm are so much higher in forensic mental health patients compared to both their inpatient and general population counterparts.

Comparably, whilst definitional issues may inflate the prevalence of self-harm amongst forensic mental health services, it is worth considering how incidents of self-harm may also be under reported. As many forensic mental health services are operated by private organisations, they are not required to publically publish statistics relating to self-harm, as is expected of public healthcare organisations (GP's, hospitals, community mental health teams and prisons). This means that unlike other publically funded healthcare services (whose statistics are published through the Office of National Statistics or made available though publically accessible bulletins), there is a distinct lack of statistics evidencing the prevalence rates of self-harm within forensic mental health services. According to the National Confidential Inquiry (2016), this can result in substantial delays in the formal recording of incidents and collation of statistics, meaning published information if often out of date. Working with data that is not up to date, arguably creates difficulties in fully understanding self-harm within forensic settings and does not provide a complete picture of the prevalence rates. As a result, this may hinder the ability to appropriately identify those at risk or understand how best to implement prevention strategies, as is intended for routinely collected statistics (WHO, 2014).

Figure 2: Self-harm rates per 100 admissions for inpatient services (James et al, 2012)



1.2.1 Risk Factors for Self-Harm

Whilst the reasons for self-harm are known to be highly individualised (NICE, 2013), there are generally accepted risk factors thought to increase the likelihood of the behaviour occurring. It is important to note that risk factors are unable to identify for certain who will enact self-harm; however, they are useful in highlighting populations or individuals who are more vulnerable to the behaviour (WHO, 2014). This is helpful in terms of targeting policies and

treatment towards those most likely to need assistance. Whilst the volume of literature is disproportionate between populations, research has identified shared risk factors between the general, psychiatric, forensic mental health and prison populations, which are thought to increase the risk of enacting self-harm. Notably, it is generally accepted that younger women who have experienced childhood trauma, and who have a history of self-harm are at greatest risk of engaging in self-harm behaviours (Isohookana et al, 2013; Rogers et al, 2011; Fleige et al, 2009; Lohner & Konrad, 2007). Critical life events within the last year, lack of social support, concerns about health/somatic problems, low self-esteem and aggressiveness and hostility have also been identified as predicted of self-harm across the general, psychiatric, forensic, and prison population (Oakes-Rogers & Slade, 2015; Isohookana et al, 2013; Fleige et al, 2009).

Unsurprisingly, mental illness has consistently been identified across populations as a risk factor for self-harm (O'Connor et al, 2008; Haw et al, 2005; Hawton et al, 2002). In particular, major depression and other mood disorders are thought to be the most common psychiatric diagnosis amongst members of the general population who self-harm (Hetrick et al, 2018; Knorr et al, 2016). These findings mirror those for forensic mental health patients, whereby those with a diagnosis of affective disorder (depression, anxiety and bipolar) are considered most likely to self-harm (Isohookana et al, 2012; Mannion, 2009). This is also true for a diagnosis of Borderline Personality Disorder, which again has been consistently linked to increased risk of self-harm amongst the general, prison and forensic mental health populations (Mannion, 2009; Jacobson et al, 2008). There are however some differences between the general and forensic populations, whereby research has shown a diagnosis of Schizoaffective disorder (Beer et al, 2009), particularly those who experience command hallucinations with self-harm content is predictive of self-harm in women receiving forensic mental health care (Rogers et al, 2011). Considering the link between mental illness and self-harm, it stands to reason that women in forensic mental health services would be at greater risk on account of their detention into secure services because of their mental illness.

The extent to which risk factors enhance risk amongst each population also appears to differ for those who have experienced recent adverse live events and/or childhood trauma. Whilst it is well evidenced that childhood trauma and adverse life events increase risk of self-harm in the general population (Fleige et al, 2009), the impact of sexual and/ or physical abuse (Isohookana et al, 2012; Beer et al, 2009; White, Leggett & Beech, 1999) and family discord (Isohookana et al, 2012) on women receiving care in forensic mental health services is particularly high. This is more the case for women who have experienced multiple adverse life events during childhood, or who have been subjected to prolonged neglect or abuse

(Isohookana et al, 2012). Sadly, multiple childhood traumas are extremely common amongst the forensic mental health population (Beryl et al, 2018), which may explain why previous literature has identified it as a strong predictor for self-harm. Beryl et al (2018) also noted that may women in forensic mental health services have had chaotic upbringings characterised by neglect, trauma and emotionally unavailable care-givers, which may lead to difficulties with emotional expressivity and hinder the development of adaptive coping skills. This may also go some way to explain why the risk of self-harm is more pronounced for women in forensic mental health services compared to the general population, as those with acute trauma histories are less likely to have developed affective coping and self-soothing strategies to help manage interpersonal difficulties.

Whilst the body of literature pertaining to forensic mental health specific populations is limited, there is evidence to suggest additional differences between the populations, and literature has identified risk factors thought to uniquely enhance risk of self-harm amongst forensic mental health patients (Isohookana et al, 2013; Rogers et al, 2011; Mannion, 2009; Young et al, 2006; White, Leggett & Beech, 1999; Hillbrand, Young & Krystal, 1996). These include being convicted of a non-sexual violent offence, a strong sense of guilt and/or anger, anxiety concerning legal matters, aggressive behaviour towards staff and peers, concerns relating to therapy and longer length of admission to a forensic mental health hospital. Arguably such risk factors will always be unique to populations with offending histories, or who find themselves detained within an establishment, as similar risk factors have also been cited for the individuals within the prison population, which are not applicable to the general population. These include environmental features such as being housed in a single cell or within an isolative setting (segregation) and being exposed to others self-harm, and factors related to offending behaviour such as being on a life sentence, being in the early stages of custody and having an increased number of disciplinary infractions in custody (Lohner & Konrad, 2007; Meltzer et al, 2003). Such evidence is however limited, meaning our understanding of forensic mental health population specific risk factor is limited, highlighting an interesting and important area for future research to explore.

Further research into the risk factors for self-harm amongst the forensic mental health population is required as currently, much of our understanding is derived from studies using non-clinical samples that seek medical treatment in general hospitals, (Haw et al, 2005; 2015), college students and adolescents (Nock et al, 2009). This is interesting as despite consensus that self-harm is more prevalent amongst the forensic mental health population than in any other population, to the author's knowledge, there is yet to be a study to explore the risk

factors specifically associated with self-harm amongst women receiving forensic mental health care. Instead, studies have explored risk factors using 'offending populations', meaning findings of studies using psychiatric inpatients, forensic mental health patients and prisoners are conflated without specifying differences between types of service (Dixon-Gordon et al, 2012). This makes it difficult to determine which risk factors belong specifically to the forensic mental health population.

1.3 Suicide

Suicide is a major international health issue and is the one of the leading causes of death in the world (WHO, 2016). In 2013, the suicide rate in the United Kingdom rose to 6242. This was the highest rate recorded since the late 1990's (Office of National Statistics, 2016). The rate of suicide amongst the general population has since reduced to 5821 (ONS, 2018), however the age-standardised rate for suicides within the UK remains shockingly high. According to the ONS, (2018) the suicide rate stands at 10.4 deaths per 100,000 people: 15.5 per 100,000 for males and 4.9 per 100,000 for females. It is estimated that a fifth of all adults (20.6%) report to have thought about taking their own life (McManus et al, 2014), and one in fifteen have made a suicide attempt (APMS, 2014).

Internationally, males have long been identified at greater risk of suicide compared to females and each year they continue to account for more suicides than women (ONS, 2017; Narishige et al, 2014). In fact, males accounted for three-quarters of all suicides registered in 2017 (ONS, 2018). It is however important to note that *thinking* about suicide and *attempting* suicide is more common amongst women than it is in males (APMS, 2014; Tsirigotis et al, 2011; Nock et al, 2008; Kessler et al, 1999). Since 2013, suicide has been most common in males aged between 45 and 59 (ONS, 2018). This marks a notably shift in the age most at risk of suicide, as previously, males aged between 25 and 34 years have been known to have the highest suicide rates internationally (ONS, 2018). Interestingly, this currently makes the highest age-specific suicide rate (45-59) the same age category for males and females (ONS, 2018). In line with previous years, the rate of suicide amongst women is declining, however, sadly the number of registered suicides has increased amongst girls and young women aged 10 to 29 years (ONS, 2018). Considering the rates of suicide in the UK, it is clear to see why suicide prevention has been at the forefront of many government initiatives and healthcare policies such as Preventing Suicide in England (Department of Health, 2012).

In 2017, hanging, suffocation or strangulation was the most common method of suicide for both males and females in the UK (ONS, 2018). This mirrors the same pattern for males, whereby hanging has always been the most common form of suicide. This is however not the case for females and hanging being the most common form of suicide represents a marked change in suicide method, as until recently, women most commonly enlisted poisoning as a method of suicide (ONS, 2018). This change has largely been attributed to means restrictions (hindering access to certain methods of suicide), which will be discussed at lengths in Chapter 2, (Section 2.7.2). The change in methods for women marks in interesting turning point within suicide literature that urgently needs investigating. This is because the disparity between male and females in relation to the number of deaths by suicide has long been attributed to the notion that males use more lethal methods than their female counterparts (Stack & Bowman, 2017). Kim et al, (2019) and Mohammed, (2017) suggest the move towards hanging/ strangulation may in part be attributed to the notion that hanging is a clean and fast way of dying, despite the reality being somewhat different.

Table 1: Methods of suicide amongst males and females in the general population (ONS, 2018)

Method	Males	Females
Hanging, suffocation or strangulation	59.7%	42.1%
Poisoning	18.2%	38.3%
Drowning	4.0%	5.2%
Fall and Fracture	3.7%	3.1%
Other	14.2%	11.0%

It is well known that people in contact with the mental healthcare systems are at increased risk of dying by suicide. Between 2003 and 2013, 13,972 people with mental health problems died by suicide (University of Manchester Annual Report, 2015). This accounts for over 28% of all suicides within the same time period across the United Kingdom (ONS, 2017). The risk of suicide heightens for those with severe mental illness, who have an estimated 20 to 50 fold higher suicidal mortality rate than people within the general population (Hallgreen et al, 2018). Like members of the general population, the most common method of suicide amongst community mental health patients was hanging (NCSHI, 2015). Suicide amongst mental health patients is not however exclusive to those who manage their mental health conditions within the community and suicides within inpatient services are also frequent, particularly so

amongst males (Kapur et al, 2013; Bowers et al, 2011; Qin & Nordentoft, 2005). Between 2003 and 2013, there were 1295 inpatient suicides, equating to 9% of all suicides amongst mental health patients (NCSHI, 2015). Furthermore, out of the 1295 inpatient suicides, 351 or 27% involved people who were detained under the mental health act (NCSHI, 2015).

It is important to note that whilst inpatient suicide remains high, over the last decade the number of suicides has decreased substantially (The NHS Information Centre, 2016; Kapur et al 2012). The estimated decline is over 60% between 2003 and 2014 (NCISH, 2016), and has been largely attributed to a major policy change introduced by the Department of Health, which saw the removal of all ligature points, and the introduction of collapsible curtains and shower rails (Department of Health, 2003). Sadly, despite these changes, it is still estimated that between 20 and 30 deaths occur by hanging each year within inpatient services (NCISH, 2016). Whilst these figures suggest improvements in ward safety may be responsible for the decline in inpatient suicides, it is important to note that in general, the number of inpatient beds and admissions have also significantly reduced, (40% and 20% respectively, HSCIC, 2012). It is therefore possible that the decline in inpatient suicides may also be a result of limited bed space, meaning fewer people are cared for within inpatient settings. It is also of interest to note that whilst inpatient suicides continue to fall, suicides in patients recently discharged from inpatient services increased by 34% between 2004 and 2014 (NCISH, 2016). This may suggest that the rate of suicide amongst people who typically would be cared for within inpatient environments has not actually fallen but is instead occurring in different parts of the mental health pathway.

1.3.1 Risk Factors for Suicide

Understanding the risk factors associated with suicide is a challenging, but important task to undertake. The reasons for this challenge are partly due to the impossible task of asking people who die by suicide what led them to take their own life (Cavanagh et al, 2003). As a result, many studies exploring the risk factors associated with suicide either adopt a psychological autopsy approach (whereby researchers consult sources close to the deceased), or they attempt to learn lessons from the survivors of suicide attempts. Despite such difficulties, it is generally accepted that for the general and forensic mental health populations there is a set of accepted risk factors, which for some, increase the likelihood of suicide occurring. According to The World Health Organisation's Mental Health Surveys and drawing from literature (Chan et al, 2018; Maple et al, 2017; Jacobson et al, 2008; Cavanagh et al, 2003; Suokas et al, 2001; Perez-Carceles, 2001), these include; being young, male gender, having a

mental health diagnosis, lower education and income, unmarried status, unemployment, parental psychopathology, physical health problems, anxiety or mood disorders, familial suicide, alcohol and/or substance dependence, poor problem-solving skills, worry and agitation, hopelessness, greater insight into a mental health disorder, medication non-compliance, loss of social support, panic attacks and extreme anhodonia (no longer experiencing pleasure).

There is however scant literature exploring the risk factors for suicide in forensic mental health patients. To the author's knowledge, there have only been two studies exploring the risk factors for suicide specifically in a forensic mental health setting (Sarkar, 2018; Gordon, 2002). Consequentially, the majority of research has been conducted on psychiatric inpatients, which considered those detained under the mental health act within mental health facilitates (including forensic patients) as a whole population, meaning they fail to provide findings specific to sub-types of inpatients (e.g. PICU, forensic or acute patients). Additionally, research often focuses on specific time points of psychiatric admission (the first week (Bowers et al, 2011; Qin & Nordentoft, 2005), or at discharge (De Leo, 2010; Hunt et al, 2007; Meehan et al, 2006), meaning our understanding of risk factors for suicide is skewed to particular time points.

Consequentially, due to the similarities between the prison, forensic and general psychiatric inpatient populations (both in terms of offending histories and the secure nature of the environments in which they live), often literature pertaining to prisoners and general psychiatric populations is used to inform our understanding of the forensic mental health population. Whilst such an approach appears logically, the lack of literature is concerning as not understanding the specific risk factors associated with suicide amongst forensic mental health service users may hinder appropriate treatment and prevention (Gordon, 2002).

Despite the lack of literature, combining the work from Sakar (2018) and Gordon (2002) with that from the general and prison populations, the following risk factors are thought to play the most significant role in the development of suicidal ideation and suicidal behaviour across the general, prison and forensic mental health population.

History of Self-Harm

A history of self-harm is thought to be the strongest, most valid risk factor for suicide across the general population, (Bergen et al, 2012) the prison population amongst forensic mental health inpatients (Hunt et al, 2013; Large et al, 2010; Andover & Gibb, 2010; Bowers et al, Powell et al 2000) and the forensic mental health population (Sakar, 2018; Gordon, 2002). It is

known approximately 50% of adults (NICE, 2013; Cooper et al, 2005; Hawton et al, 2003) and around two-thirds of adolescents and young adults who die by suicide have a history of self-harm (Appleby et al, 1999). In particular women who enact self-harm on five or more occasions within a 12-month period, are thought to be at greatest risk of dying by suicide (Hawton et al, 2014). Similar findings have also been demonstrated amongst the prison population, where those who die by suicide are more than nine times more likely to have been identified and managed for self-harm prior to their death (Humber et al, 2013).

Mental Health Diagnosis

Having a mental health disorder is considered one of the most robust risk factors for suicide (Batterman et al, 2018; Chesney, Goodwin & Fazel, 2014; Harris & Barraclough, 1997). It is estimated that between 80-87% of all individuals who die by suicide have a mental health disorder (Fleischmann et al, 2005; Arsenault-Lapierre et al, 2004), and around 50% of those who die by suicide have had contact with mental health services within the 12 months prior to their death (NCSHI, 2014; Hunt et al, 2009). Amongst the general population, the risk of suicide is thought to be particularly high amongst those with major depression, (Janiri et al, 2018; Hallgreen et al, 2018; Ferrari et al, 2014) and those with bipolar disorder and schizophrenia (Hallgreen et al, 2018). Although all individuals receiving care in an inpatient or forensic service will have a mental health disorder, literature has shown that a diagnosis of schizophrenia, affective disorder or major depressive illness has the strongest relationships with suicide (Large et al, 2010; Hunt et al, 2007; Kapur et al, 2006; Gournay & Bowers, 2001; Powell et al, 2000). Such a relationship is thought to be even stronger when there is a dual-diagnosis of severe mental illness and substance misuse (Gournay et al, 2001). Whilst the evidence base for the relationship between mental health and suicide is considerable, it is important to highlight that very few people who meet the aforementioned conditions will ever think about suicide and even fewer go on to attempt or die by suicide (Joiner, 2005).

Experiencing adverse life events

Literature has shown recent negative life events are a risk factor for suicide amongst the general population (Jaiswal et al, 2016; Pompeli et al, 2011; Heikkinen & Lonnqvist, 1994). The relationship between negative life events and suicide has been demonstrated in both adult (Yanzheng & Zhang, 2018; Foster et al, 2011) and adolescent samples (Olliac et al, 2018; Lee et al, 2018). For adults, adverse events include difficulties in, or breakdown of

marriage/relationship, family discord, and friendship breakdowns (Liu & Zhang, 2018; Heikkinen & Lonnqvist, 1994). In adolescents, a recent study found specific life events that increase the risk of suicide include events related to family (parental/divorce or separation), disruption or breakdown of significant relationship (death of a close friend or a romantic break-up), and legal or disciplinary problems (Olliac et al, 2018). Most notably, amongst the general population, childhood emotional abuse (Janiri et al, 2018; Sachs-Erricsson et al, 2016), childhood sexual abuse (Davies et al, 2014; Norman et al, 2012; Rhodes et al, 2011), childhood physical abuse and neglect (Norman et al, 2012) have all been shown to significantly predict suicide.

As was shown amongst the general population, experiencing adverse life events has been shown to be a consistent risk factor for suicide amongst psychiatric inpatients (Hunt et al, 2013). Events that occur during childhood appear to have a particular impact on risk for suicide, including emotional, sexual and physical abuse, divorce, and parental alcohol or drug abuse (Schilling, Aseltine & Gore, 2007; Dube, Anda & Felitti, 2001; Chapman et al, 2005). Experiencing childhood sexual abuse has a 2.3-fold increase in risk for suicide amongst girls and adult women (Isohookana et al, 2013). As was shown for self-harm, literature also evidences a cumulative effect of experiencing multiple adverse life events for female forensic mental health patients, with those experiencing three or more adverse life events during childhood being at an eight-fold increased risk of suicide during late childhood and three-fold increased risk in adulthood (Dube et al, 2001). Furthermore, Andreasson et al (2014) evidenced that those with multiple adverse life events are likely to have significantly longer psychiatric admissions compared to those with singular or no adverse life events. This is interesting as longer admissions also increase suicide risk (De Leo et al, 2011). The same pattern has been noted amongst the prison population, and experiencing adverse events including physical, sexual and psychological trauma has been linked to an increased number of suicide attempts (Oakes-Rogers & Slade, 2015; Friestad et al, 2014; Clements-Nolle et al, 2009; Miligan & Andrews, 2005). As was previously discussed in section 1.2.1, this is concerning as the prevalence of childhood trauma and adverse life events is notably higher amongst the forensic mental health population compared to the general population (Beryl et al, 2012), suggesting they are more vulnerable to suicide.

The increased vulnerability of forensic mental health patients compared to the general population was identified by Powell et al (2002), who argued that the risk factors for psychiatric inpatients are not entirely the same as members of the general population. In particular they report differences in psychological and social risk factors, which are enhanced

by additional treatment and environmental risk factors. Such factors include co-morbid mental and physical health problems, being transferred to secure services because of a suicide attempt, long-term admission, poor medication compliance, a history of multiple psychiatric admissions, poor or disruptive ward atmosphere and frequent changes to an individual's treatment plan.

1.4 Protective Factors

Whilst much of the self-harm and suicide literature focuses on psychological and social factors known to increase risk, comparably few studies explore factors that can be protective against such behaviours (Larkin et al, 2014). When faced with stress or adversity, protective factors are said to 'diminish the risk of developing a disease' (Antonovsky, 1987). Protective factors can take the form of personal resilience and resources (i.e. – coping strategies) or social resources (support family and friends) (Bendersky & Lewis, 1994). It has been suggested protective factors either compensates for the negative effects of risk factors (Bendersky & Lewis, 1994), or moderates the association between risk factors and outcome (Rutter, 1990; Garmezy, Masgten & Tellegen, 1984).

Although limited in quantity and lacking in population specificity, current literature has shown non-white ethnicity; higher levels of education and being employed are protective against repetition of self-harm (Larkin et al, 2014). Additionally, amongst adolescents, the ability to understand and manage emotions (Cha & Nock, 2009), problems solving confidence and locus of control (Donald et al, 2009) are also considered protective factors. By far however the most commonly reported protective factor against both self-harming and suicidal behaviour is social connectedness and social support (Larkin et al, 2014; Donald et al, 2009; Eisenberg, Ackard & Resnick, 2007).

The importance of protective factors is now far more recognised than before, and identifying protective factors plays a key role within the Recovery Model of community mental health care – a model that emphasises a person's ability to recover from mental illness (NICE, 2018; Jacob, 2015). Despite a new approach to managing risk, as few studies explore specifically protective factors, according to Fleige et al (2009), the evidence is far from complete. This is concerning as protective factors can be moderated and enhanced by interventions, meaning they can in part reduce the risk of self-harm and suicidal behaviours (Fleige et al, 2009). Therefore, there have been calls for future research to specifically look at identifying protective or resilience factors and incorporating them into assessments (Abidin et al, 2013).

1.5 Conclusion

Across the United Kingdom, statistics relating to self-harm and suicide are routinely collected and held on public databases. Not only do these statistics serve to provide information regarding the occurrence of self-harm, suicide attempts, and completed suicides, they also help to profile people who may be at increased risk of suicide (WHO, 2014). There are however many limitations to the current literature pertaining to prevalence rates and risk factors. Firstly, it is known that many incidents of self-harm within the general population go unrecorded. This is largely because people do not always seek medical treatment for self-harm injuries, meaning the available statistics may vastly underestimate the true prevalence of self-harm within community settings. This is however in stark contrast to those in forensic services, where a far broader spectrum of behaviours is recorded as self-harm compared to the general population (Slade, 2011). This coupled with the fact that individuals often must directly alert staff of their behaviour due to the limited availability of resources to manage their own self-harm injuries, may mean the prevalence of self-harm amongst forensic mental health populations is overinflated.

In addition to issues surrounding the potential under or over reporting of incidents, the way in which the behaviours are defined and therefore documented also becomes problematic when learning from such data. In many cases, the definitions used to define self-harm and suicidal behaviour differ amongst clinicians and academics. Therefore, what one person interprets as an act of self-harm, could well differ to another who could instead view the same incident as a suicide attempt. Contributing to this issue is the inconsistency of definitions used across both healthcare and academic research (for a full discussion see Chapter 2). In short however, the language used to describe self-harm and suicide is inconsistent meaning interchangeable, varied terms are often used to describe the same behaviour (Andover et al, 2012). This is problematic in terms of recording the prevalence of self-harm and suicidal behaviour and may alter the true prevalence of either behaviour.

Currently the literature relating to risk factors for self-harm and suicide is limited in that it is not yet known how accurately such risk factors identify those at risk (Slade, 2011). Although literature has confirmed relationships between these behaviours and a range of psychological, social and environmental factors, few have been directly tested for their ability to accurately predict self-harm and/or suicide amongst the populations discussed above. This is partly because the risk factors addressed in the previous sections apply to such a large proportion of people within the same population e.g. forensic and inpatient settings, that their utility

becomes limited (Slade, 2011). For example, it is well known that many women receiving forensic mental health care have experienced unstable childhoods and family discord, have committed violent offences, have complex mental health needs, have an extensive history of self-harm and have been admitted to psychiatric hospitals on multiple occasions (Beryl et al, 2018; Bland et al, 1999). Furthermore, it is well known that the levels of trauma (sexual, physical, psychological and neglect) amongst women in forensic services is staggering (Beryl et al, 2018). Yet despite the high prevalence of these known risk factors, not all individuals engage in self-harm and suicidal behaviours. Therefore, consequentially, some of those identified as 'at risk' are not.

The limitations of the current literature therefore impact upon our ability to assess, and correctly identify individuals who are at risk of self-harm, and/ or dying by suicide. As discussed by Fleige et al (2009), this is because there has only been one study that tests the interaction effect amongst known risk factors prior to self-harm. This means whilst individual risk factors may significantly predict self-harm, we are yet to fully understand which combination of risk factors increase the likelihood of the behaviour occurring. Achieving this may offer a way to solve the ongoing problem of poor identification of those at risk, and over identification of those who seemingly fit the 'at risk profile', but who never go on to enact self-harm or suicidal behaviour. Rudd (2003), Fawcett (2001) and Berman & Jobes (1991) suggest the answer lies within new assessment instruments that focus on the proximal risk factors (changing, dynamic risks) as apposed those that are more chronic and unchangeable (historical abuse or multiple psychiatric admissions).

With specific reference to the forensic mental health population, the clearest limitation is the lack of research. Whilst there is an abundance of literature pertaining to the general, prison and other psychiatric populations, our understanding of the risk factors associated with self-harm and suicide in the forensic mental health population is notably lacking. Instead, the focus of forensic mental health research is often the prevalence, reasons and risk factors for violent and aggressive behaviour towards others, not the self (Wilson et al, 2013; Dickens et al, 2013; Nicholls et al, 2009; Stalenheim, 2001). Consequentially, our understanding of what we think we know about self-harm and suicide is generalised from prison and alternative inpatient literature to the forensic mental health population without identifying whether it is useful, or indeed valid. The lack of research, and therefore lack of understanding amongst this population may in part explain why the rates of self-harm and suicidal behaviours are so staggeringly high amongst the forensic population compared to all other psychiatric inpatients and the general population (James et al, 2012). In other words, we cannot treat or prevent

behaviour we only partially understand. There is therefore a clear need for additional investigation within this area – a contribution which can only aid to support and refine current self-harm and suicide prevention strategies and help to develop more refined and targeted treatment plans.

The present study therefore aims to address the clear current gap in knowledge by exploring the differences between self-harm and suicidal behaviours within the forensic mental health population. Considering previous literature and recommendations, less emphasis will be placed upon understanding static, unchangeable risk factors relating to self-harm and suicidal behaviours. Instead, the first-hand, lived testimony of women and staff who live and work within forensic mental health services will be used to develop a more nuanced account of the dynamic, changeable nature of self-harm and suicidal behaviour. In particular, the present study will focus on better understanding the function of and pathways to self-harm that is serious enough to bring about death, and to clarify its relationship with suicide. It is hoped that in doing so, the present study will help to improve understanding regarding what contributes to serious self-harm behaviours and assist with the identification of those who are at risk.

1.6 Secure Forensic Hospitals: An Overview of Services in the UK

1.6.1 Introduction

Forensic hospitals within England and Wales offer a secure mental health provision, primarily for patients who have committed serious offences (Vollm et al, 2017). Whilst the majority will have extensive or serious offending histories, a small number will have had no contact with the criminal justice system. In this instance, it is likely detention within forensic care occurred as standard inpatient facilities unable to manage their mental health conditions or behaviours safely (NHS England, 2014). Forensic services are designed to provide mental health provisions for people with mental health disorder, personality disorder, neuro-developmental disorder, or organic brain injury (NHS England, 2014). Typically, patients receiving care in forensic services present with co-morbid difficulties of substance misuse, and or personality disorder, and have a history of offending or irresponsible behaviour (Vollm et al, 2017). There is a twofold purpose of providing forensic care – firstly to facilitate treatment and recovery, and secondly, to reduce the risk that an individual pose to themselves and the public (Vollm et al, 2017).

England and Wales offer secure forensic care within three types of inpatient facilities (excluding those cared for by community forensic mental health teams). These hospitals offer a high, medium or low security environment. Each service offers a range of physical, procedural, and relational security measures (i.e. – physical boundaries, prohibition of risk items within the service grounds, and staff training to ensure effective understanding of different types of mental illness and offending behaviour). The differing levels of secure hospitals offer a 'step-down' service, which allows patients to safely transfer to lower secure services, return to the community or prison, and/or transfer out of secure services, (NHS Standard Contract, C03/S/A, 2014). To achieve this, along with providing a safe and secure environment, care providers have a duty to offer a range of therapeutic and offending behaviour-based treatment programmes, delivered by appropriate experienced mental health practitioners (Royal Collage of Psychiatrists 2016). Within England and Wales, these services are known as the 'Forensic Pathway', and are commissioned by NHS England, governed by the Mental Health National Programme of Care, and are run by either the NHS itself, or independent organisations.

Usually, service users of forensic hospitals are detained under the Mental Health Act (1983, amended in 2007). This means a patient is "suffering from a mental disorder… of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available" (Great Britain Mental Health Act, 1983, as amended in 2007). In few instances, admissions to secure forensic hospital may be on an informal basis, meaning the individual in question is not detained under the mental health act. Referral to secure forensic services are made through several routes including; court referral, referral from prison, referral from another secure forensic service, or referral from generic mental health inpatient services (Vollm et al, 2017; NHS Standard Contract, C03/S/A, 2014). When determining what level of care is most suitable (high, medium or low secure), the following criteria is considered (NHS CO3/S/A standard contract, 2014)

- The nature, and degree of mental disorder, and its relationship to risk
- Risk posed to others
- Level of care and supervision required
- Need for input from specialist services or staff
- Need for offence/risk behaviour related therapy
- Level of compliance with treatment/care plan
- Engagement in structured and meaningful activities

- History of drug and alcohol misuse

1.6.2 Low and Medium secure services

Individuals admitted to either low or medium secure services are usually detained under the Mental Health Act (1987 amended in 2007). Patients are assessed for Medium and Low Security care using the NHS criteria detailed above; however, patients also need to fulfil the following as outlined in the NHS Standard Contract, C03/S/A, (2014)

- There is a need for a hospital admission
- There is a need for additional psychiatric, and or risk assessments
- They present a risk to others
- They present a risk of escape or absconding, however in the event of an escape, the individual must not pose immediate or significant risk of harm to others
- They have progressed, or show evidence of being able to integrate back into the community (evidenced through successful use of escorted or unescorted leave)
- They do not require a category B or above perimeter.

1.6.3 High Security Services

All individuals admitted to High Secure Services will be detained under the Mental Health Act (1983 amended in 2007), and fulfil the criteria as defined by the NHS Act (2006) as people who "require treatment under conditions of high security on account of their dangerous, violent or criminal propensities" (NHS Standard Contract, C03/S/A, 2014). All High Security Services are provided in hospital settings and have the same physical arrangements as category B prisons. Within England and Wales, there are three High Security Hospitals, one of which provides the national women's service. Each High Security Service is commissioned and provided by NHS England. To assess patients for High Security care, the NHS criteria detailed above is used; however, patients also need to fulfil the following, according to the NHS Standard Contract, C03/S/A (2014)

- There is a need for category B or above perimeter
- They present a grave danger to the public
- They present a severe risk of escape or absconding from a lower degree of security
- They require enhanced levels of physical, relational, and procedural security provided in a high secure environment.

Unlike with a prison sentence, detention within the forensic pathway is not time limited, and discharge or transfer is dependent on making significant progress and demonstrating a reduction in risk to the public and themselves (Vollm et al, 2017). The decision to discharge or transfer a patient is not the responsibility of the courts and is instead made by members of the patient's multidisciplinary staffing team, hospital managers, mental health tribunals and the Ministry of Justice (MOJ, 2017).

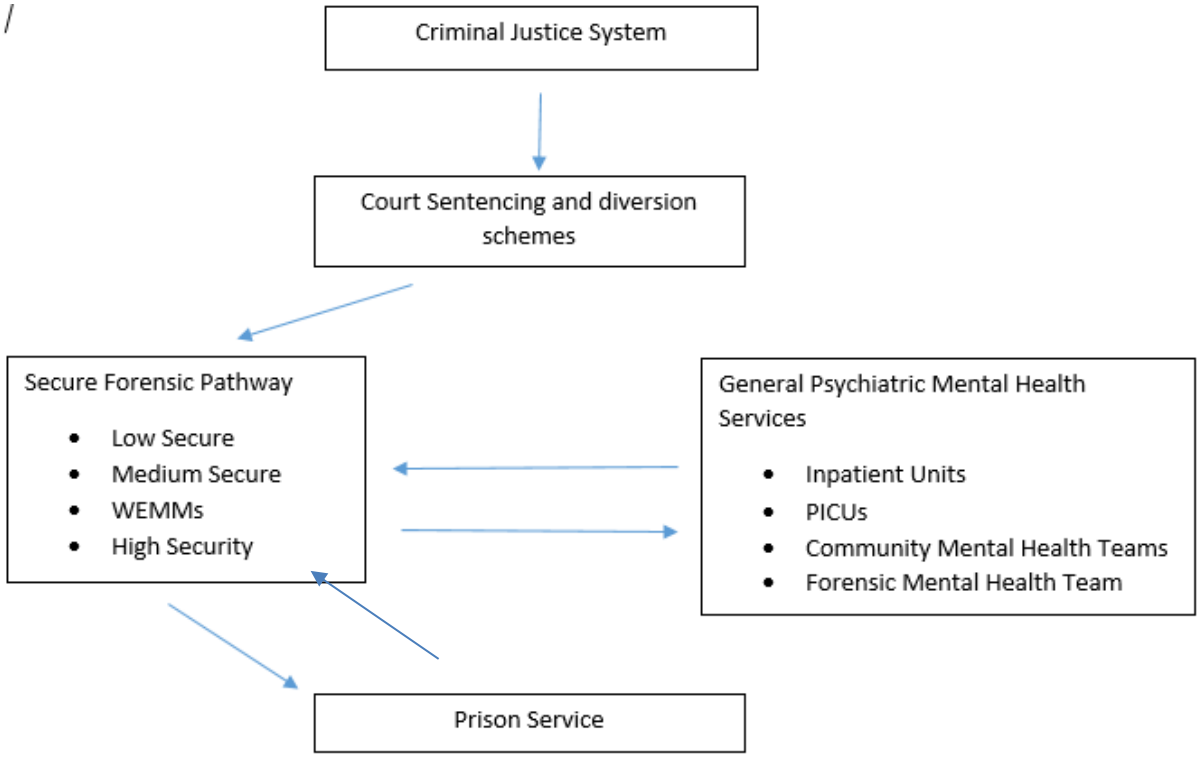
1.6.4 Services available to women

Within England and Wales, there are approximately 1625 forensic beds for women - 990 are low secure, 589 medium, 46 enhanced medium, and 47 are high secure beds (Bartlett et al, 2014; Harty et al, 2012). In light of the Corston Report (2007), all secure services are provided on a female-only basis and aim to integrate gender specific needs into their care provision. The Corston Report (2007) suggested that women, more often than their male counterparts, experience several vulnerabilities, which can contribute to their offending behaviour and make them more likely to experience mental health crises. Unlike with men, on whom the prison service and forensic care provisions were designed to meet their offending needs, Corston (2007) suggested that the same provisions for women were inadequate and did not meet the therapeutic needs of women in contact with the criminal justice system.

Currently, there are three high secure hospitals, only one of which provides women's services. Rampton High Security Hospital offers the National High Secure Healthcare Service for women, which offers a 47-bed service, divided into 5 wards. For those who require the care of medium secure services, there are currently two types of hospital available to women: medium secure and women's enhanced medium secure (WEMMS). Standard medium secure services offer the same security levels offered to their male equivalents, and admissions normally take place via transfer from prison, or from low secure services (Barltett et al, 2014). WEMMS services were first commissioned and piloted in 2007 and offer speciality units designed for women 'who require enhanced levels of treatment within a medium secure service, but for whom current medium secure services are not appropriate' (NHS England, 2007). WEMMS services are usually separate wards found within standard medium secure hospitals that admit patients from either high or low secure hospitals, or from Psychiatric Intensive Care Units. The third level of the forensic pathway consists of low secure services. Within low secure services, there will be women detained under the Mental Health Act (1983, amended in 2007), and women detained informally, or under civil sections of the MHA. Women in low secure services will often be admitted via referral from general psychiatric beds, and many require secure services

because of the risk they pose to themselves, rather than members of the public, (Bartlett, 2014). As with many service provisions, there are far fewer forensic beds available to women within England and Wales compared to their male counterparts (NHS England, 2014).

Figure 3: Secure Forensic Pathway – admission, diversion and discharge (adapted from Natarajan et al, 2012).



1.7 Legal responsibilities of Mental Health Providers

A major priority of psychiatric inpatient care services is to provide and maintain a safe and secure environment and to protect individuals from engaging in behaviours that pose a risk to life (Bowers et al, 2006). Several laws exist to help fulfil these aims, including protecting patient wellbeing and keeping people safe from harm, abuse and injury. This is known as The Duty of Care and is applicable to all staff that work within healthcare settings or have a job that brings them into contact with any person receiving any form of physical or mental health care (NHS England, 2016). Duty of Care is underpinned by Article 2 of The European Convention on Human Rights (1998), which protects everyone's life to right. This means that all healthcare services have a duty to ensure that they take general measures to protect the lives of all physical and mental health patients (Lord Rodger, 2008).

Maintaining the safety and wellbeing of those who self-harm can however be difficult, as it presents unique challenges when trying to uphold the duty to protect lives. Whilst this may be true, there is increased pressure on service providers who care for mental health patients (both detained and informal), to take steps to prevent self-harm (Lord Rodger, 2008). Unlike with community mental health providers or physical healthcare hospitals, an additional 'operational obligation' is expected of inpatient mental health services. Operational Obligation states inpatient mental health services take additional steps to prevent people from killing themselves, in instances where there is a 'real and immediate' risk to life (Lord Rodger, 2008). According to the European Courts (2012), the NHS and independent mental health providers have a duty of the state 'to protect individuals who are in a vulnerable position and for whom they are responsible, in particular prisoners and conscripts.

In order to achieve this, services that provide inpatient care adopt containment measures, whereby they enlist additional procedures to help prevent individuals from harming themselves, and/or attempting to end their lives. Such procedures include; enhanced or constant observations of patients demonstrating elevated risk of self-harm and/or suicide, nursing within segregation or seclusion, and the removal of items that a patient has previously, or may in future, use to harm themselves (see Chapter 2, section 2.7.2, restricting access to means). Such procedures are introduced after a thorough assessment of the patient's risks and are tailored to the patient on an individual care planning approach (NHS Standard Contract, C03/S/A, 2014). Any steps taken to help prevent individuals harming themselves must be 'least restrictive and last resort' (NHS Standard Contract, C03/S/A (2014). This means restrictions apply for the shortest period and are terminated as soon as risk safely subsides. Whilst all secure services must adhere to the overarching Forensic Services Polices, each individual service will have its own policy and procedures, created and updated by senior clinicians and hospital directors. A copy of each policy is available to all staff and is stored within handbooks on each ward.

1.8 Critical Reflections

1.8.1 Research within the forensic mental health pathway

As outlined within section 1.6 and 1.7, forensic mental health hospitals (FMHHs) are designed to provide secure mental health care to individuals who have a history of offending behaviour. Typically, individuals are sentenced to FMHHs based on the understanding that their mental health difficulties played a significant role in their offending behaviour, or because they have

become mentally unwell whilst in custody. Consequentially, in addition to supporting recovery, like prisons, FMHHs place a significant emphasis on security. As a result, Livingstone et al (2012) referred to the FMH population as one of the hardest to access groups for the purposes of research. This means that unlike research involving the general population, or other clinical populations, there are several unique conditions that researchers must navigate before they can conduct a study with FMH service users. Such processes include obtaining ethical approval with an at-risk, vulnerable population, being vetted and approved to visit a FMHH, navigating the political climate surrounding FMHHs, obtaining relevant documentation to enhance studies or answer important questions, and carrying out data collection whilst responding to the ever-changing environment of FMHHS.

Having conducted my doctoral research across three forensic mental health hospitals, I feel it is important to reflect on four key challenges that I faced. All of these challenges were unique to the forensic mental health population and impacted upon the time-line of the project, the scope of data collection and the ability to involve the women, staff and wider stakeholders in each aspect of the research design and implementation.

The first focus of my reflection falls upon the difficulty I had obtaining information relating to FMHH. I first noticed this when trying to collate the current statistics for the prevalence of self-harm and suicide amongst the forensic mental health population, however I was unable to find any reports or nationally published data. This was in contrast to data pertaining to the prison service, who publish quarterly reports on incidents of self-harm and deaths in custody, by month. Such data is particularly useful as it provides a comprehensive picture of the prevalence of self-harm and suicide and offers useful insight into the circumstances under which the behaviours occur. However, unlike the readily available prison data, to obtain statistics regarding the prevalence of self-harm and suicide in FMHHs I had to search through the Office of National Statistics yearly reports, which fail to specify data specifically relating to forensic mental health population. Instead, all data is grouped as 'mental health patients', meaning the data was highly limited in its ability to create a coherent understanding of the current problem, its prevalence, and the circumstances under which self-harm and suicidal behaviours occur, or compare it with other populations.

This appeared strange considering the World Health Organisation, (2017) has previously highlighted the importance and benefits of published statistics with assisting to create a picture of those at greatest risk. Reflecting on why such a gap in published data exists, I began to develop a sense that the lack of available statistics was at odds with the NHS notion of

transparency, honesty and candour, and wondered what the impact of not publishing data had on the problem itself. I reflected over the literature and the stories of the women, staff and wider stakeholders from this research, that describe self-harm and suicide as a chronic and ongoing problem within FMHH's, and considered how such a picture does not align with that presented (or not presented) by the NHS. I questioned whether a lack of data not only masks and minimises the true prevalence of self-harm and suicide within FMHHs, but also prevents it from being adequately addressed as on the surface level there does not appear to be a need to increase targeted funding or resources. I wondered whether this might explain why many of the staff that took part in the current research described high burn out rates and at times, a sense of hopelessness to resolve the situation. To help overcome this, I feel it is necessary for future research to collate all available evidence on the prevalence rates and publicise a true picture of self-harm and suicide in FMHHs.

My second reflection relates to the challenge of coping with, and overcoming, the external, organisational and political pressures placed upon FMMHs. I have reflected over whether those who took part in my research felt able to share honestly their experiences and beliefs about the impact of restricting access to means on life-threatening self-harm without feeling pressure to say certain things from internal and external sources. An example of this was hearing three members of staff describe feeling under pressure to utilise certain restrictive practises, despite believing the restrictions were not therapeutic or conducive for reducing risk. The same staff described being fearful of having to defend their practise to the organisation or indeed the coroner should they deviate from restricting access to means, which made me question whether the staff felt able to share an honest account of their understanding and beliefs about the impact of restricting access to means on life-threatening self-harm. Arguably, if the staff felt pressurised to describe the impact of restricting access to means in a certain way, it is likely that there is more knowledge to be found amongst the staff, which ought to be, identified in future research.

A similar reflection took place in relation to the women, whereby I considered how the forensic mental health environment might impact whether they felt able to be open and honest about their experiences, understanding and beliefs. Whilst every effort was made to reassure the women that their participation in the research would not affect their medical or legal rights, some may have felt they needed to answer in a certain way to either please me or reduce the potential risk of perceived adverse consequences. Again, it is important to reflect on whether this were true as it may impact the validity of the findings if the women were sharing their story or answering the questions in a way, they thought they ought to, or how I

wanted them too. As I was aware of this as a potential risk, in keeping with the PAR framework, I spent time getting to know the women who took part (both before and during the interviews), and ensured I reminded them that their participation was voluntary, their right to withdraw and that the main aim of the research was to learn from them and from their experiences.

The final reflection relates to the need to be flexible when researching within FMHHs, and how being flexible impacted the time scale of my project. In particular, due to the ethical requirements (e.g. vetting and staff acting as gatekeepers for the project), challenges with staffing levels, and the complex mental health presentations of the women, it was essential that I was open, responsive and adaptive with my project design and timeline. As a result, the timeline of my project was extended on multiple occasions. An example of this was extending the initial scoping and planning phase (which aimed to refine the initial research aims and questions and generate support for the project) to accommodate staff availability, their work commitments and the trust research seminar. In doing so, working around the needs of the organisation resulted in delays for submitting my application for ethical approval. A second example relates to the audit and recruitment process, which suffered significant delays as the trust had their Care Quality Commissioners (CQC) inspection. As HRA had stipulated a member of NHS staff had to complete the audit, because of the CQC inspection, the audit was not completed until the summer of my second year, meaning I was unable to recruit participants until the end of my second year, or begin data collection until my third. Understandably, this impacted the scope of data collection, as it was necessary to stop data collection in time to analyse the data and write the thesis within the time constraints for a PhD submission.

I have reflected how my own experiences of multiple delays may reduce the amount of research that is conducted within forensic mental health hospitals. Firstly, I think my experience highlights the need for the funding for PhDs that involve clinical research to be extended for four years. A lack of proper funding is likely to decrease the number of applicants for clinical projects and could potentially impact the quality of the findings they produce. Secondly, as many research projects are funded by time-limited grants, it is possible that those who seek to study the FMHP are disadvantaged as the need to be flexible makes it challenging to meet the stringent timelines required of funded projects. This could explain why the body of evidence amongst the forensic population is limited, and why Livingstone (2012) describes them as one of the hardest populations to engage in research. I believe this highlights and important need for funding bodies to review their approval or refusal of funding for research with the FMHP, and factor in the need for flexibility when setting stringent funding timelines.

Chapter 2: Defining Self-Harm and Suicide

2. Overview

Academic and clinical understandings of self-harm and suicidal behaviours are informed by theoretical models and research situated within literature. Understanding such literature is however a complex task, which unfortunately is further complicated by the use of inconsistent and interchangeable definitions and terminology. To try and assist with clarifying the complex differences between self-harm and suicide, this chapter begins with widely accepted working definitions for a range of self-harm and suicidal behaviours. The following section will provide an overview of the on-going debate regarding if, and how, self-harm and suicidal behaviours differ, and critically discuss how accurately they can be separated. The same section will also explore the literature that issues caution when separating self-harm from suicide, with an aim of building the foundations from which to argue self-harm and suicide exist upon a continuum of behaviours. In doing so, it will become clear this section argues that upon this continuum, there is a distinct gap in our understanding about self-harm behaviours that are enacted without suicidal intent but do so in a way that looks remarkably like a suicide attempt. Consequentially, it is argued that further research is required to address such a gap and explore this type of behaviour as without a foundation of knowledge, arguably life-threatening self-harm enacted without suicidal intent falls between the gaps of current assessment, treatment and preventative strategies. In the interest of providing clarity, the definitions that will be taken forward and used to describe self-harm and suicidal behaviours within this thesis will be presented.

2.1 Current Definitions and Distinguishing Factors

The following section of this chapter aims to present widely accepted working definitions of self-harm, self-injury, non-suicidal self-injury, attempted suicide, suicide, and self-inflicted death and provide an overview of the behaviours.

2.1.1 Self-Harm

Self-harm, self-injury and self-mutilation are broad terms historically used to describe behaviour that involves intentionally injuring the self. Self-harm can be defined as an act of intentional self-poisoning or injury carried out by a person irrespective of their motivation or intentions (NICE, 2013). Within the term self-harm, generally a number of behaviours are excluded including; eating disorders and substance misuse, daily behaviours such as lack of exercise, over exercise, and unhealthy eating, and behaviours that bring about psychological harm, such as engaging in an abusive relationship (NICE, 2013; Fliege et al, 2009).

2.1.2 Self-Injury

The term self-injury is also frequently found within literature and refers to a broad range of behaviours including cutting, scratching, and burning, hitting body parts and interfering with wounds (Briere & Gill, 1998; Herpertz, 1995; Favazza & Conterio, 1989). Unlike the term 'self-harm', which makes no reference to the functions of, or the intentions behind the behaviours, self-injury has been defined as the 'intentional, direct injuring of body tissue *without* suicidal intent' (Klonsky & Muehlenkamp, 2007). In the absence of suicidal intent, it is largely accepted that self-injury is associated with emotional regulation and overcoming negative feelings (NICE, 2013; Nock et al, 2009). This definition has been highlighted as being more helpful than the blanket term 'self-harm' in that goes some way to describe the functional, motivational and emotional aspects of self-harm enacted without suicidal intent (Manca et al, 2014).

2.1.3 Non-Suicidal Self-Injury

Non-suicidal self-injury (NSSI) refers to the 'intentional destruction of body tissue without suicidal intent, using non-lethal methods not socially sanctioned for either religious or political purposes' (DSM-5, 2012; Braush & Gutierrez, 2010; Jacobson et al, 2008; Nock & Kessler, 2006). Common methods of NSSI include "cutting, scratching, burning, and interfering with wound healing… carving words of symbols into one's skin, banging body parts, and needle-sticking, (Klonsky, 2007; p.1039). Self-destructive behaviours including cigarette smoking, whereby harmful effects occur but are unintended, and culturally sanctioned body modifications (including tattoos and piercings), are excluded from the definition of NSSI (Nock, 2009). In 2013, Non-suicidal self-injury (NSSI) was included within the Diagnostic and Statistical Manual of Mental Disorders (5^{th}.ed) as a condition requiring further research (DSM-5; American Psychiatric Association (American Psychiatric Association, 2013). Although NSSI has been found to have high life-time prevalence rates across many populations including the

general population, university students, and adults (Swannel et al; 2014; Kuentzal et al, 2012; Klonsky, 2011), NSSI is most common in adolescents and young adults (Nock et al, 2009). A full account of theoretical underpinnings of NSSI can be found in Chapter 3, theoretical frameworks, however in short, it is widely accepted that for many, NSSI serves as a functional behaviour which can assist in the management or escape from stressful and overwhelming situations, or to elicit a social response from others (Klonsky et al, 2011). NSSI has also been linked to increased distress at various stages across the lifespan, particularly after experiencing a significant life event (Guerry & Prinstein, 2009). Many studies have shown individuals who experience emotional distress cite feelings of calm, and relief after engaging in NSSI (Wilcox et al, 2012; Nock & Prinstein, 2005).

2.1.4 Attempted Suicide

Nock (2008) defines an attempted suicide, as "engagement in potentially self-injurious behaviour in which there is at least some intent to die". Attempted suicides typically involve the use of potentially lethality methods, or one where an individual *believes* the outcome of the chosen method could be potentially fatal (Haw et al, 2005). The belief or intent to cause death is fundamental within the definition of attempted suicide and is the main distinguishing factor that separates the behaviour from NSSI. As outlined in chapter 1, individuals who attempt suicide are often young and Caucasian, and are more likely to have a mood disorder compared to those who engage in NSSI alone (specifically major depression, personality disorder, or bipolar, Jacobson et al, (2008)).

2.1.5 Suicide

According to the NHS, a suicide can be defined as 'the act of *deliberately* taking one's own life'. The definition excludes any other definition of suicide and phrases that relate to other types of intentional death including 'suicide bomber', and 'assisted suicide' (NHS England, 2018). Key to the definition of suicide is the understanding that death was intentional, and the individual enacting suicide did so with the desire to end their life. Whilst females attempt suicide more than males, males are three times more likely to die by suicide (WHO, 2013). This has been attributed in part to the fact that often, males attempt suicide with methods of greater lethality than women (Kanchan et al, 2009; Parkar et al, 2008; Kposowa & McElvain, 2006; Denning et al, 2000). Within the general population, women are particularly known for taking non-fatal overdoses (Vancayselle et al, 2016; Canetto & Sakinofsky, 2010) whereas males are more likely to enlist methods such as hanging or shooting the self (Vancayseele et al, 2016; Boots et al, 2006; Davidson, 2003). Furthermore, whilst not extensively tested, additional

explanations relate to women being more concerned about the physical consequences of violent actions (Kanchan et al, 2009), and it is thought women are more likely to seek medical help than men (Denning et al, 2000).

2.1.6 Self-Inflicted Death

When providing the context for current definitions of self-harm and suicidal behaviours, it would be prudent to provide a short overview of the term 'self-inflicted death', which is adopted by Her Majesty's Prison and Probation Service. The term self-inflicted death can be defined as 'deaths arising from non-natural causes that appeared to be directly caused by the actions of the individual concerned' (McHugh & Towl, 1997). This term was adopted as it is acknowledged that determining the intent behind a deceased individuals' actions is difficult, and the fact that individuals can die inadvertently because of self-harm behaviours (MOJ, 2014). Whilst the term self-inflicted death may be helpful in that it does not assume the intention behind an individual's actions, adopting a definition that encompasses a broader spectrum of behaviours further highlights the on-going challenge of inconsistent and non-specific terminology within the self-harm and suicide literature (Andover, 2012).

2.2 The Current Academic Position

This section aims to present the current academic position in relation to defining self-harm and suicidal behaviours and critically explore the current guidelines pertaining to the identification and separation of each type of behaviour. For a reminder of the definitions used within the thesis, see Thesis Definitions within the thesis overview (see page 12).

Self-harm and suicide are heavily researched behavioural phenomena. The implications of such research are far-reaching, affecting theoretical models, clinical practice and treatment, policy and prevention strategies. Whilst investigative studies have widened our understanding of the functions of the behaviours and the associated risk and protective factors, there are fundamental issues with the core conceptual definitions used to describe self-harm and suicide (Silverman, 2006). Within the literature, there is heavy criticism relating to the use of inconsistent terminology, and there is a distinct lack of consensus as to how the behaviours should best be defined (Gratz, 2003). As a result, there are several terms used interchangeably to describe a single concept, whilst single, broader terms describe multiple behaviours (Andover et al, 2012; Silverman 2007). This occurs within and across populations (for example general and secure mental health populations), meaning the range of behaviours considered self-harm and suicidal differs (Slade, 2011). The use of multiple definitions is concerning as

this can lead to confusion when interpreting prevalence rates, theoretical models and research findings (Silverman & De Leo, 2016). Varied terminology also creates practical issues in terms of accurate assessment and implementing appropriate treatment and intervention, as adopting definitions that encompass a broader range of behaviours is likely to increase an individual's level of risk (Andover et al, 2012; Craigen et al, 2010; Gratz, 2001).

It is therefore clear to see how using inconsistent terminology can create difficulties when trying to undertake the already exceptionally hard task of determining who is at risk. This is an unwelcome confusion as understanding self-harm and suicide is already complicated as the reasons for self-harm and suicidal behaviour are multifaceted, ever changing and highly individualised.

Consequentially, more recently there has been a call for the introduction of more specific language (Silverman, 2007) as research has indicated blanket terms such as self-harm or self-injury may not capture important differences between acts of self-harm that occur with or without suicidal intent (Andover et al, 2012; Nock, 2009; Klonsky et al, 2008; Fliege et al, 2008; Silverman et al, 2007; Nock et al, 2006; Muehlenkamp et al, 2005). For those with suicidal intent, the reason for the behaviour is at least, in part, driven by the desire to die (Joiner, 2005), whereas individuals who enact self-harm without suicidal intent are more likely to report similar levels of suicidal intent to those without a history of self-harm behaviours (Jacobson et al, 2008). Instead, literature reports many reasons why one may enact NSSI including; managing distress, emotional regulation, feeling sad or worthless, being angry with the self or another person, to counteract feelings of numbness or nothingness, feeling rejected or hurt and feeling scared or anxious (Klonsky et al, 2014; Nock & Prinstein, 2010). According to literature, this makes the two types of self-harm behaviours distinctly different (Nock et al, 2006).

Table 2: Classification of self-harm thoughts and behaviours (Nock, 2009; American Psychiatric Association 2009)

Self-Harm Behaviour	**Suicidal Behaviour**
Thoughts of self-harm	Suicidal thoughts (ideations)
Threats of self-harm	Suicide Planning
Non-suicidal self-injury	Suicide Attempts
	Suicide

Research also suggests self-harm enacted without suicidal intent can be further distinguished from suicidal behaviour based on the frequency, severity, and lethality of methods used to enact harm (American Psychiatric Association, 2013; Klonsky & Muehlenkamp, 2007; Nock et al, 2006; Whitlock et al, 2006). Typically, self-harm without suicidal intent occurs frequently, involves methods that pose low risk to life, and results in minor injuries that require little or no medical attention (Klonsky, 2011; Nock et al, 2006; Muehlenkamp, 2005). Arguably this is distinctly different to behaviour enacted with suicidal intent, which comparably will occur less frequently, will be enacted with the aim of ending life, and will involve the use of highly lethal methods that often result in death or injuries that require medical attention (Muehlenkamp, 2005; Walsh & Rosen, 1988). Individuals who engage in medically serious behaviour are more likely to report higher levels of suicidal intent, depression and hopelessness, and are less likely to communicate the difficulties they are experiencing (Trakhtenbrot et al, 2016).

Additional support for differences between self-harm enacted with and without suicidal intent comes from research that considers the differences in psychopathology between those who engage in self-harm without or without suicidal intent, (Joiner, 2005). Notably, differences have been found between levels of depressed mood, hopelessness, and psychological distress, with those engaging in self-harm without suicidal intent demonstrating less severe clinical symptoms compared to those engaging in suicidal behaviour in both adult (Claes et al, 2010; Joiner et al, 2005; Muehlenkamp, 2005) and adolescent populations (Jacobson et al, 2008).

Therefore more recently self-harm enacted with *or* without suicidal intent has been thought of as two distinctly different behaviours, which are said to be distinguishable based on the presence or absence of suicidal intent, the frequency and severity of behaviour and methods of self-harm (American Psychiatric Association, 2013; Nock et al, 2009). In light of these differences, some suggest self-harm carried out without suicidal intent ought to be considered non-suicidal self-injury, (NSSI), whereas self-harm enacted with any element of suicidal intent ought to be defined as suicidal behaviour (SB), as it better reflects a suicide attempt (SA) (Nock & Kessler, 2006).

Table 3 – Adaptation of Muehlenkamp (2005) 'differentiation between self-harm and suicidal behaviours'

Feature	**Self-harm**	**Attempted Suicide (with fatal or non-fatal consequences)**
Intent	Non-suicidal	Suicidal – a desire to end life

Lethality / Severity	Low, rarely requires medical attention	High, often required medical attention
Chronicity	Repetitive, frequent	Infrequent
Methods	Will not pose high risk to life – scratching, burning, cutting	Will post high risk to life – hanging, jumping from height, overdose

Whilst our understanding of NSSI as a separate construct to SB grows, there remain significant limitations with the current research, largely based on the disproportionate use of non-clinical adolescent samples (Claes et al, 2010; Cloutier et al, 2010; Heath et al, 2008; Nixon et al, 2008; Muehlenkamp & Gutierrez, 2007; Nixon et al, 2002). Despite NSSI being a highly prevalent behaviour amongst adolescents and young adults (Hamza et al, 2012), arguably, this restricted evidence base fails to assess whether these findings are true for other populations including adult mental health inpatients, where self-harm is markedly frequent (Nock & Prinstein, 2004), and adults within the general population. Furthermore, within the literature there is also an overrepresentation of women with Borderline Personality Disorder (BPD), meaning our understanding of NSSI may be skewed. Whilst the prevalence of NSSI is believed to be as high as 68% amongst individuals with BPD (Sim et al, 2009), not all individuals who engage in NSSI have BPD (Zetterqvist, 2015; Glenn & Klonksy, 2013; Whitlock & Muehlenkamp et al, 2011). Therefore, generalising findings from studies using BPD samples may be misleading. As a result, future investigations are required across a range of populations to clarify whether the nature of NSSI is the same within alternative samples.

Additionally, despite a growing body of evidence to support the separation of NSSI and SB, it is important to approach such a distinction with caution, as there is strong evidence of a relationship between self-harm and suicide (American Psychiatric Association, 2013; DSM-V, 2013; Hawton et al, 2014). It is in fact well known that a history of self-harm is the most reliable risk factor beyond all others for future suicide (Bergen et al, 2010), with 50% of those who die by suicide having historically engaged in self-harm behaviours (NICE, 2013; Cooper et al, 2005; Hawton et al, 2003; Forester et al, 1997). Furthermore, research has shown that amongst those who report self-harm *without* suicidal intentions, only 15-45% do *not* have a history of suicide attempts (Muehlenkamp, 2005). This suggests more than half of such individuals will. This coupled with the knowledge that there are many shared risk factors underlying both self-harm and suicide (see Chapter 1, where the risk factors for self-harm and suicide are discussed), some have suggested that NSSI and SB would be better conceptualised as existing upon a continuum of behaviours (Kapur et al, 2013; Butler & Malone, 2013;

Klonsky, 2013; Muehelenkamp & Gutierrez, 2007; O'Carroll et al, 1996; Stanley et al, 1992). Upon such a continuum, unlike adopting a categorical separation of the behaviours, it is understood that both self-harm and suicide are changeable, fluid behaviours whereby individuals have the potential to adapt from one to the other (Kapur et al, 2013; Muehelenkamp & Gutierrez, 2007).

Despite a strong evidence base for the relationship between NSSI and suicide, there are methodological limitations due to the overrepresentation of self-report surveys used to study the relationship between self-harm and suicide risk. Self-report surveys are limited by a number of factors, including a heavily reliance on the honesty and transparency of participants, and the ability to quantify their self-harm behaviour (Fan et al, 2006; Wilcox, 2005). For many this may be difficult, and often answers can be over or under exaggerated, meaning such research may provide a slightly skewed picture of the relationship between NSSI, SA and suicide. Despite their limitations, these findings have important clinical implications, as the presence of NSSI alone can increase the risk of suicide, as repetitive as NSSI is statistically predictive of suicide (Hawton et al, 2014).

2.3 Limitations of a Dichotomous Approach

The follow section aims to explore the limitations of adopting a dichotomous approach to separating self-harm and suicidal behaviours as either NSSI or SB.

2.3.1 Frequent Self-harm and Suicide Risk – the ignored potential for harm

As detailed above, the DSM-5 (American Psychiatric Association, 2013) posits NSSI and SB can be separated based on the frequency, severity and the methods of self-harm. To summarise, NSSI will be frequent, involve methods that pose low risk to life, and result in low severity injuries. In comparison SB will be less frequent, involve potentially lethal methods, and often result in severe injuries that require medical attention (American Psychiatric Association, 2013). Despite expanding literature that supports this standpoint, assuming behaviour is either NSSI or SB based on frequency, severity and lethality of methods fails to consider the potential for harm via repetitive NSSI (Howe-Martin & Murrell, 2012; Hawton et al, 2003). This is a notable weakness of a dichotomous approach because there is a need to consider the potential severity and lethality of self-harm, as unlike with accidental injuries, there is an increased likelihood that the self-harm behaviours will be repeated (Howe-Martin & Murrell, 2012; Hawton et al, 2003).

To help illustrate this point, consider an individual who self-harmed by tying a ligature around their neck. Such behaviour could result in a minor red mark requiring little or no medical attention, meaning it meets the criteria of NSSI. Whilst this assessment is valid in terms of the level of injury sustained, arguably it is too simplistic as it negates that fact that self-harm involving ligatures has the potential to cause death, intentional or not. In this instance, by categorising the incident as NSSI, (despite the fact the behaviour itself has the potential to pose a high risk to life), opportunities could be missed to help educate individuals of the risks associated with their behaviour. This is concerning as it is known self-harm behaviour is likely to be repeated (Howe-Martin & Murrell, 2012; Hawton et al, 2003), and there is a proven relationship between repetitive NSSI and suicide (Hawton et al, 2014; Yip et al, 2011; Joiner, 2005).

Despite this, the offered classification system does not consider the potential for harm arising from escalating levels of harm, even though it is widely accepted that women in prison who engage in five or more incidents of self-harm within a one-year period have a heightened risk of suicide (Hawton et al, 2014). In fact, the current diagnostic criteria for NSSI is in direct contrast to literature, whereby individuals must have engaged in five or more episodes of NSSI within the last year to meet the clinical threshold for a diagnosis of NSSI (American Psychiatric Association, 2013). Highlighting the relationship between frequent self-harm and suicide, theoretical models have tried to explain how frequent self-harm increases the risk of suicide. According to Joiner (2005), providing a number of inter and intrapersonal circumstances are met (see chapter 3, Theoretical approaches), some individuals who self-harm frequently can acquire the capacity to enact potentially lethal self-harm. Such capacity occurs via the habituation to the pain and fear associated with harming the self and has been linked to increased risk for suicide (Smith et al, 2010; Bryan et al, 2011; Haw et al, 2005). In other words, the more frequently an individual enacts self-harm, the less fearful and more capable they are of dying by suicide.

When considering the potential for harm, a dichotomous categorisation system of NSSI or SB based on the lethality of methods also fails to take into consideration important individual differences that can impact the lethality of a method. To help illustrate this point, consider an incident of head-banging. Whilst in the majority of incidents head-banging is considered a method of low lethality that often result in injuries that pose low risk to life (James et al, 2012), head-banging is known to be linked to numerous negative health outcomes including significant brain damage and infections (Chester & Alexander, 2018). The potential lethality of head-banging is however in part determined by any pre-existing vulnerabilities an individual

may have, including open head wounds and a history of repetitive head-banging (Chester & Alexander, 2018). For an individual who has similar vulnerabilities, engaging in head-banging could result in life-threatening injuries or death, despite it being widely considered a low-lethality method. This demonstrates how the level of risk a method of self-harm poses to one person does not always present the same level of risk for another.

Therefore, despite knowing individual differences impact the lethality of a method and injury severity, the current system of separating NSSI with SB does not account for the potential risks associated with repetitive or escalating self-harm. This is because it views self-harming and suicidal behaviours too simplistically and fails to acknowledge the complex intertwined nature of the two. Furthermore, it does not recognise that NSSI can change and evolve over time, which is important to consider when deciding how to best prevent, or reduce the risks associated with the behaviours. Therefore, whilst using the aforementioned factors may be helpful in understanding self-harm behaviours in the immediate instance, adopting a categorical approach could result in dichotomous thinking whereby the ever change trajectory of self-harm behaviours, and future risk of suicide are ignored.

2.3.2 Suicidal Intent and the role of ambivalence

Understanding why an individual takes their own life and determining whether their behaviour was motivated by suicidal intent presents a significant challenge. This is because the reasons for enacting suicidal behaviour differ vastly between individuals, and it is fundamentally difficult to establish the intent behind one's actions when the person in question is deceased. As a result, our understanding of why people enact suicide is largely informed by research involving survivors of suicide attempts (Marzano et al, 2009). This is because research suggests those who make medically serious suicide attempts are epidemiologically similar to those who die by suicide, meaning they make good proxies to learn from (Rivlin et al, 2012; Marzano et al, 2009; Mosciki, 1995). It is however necessary to consider whether those who attempt but survive suicide can provide accurate insight into the intentions of those who die by suicide, as this approach assumes everyone who dies by suicide intended to end their lives. This is contrary to evidence that suggests the relationship between suicidal behaviour and suicidal intent is far more complex, and people do not always fit into simple homogenous groups (Kapur et al, 2013). This is because many people who do attempt suicide are unsure about their wish to live or die (Bergmans et al, 2017), and some instances of NSSI can be fatal, despite there being no intention of dying (Ciuhodaru et al, 2013: Andriessen, 2006; Douglas et al, 2004).

Being unsure about wanting to live or die, or "a state of confusion, or a lack of clarity surrounding the desire to die" (Joiner, 2005), has been termed ambivalence. Many people are known to experience ambivalence (Ciuhodaru et al, 2013), and the term refers to the experience of co-occurring or conflicting wishes to live and die without having a clear commitment to either life or death (Bergmans et al, 2017). Research suggests suicidal behaviour enacted with ambivalence is different to that of someone who is clear in their desire to end their life (Henriques et al, 2005). This is because research has suggested ambivalence increases the risk of suicide as ambivalent individuals can act impulsively, as they experience fleetingly changing desires to live or die (Yip et al, 2012). In other words, people who enact suicidal behaviour whilst experiencing ambivalence may act on their feelings suddenly, without thinking through their actions in the same way as those who enact a suicide attempt with the clear intention of dying (Yip et al, 2012). Interestingly however whilst for some it increases the risk of suicide, ambivalence is also known to change the course of suicidal behaviour and may act as a protective factor (O'Connor et al, 2012). This is because for some people, ambivalence is thought to extend the period of time between thinking about suicide and acting on suicidal thoughts, as if affects their ability to make the decision to end their lives (Bergmans et al, 2017).

With this research in mind, it may therefore be prudent to place less emphasis on understanding suicide attempts solely in the context of suicidal intent and explore additional reasons why someone may enact potentially fatal behaviour (Fox et al, 2016). This is because viewing suicide attempts and near-lethal behaviour in the context of suicidal intent alone fails to consider the complex ever-changing psychological mind-set of people who die by suicide, and the individual differences that go into making the decision to harm oneself. By accepting this research and considering SB with ambivalence, it makes it difficult to determine where such people would fit within a categorical system designed largely on the presence or absence of suicidal intent. Consequentially, this lends support to the idea that NSSI and SB can be better understood as existing upon a continuum of behaviours with those self-harm and SB with ambivalence being considered as a separate group of people, found somewhere towards the end of the continuum (i.e. closer to suicide).

2.4 A missing piece of the puzzle - Near-Lethal Self-Harm

Near-lethal self-harm, near-fatal self-harm, near-fatal suicide attempts, medically serious suicide attempts and near-fatal self-harm are all phrases found amongst literature exploring self-harm that poses high-risk to life. Although in comparison to NSSI or SB this behaviour is

largely under researched, it has been noted within the general population (Fox et al, 2018; Douglas et al, 2004) and the prison population (Marzano & Colleagues, 2009; 2011a; 2011b; 2012; 2013). Amongst such literature, the overall assumption is that near-lethal self-harm is driven by suicidal intent (Levi et al, 2008; Douglas et al, 2004). This is largely because similarities have been noted between near-lethal self-harm behaviours and suicide including demographic, social, and clinical risk factors, and methods and medical severity (Gvion & Levi-Belz, 2018). Whilst sufficient evidence exists that supports this assumption, there are a growing number of studies that identify some people who enact near-lethal self-harm without suicidal intentions (Fox et al, 2018). Collectively, the conflicting evidence base makes near-lethal self-harm particularly hard to understand within the wider context of self-harm and suicidal behaviour, as it does not appear to fit align fully with either NSSI or SB.

When reviewing the literature pertaining to near-lethal self-harm behaviours, it is apparent there is a clear need for future research as currently, such literature is dominated with studies that involve the prison population. Whilst this literature has made a notable contribution to our understanding, it remains unknown whether the understanding of near-lethal self-harm behaviours is translatable, or indeed generalisible to members of other populations. Notably, this is true for the forensic mental health population, where to the authors knowledge, there is yet to be a study that explores near-lethal self-harm behaviours. Therefore, when approaching this largely unknown behaviour, the first challenge to undertake is defining near-lethal self-harm behaviours, however currently there is not a clear, universally adopted definition. To further complicate such matters, the definitions that have been suggested differ between general and prison populations.

Therefore, in light of the differences in the definitions used between populations, to help build a clearer picture of the evidence base surrounding this complex behaviour, an overview of recent literature will be presented separately for general and prison populations. This will allow for a clearer comparison of the behaviour between populations and assist with building a foundation from which to better understand near-lethal self-harm behaviours. In the absence of an evidence base pertaining to the forensic mental health population, it is appropriate to look at the prison population as they are considered the most like those in receipt of forensic mental health care. It will also break down separately literature that supports the idea that near-lethal behaviour is enacted with suicidal intent, and that which posits it can occur without suicidal intent. Therefore, within this section of the chapter, a critical overview of near-lethal self-harm behaviours will be presented.

2.4.1 General Population

When describing self-harm whereby the outcome is medically serious and potentially life-threatening, Douglas et al (2004) adopted the term 'near-fatal deliberate self-harm' (NFDSH) and defined it as:

- "Any act of self-harm using a method that would usually lead to death, e.g. hanging, drowning, self-poisoning with car exhaust fumes, jumping from a high place or in front of a moving vehicle" OR
- "Self-injury to a 'vital' body area (e.g. throat, chest or abdomen, not wrists, legs or arms)" OR
- "Self-poisoning that requires admission to an intensive care unit or is judged to be potentially lethal by an accident and emergency doctor".

The term 'medically serious suicide attempt' (MSSA) has also been adopted amongst literature and refers to self-harm that "causes a significant physical injury requiring intensive, substantial medical treatment" (Gvion & Levi-Belz, 2018). Unlike the term offered by Douglas et al (2004) that does not refer to the motivations underpinning NFDSH, the term MSSA infers the behaviour is enacted with suicidal intent, and concludes it is similar to a suicide attempt (Gvion & Levi-Belz, 2018).

2.4.1.1 Risk Factors

Whilst near-lethal self-harm remains relatively under researched, Gvion & Levi-Belz, (2018); Gvion et al, (2014) and Douglas et al (2004) have suggested the following risk factors increase risk for near-lethal self-harm amongst the general population:

- History of self-harming behaviour
- History of suicide attempts (particularly when there was a plan to avoid discovery)
- Suicidal Intent
- Binge drinking (particularly for males)
- Diagnosis of Borderline Personality Disorder
- History of childhood sexual abuse
- Over arousal
- Loneliness

2.4.1.2 Suicidal Intent

Although limited in quantity, much of the literature exploring medically serious acts of self-harm amongst the community population posits near-fatal self-harm is enacted with suicidal intent. This is largely informed by research that highlights similarities between NFDSH and suicides, including the use of highly lethal methods and serious injuries that require fast medical treatment (Gvion & Levi-Belz, 2018; Douglas et al, 2004). As presented in previous sections of this chapter, both medical severity and increased lethality of methods have a proven relationship with suicidal intent (Haw et al, 2005; Eddleston et al, 2005;). Furthermore, those enacting NLSH have been found to have similar levels of suicidal intent to those attempting suicide and report significantly higher suicidal intent than those enacting self-harm of a lower lethality (Douglas et al, 2004). Providing further support NFDSH may be indicative of suicidal intent, literature shows people enacting NFSDH have similar demographic, social and psychological risk factors with those who die by suicide (Levi et al, 2008; Douglas et al, 2004). In particular shared risk factors include being male, unmarried, a history of previous self-harm, a desire to die, and trying to avoid discovery (Douglas et al, 2004).

2.4.1.3 Non-Suicidal Intent

It is however important to approach the aforementioned literature with caution, as there is also a respectable evidence base that suggests the motivations or intentions that underpin NFDSH may be multifaceted (Fox et al, 2018). Firstly, whilst such research does not reject evidence that shows there are similarities between those who engage in NFDSH and those who attempt or die by suicide, it makes it clear those enacting NFDSH also share many similarities with individuals who enact self-harm *without* suicidal intentions (Ciuhodaru et al, 2013).

In fact, the idea that NFDSH may be underpinned by motives other than suicidal intent has been suggested since the 1970s, with Morgan et al (1975) reporting few people admitted to hospital following an overdose want or expect to die, despite using a method they understand is potentially lethal. Instead, alternative reasons for enacting potentially lethal forms of self-harm include gaining relief from an unbearable state of mind, to seek help or influence someone (Bancroft et al, 1976; Casey, 1989; Stephens, 1995), relieving the self from physical pain (Bancroft e al, 1979), to punish the self (Madge et al, 2008), or because they were unable to resolve their distress in an alternative way (Schnyder et al, 1999). As discussed in the previous chapter, all of the aforementioned reasons cited for NFDSH have also previously been

cited for NSSI (Nock et al, 2009). More recently, Madge et al (2008), Rodham et al, (2005) and Canetto & Sakinofsky (2010) have corroborated such findings. Of particular interest, such literature estimated as few as 18.4% women and 27.7% of males actually enact near-fatal self-harm with the intention of death (Canetto & Sakinosfky, 2010), whilst other literature found as many as 42% explicitly report their behaviour was not underpinned by suicidal intent (Drew et al, 2005). Interestingly, whilst literature has shown significant differences between NFDSH and SB in terms of suicidal intent, wishes to die and beliefs that the behaviour will result in death, studies often find no differences between those who enact NSSI and those who engage in NFDSH (Fox et al, 2016; O'Connell & Clare, 2004). Collectively, the aforementioned literature may indicate that within the general population NFDSH without suicidal intent is more common than is currently thought (Fox et al, 2016), and NFDSH may be more akin to NSSI than to SB (O'Connell & Clare, 2004).

Fox et al (2016) have however called for further research to expand such work based on the discrepancies found amongst the literature pertaining to the role of suicidal intent. This is important, and may be attributable to the overrepresentation of young, Caucasian, female participants. This may mean our current understanding is skewed towards a population where the prevalence of NSSI and SB is known to be markedly higher than most other populations (Nock, 2009). It would therefore be prudent for future research within the community to expand their population samples and include more males, and older adult participants. Furthermore, within general population studies, many enlist participants who have enacted medically serious self-poisoning (Gvion & Levi-Belz, 2018; Douglas, 2004). It is likely this is in part due to the fact that self-poisoning is one of the most common forms of self-harm behaviours that lead individuals to seek emergency medical care (Hawton et al, 2015), meaning more individuals enlisting this method are available to participate in research. Whilst this may be true, to establish whether findings from the current literature can be generalised to individuals using different methods, individuals using other methods of NFDSH need to be included in future research. This is again important, as method selection has been reported as a fundamental indicator of suicidal intent (DSM-5, APA, 2013). It is therefore necessary to clarify the relationship between method selection and the motivations underpinning NFDSH, as some research has reported individuals who enact NFDSH often do not select methods on account of suicidal intent. Instead, studies have reported some select methods based on their physical availability, or a lack of alternative choices - not based on the understanding that a particular method is more or less lethal than another (Eddleston et al, 2015).

2.4.2 Prison Population

Within the prison literature, the term near-lethal self-harm has been adopted. Near-lethal self-harm (NLSH) has been described as a 'deliberate act of harm to oneself that could have been fatal without rapid and effective care and/or emergency treatment' (Beautrais, Joyce, & Mulder, 1999), and refers to self-harm behaviour enacted with methods that pose a reasonably high probability of death, (Marzano et al, 2011). To date, our understanding of NLSH within prisoners is largely attributed to Marzano and Colleagues, who have identified many of the risk factors and triggers for NLSH. Furthermore, such literature has also made headway into determining the preventative or protective factors that may in part help to reduce the risk of NLSH, which has important implications for policy and preventative strategies. The work from Marzano & Colleagues has also assisted in enriching our understanding of why people enact NLSH using the reasons prisoners provide after an incident of NLSH. These findings have been combined and are detailed below in Table 5. This table demonstrates how the reasons behind NLSH are multifaceted and can be driven by both suicidal and non-suicidal intentions. The table also highlights how NLSH amongst prisoners is complex and for many, appears to be driven by a range of psychological and environmental (prison related) factors.

2.4.2.1 Risk factors

Whilst the body of literature pertaining to near-lethal self-harm remains in its infancy, over a number of both qualitative, and quantitative studies, Marzano and Colleagues (2016a, 2016b, 2013a, 2013b, 2012, 2011a, 2011b, 2010, 2009) have identified a comprehensive list of risk factors related to near-lethal self-harm within both male and female prisoners. It has been suggested that demographic factors are unhelpful in identifying those at risk as typically people who enact near-lethal self-harm are representative of the wider prison population in that they are young, single, heterosexual and white (Rivlin et al, 2013; Marzano et al, 2011; Suto & Arnaut, 2010).

Summarising the findings from Marzano and Colleges, and combining them with the work from Sanches et al (2017); Suto & Arnaut, (2010); Bonner, (2006); Borrill et al, (2006); Blaauw et al, (2001); the following risk factors are thought to increase the risk of engaging in near-lethal self-harm

Historical

- History of self-harm and/or suicide attempts (both in and out of custody)

- History of psychiatric inpatient care
- Family history of suicide
- Historical childhood trauma (including sexual abuse and neglect)

Internal

- Suicidal Intent
- Experiencing flashbacks, voices, or intrusive thoughts related to emotional, physical and sexual trauma (whereby the risk is further enhanced in the presence of all three)
- A diagnosis of two or more mental health disorders (particularly for major depression and anxiety disorders)
- Lower self-esteem
- Feeling guilt
- Hopelessness
- Major Depression
- Paranoia
- Impulsivity
- Aggression/hostility
- Mood disorders
- Psychosis
- Anxiety
- Anxieties about prison sentencing, transfer or release

Interpersonal

- Lower perception of social support
- Family related distress
- Having concerns about family and friends outside of prison

Environmental

- Early days of custody
- Having arguments with prisoners and/or staff
- Detoxification issues
- Struggling with prison life
- Feeling let down by the prison system
- Experiencing an adverse life event within the last 6 months

- Unemployment in prison
- Increased number of disciplinary infractions

Diagnosed Mental Health Disorder

A psychiatric diagnosis or current mental health problems have been shown to have one of the strongest associations with near-lethal self-harm. Literature has shown a disproportionate number of male and female prisoners who enact NLSH will experience major depressive symptoms psychosis and anxiety, compared to those who do not (Lohner & Konrad, 2006). Furthermore, co-morbid disorders (two or more) have been shown to be significantly associated with NLSH (Marzano et al, 2010).

Recent significant life events

Research has shown experiencing a significant life event within the last 6 months increases the risk of enacting NLSH (Oakes-Rogers & Slade, 2015). Such events can include; children being adopted, relationship breakdowns, being bullied, being threatened with violence and being intimidated to hand over possessions (Marzano et al, 2016).

2.4.2.2 Suicidal Intent

As is the case within the general population, in most studies amongst the prison literature, NLSH is discussed within the context of suicidal behaviour. This is because in most studies, near-lethal acts are said to have taken place with high suicidal intent (Lohner & Konrad, 2006; Marzano et al, 2010; Borril et al, 2005). In fact in some studies, up to 91% of prisoners who enacted NLSH reported doing so with the intention of dying (Rivlin et al, 2012), whilst others found that over three quarters of prisoners believed the methods they used were serious enough to end their lives (Rivlin et al, 2012). This is important for understanding the motivations behind NLSH, as the DSM-5 (American Psychiatric Association, 2013) states suicidal intent is indicative of suicidal behaviour and separates it from non-suicidal self-injury (NSSI) (see chapter 2, defining self-harm and suicide). As a result, individuals who survive NLSH are often regarded as close comparative proxies to those who die by suicide (Rivlin et al, 2012; Marzano et al, 2009; Fortune et al, 2007). This means the experiential knowledge of those who enact and survive NLSH are currently seen as central to investigating the suicidal process, as arguably meaningful lessons can be learnt from the experiences of those who have come close to dying (Marzano et al, 2009).

2.4.2.3 Non-Suicidal Intent

Whilst many studies have demonstrated a relationship between suicidal intent and NLSH, as can be seen within table 5, prisoners have also provided other reasons for enacting NLSH that do not always co-occur with suicidal intent (Rivlin et al, 2011; Jelic et al, 2005; Deer et al, 2005). Interestingly, whilst there are clear similarities between NLSH and suicide, many of the reasons cited for NLSH have also been provided as reasons why individuals engage in NSSI. These include feeling overwhelmed, being angry with other people, and experiencing emotional pain including sadness, fear and anxiety (Nock & Prinstein, 2010). Further shared reasons include using NSSI and NLSH as a way of articulating distress to others, experiencing self-hatred, and for instrumental purposes to achieve a clear goal other than to die (Jelic et al, 2005; Deer et al, 2000). Whilst many, if not all the above reasons can co-occur with suicidal intent, clearly for some, NLSH is enacted *without* the desire to die and may more closely resemble NSSI than is currently thought. Therefore, considering the shared reasoning for NSSI and NLSH, it is important to approach NLSH with caution, and ensure NLSH is not automatically placed within the context of suicidal behaviour until research clarifies the relationship further between NSSI and NLSH. This is essential as currently viewing NLSH as a suicidal behaviour means such behaviour is targeted with suicide prevention policy and treatment, when in fact it may be more appropriate for treatment to target non-suicidal reasoning.

Despite a picture forming in relation to NLSH within prison populations, during a recent literature review, Marzano et al (2016) noted research into NLSH is predominately conducted using male samples (only two included female prisoners, and two included mixed sample). This means that as with many aspects of self-harm and suicidal behaviour, our understanding of NLSH is dominated by studies based on the experiences of men (Oakes-Rogers & Slade, 2015). Consequentially less is known about NLSH in women samples, meaning gender differences may be unaccounted for in the current literature. It would therefore be important for future research to enlist more female participants, as research has previously shown there are discrete gender differences between male and females who enact self-harm and suicidal behaviour (Bresin & Schoenleber, 2018). Such research is likely to have important practical implications if gender differences are noted and may serve to inform and improve current preventative policy.

Furthermore, whilst it is clear the literature relating to the prison population has made a significant impact on our understanding of NLSH amongst both male and female prisoners, to date there is yet to be a study that explores such behaviour within secure forensic mental

health populations. There is therefore a clear need for such research, as it is known the rates of self-harm and suicidal behaviours are highest amongst forensic patients compared to all other individuals receiving mental health treatment (James et al, 2012).

Table 4: Reasons provided for near-lethal self-harm

Reason Cited	NSSI	NLSH (General Population)	NLSH (Prison Population)	SB
Wanting to die	N	Y	Y	Y
To cope and manage emotional distress and pressure	Y	Y	Y	
Wanting a temporary escape from mental pain	Y	Y	Y	Y
Feeling rejected or hurt	Y		Y	N
To communicate distress and elicit help from others	Y	Y	Y	
Experiencing a significant life event (relationship breakdown, bereavement, conflict etc)	Y	Y	Y	Y
Receiving threats to kill from the outside	N	NA	Y	Y
To elicit a sense of peace, calm or happiness	Y	Y	Y	N
Believing they were wrongly accused of a crime	N	NA	Y	Y
Being angry at another person	Y	N	Y	N
Self-hatred	Y	Y	Y	N
Reading a witness statement or seeing photos of the crime their had been sentenced for	N	NA	Y	N
Feeling sad or worthless	Y	Y	Y	Y
Being placed in segregation	Y	NA	Y	Y
For instrumental purposes (not suicidal but to gain a clearly identified goal)	Y	Y	Y	Y
Feeling overwhelmed	Y	Y	Y	Y
Feeling numb or nothing	Y	N	N	N
Experiencing Psychotic symptoms	Y	Y	Y	Y
Being unable to cope with drug and/or alcohol withdrawal	N	Y	Y	Y
Feeling unsupported, or having no one to talk to	Y	Y	Y	Y
Being angry at the self	Y	Y	Y	N
Feeling scared or anxious	Y	Y	Y	N

2.5 Concluding Thoughts

Understanding why people harm themselves or enact suicide is a complex task. Adding to this already complicated challenge, between academics and clinicians there is an overwhelming use of inconsistent terminology to define self-harm and suicide (Silverman, 2007; Grey, 2003). This has wide-reaching academic and practical implications on both the interpretation prevalence rates and research findings, and the introduction of preventative and treatment measures. Therefore, most famously attributed to Nock and Colleagues (2009), research and practise now leans towards using more concise language that separates self-harm from suicide on the basis of suicidal intent, the frequency and severity of self-harm and the lethality of the methods used (American Psychiatric Association, 2013).

Whilst practically this is useful in terms of knowing whether it is appropriate to make a diagnosis (i.e. – Non-suicidal self-injury or suicidal behaviour disorder), there are several cautions issued when separating the two types of behaviours. Firstly, and arguably most importantly, such caution comes from literature that evidences self-harm and suicide do not always occur exclusively (Klonsky et al, 2013; Kleespies et al, 2011; Wilcox et al, 2011). Many people who engage in NSSI also have a history of suicidal attempts and many go on to attempt suicide again (Hawton et al, 2014; Van Orden et al, 2010; Hilt et al, 2009; Asarnow et al, 2011; Jacobson et al, 2008). This is true for both historical self-harm enacted with and without suicidal intent, (American Psychiatric Association, 2013; Lofthouse et al, 2008; Whitlock & Knox, 2007), and for individuals whose self-harm is repetitive (Hawton et al, 2014). Such literature provides strong evidence that self-harm and suicidal behaviours are related and has been replicated within many populations, including adolescents (Hawton et al, 2012; Muehlenkamp et al, 2007), adults within the general population (Bebbington et al, 2010), and psychiatric inpatients (Claes et al, 2010; Andover et al, 2010). Such findings may be explained by other literature that evidences many shared risk factors between NSSI and SB (Mars et al, 2014), suggesting the differences between the behaviours may not be as pronounced as recently proposed. It is therefore important to approach a dichotomous distinction with caution, as there are substantial clinical implications for confusing the two types of behaviours.

Reflecting over the aforementioned literature, it is also important to consider whether all instances of self-harm and suicidal behaviour align within a dichotomous separation of behaviours. Arguably, this is not the case, and as identified above, there will be many instances where self-harm behaviour falls outside of the diagnostic guidance for NSSI or SB. This includes people who enact self-harm and suicidal behaviours but are ambivalent about

their desire to live or die (Lungu, Wilks & Coyle, 2018), and those who's self-harm is enacted without suicidal intent but who die as a result of their injuries (Douglas et al, 2004). Furthermore, more recently, research has identified people who enact self-harm that is potentially lethal but do so without the desire to die. Whilst the overarching literature into near-lethal self-harm posits such behaviour is driven by suicidal intent, in almost all instances, research studies have identified a proportion of people who report enacting near-lethal self-harm without the desire to die.

Therefore, considering the evidence that demonstrates the intertwined relationship between self-harm and suicidal behaviours, and literature identifying behaviours that do not fit within dichotomous categories, there is continued support for self-harm and suicidal behaviours to be understood as part of a continuum of behaviours (Walsh, 2007; Cloutier et al, 2010). By viewing self-harm and suicidal behaviours upon a continuum, arguably it becomes possible to explore behaviours that do not align with the conventional definitions of NSSI or SB or fit with a dichotomous category of either 'with intent' or 'without intent'. Such behaviour would include near-lethal self-harm (O'Connell & Clare, 2004), which currently is largely under researched and poorly understood outside of the prison population. This highlights an important gap in the literature, which the current thesis aims to address.

2.6 Method Selection, Restricted Access to means and Method Substitution. The relationship with near-lethal self-harm

2.6.1 Overview

Considering the standpoint adopted within the DSM-5 and its emphasis on the role of method selection in determining whether behaviour is representative of NSSI or SB (see chapter 2, defining self-harm and suicide), it is important to consider why people select certain methods of self-harm and what factors influence such a decision making process. Therefore, this section aims to consider method selection, and critically evaluate how the research surrounding method selection within the general population translates to the forensic mental health population. Additionally, this chapter will explore the role of restricting access to means (a suicide prevention policy adopted within the community and forensic mental health settings), and discuss the impact this has on method selection and the severity of self-harm and suicidal behaviours. In doing so, this chapter aims to highlight there may be alternative reasoning why women in forensic mental health hospitals may enact near-lethal self-harm without suicidal intent (see chapter 2, defining self-harm and suicide). This is important as

currently near-lethal self-harm is conceptualised as suicidal behaviour, despite emerging evidence that demonstrates there are a range of other non-suicidal reasons for the behaviour.

2.6.2 Method Selection

To help determine whether an individual's behaviour is consistent with either NSSI or SB, the DSM-5 states clinicians ought to consider the frequency, severity and the method of self-harm. By considering these factors together, it is claimed "the absence of suicidal intent can be inferred by the individual's repeated engagement in a behaviour that the individual knows, or has learned, is not likely to result in death" (American Psychiatric Association, 2013). Typically method selection is discussed within the context of suicidal intent, as according to literature, there is an evidenced relationship between the use of potentially lethal methods, increased suicidal intent and future suicide attempts (Haw et al, 2015; Huang et al, 2014; Wang et al, 2015; American Psychiatric Association, 2013; Andover & Gibb, 2010; Kumar et al, 2006; Haw et al, 2005; Carter et al, 2005; Douglas et al, 2002;). The use of potentially lethal methods has been shown to co-occur with enacting harm in a place and at a time where the chance of rescue is low, providing further evidence to suggest potentially lethal methods are used when behaviour is enacted with an aim of ending life (Kumar et al, 2006). Comparatively, suicidal intent has been found to be lower amongst those who use lower lethality methods of self-harm (Haw et al, 2015), and as such, low lethality methods are believed to be indicative of non-suicidal self-injury (American Psychiatric Association, 2013; DSM, 2013; Nock et al, 2009). This suggests method selection is a useful predictor of suicide risk (Hawton, 2002), and those engaging in methods of high lethality are more likely to so do with suicidal intent compared to those engaging in low lethality methods (Wang et al, 2015; Chang et al, 2009; Elnour & Harrison, 2008; Miller et al, 2004).

There are however a number of issues with determining suicidal intent on the basis of method selection. Firstly, understanding how and why people select methods of self-harm is complicated and highly individualised. This is because many argue the decision-making process behind method selection is more complex than a 'simple dichotomy between more or less lethal methods' (Kposowa & McElvain, 2006). Instead, evidence suggests a range of cultural, social, psychological influences method selection, and environmental factors that change over time (Cantor & Baume, 1998). Such factors include gender, cultural and religious backgrounds, diagnosis of mental illness, the presence or absence of suicidal intent, the physical availability of methods and the social acceptability of methods (Baker et al, 2013; Wu

et al, 2012; Hawton et al, 2009; Gratz & Gunderson, 2006; Cantor & Baume, 1998). Literature suggests such factors help to explain the differences in methods used between countries, for example the high prevalence of self-immolation (setting oneself on fire) in Asian cultures that link fire to protecting against injustices of life (Wu et al, 2012), or the disproportionate use of firearms in suicides within America where unlike in most of the world, it is socially and legally acceptable to own a firearm (Pirelli, Wechsler & Cramer, 2018).

Additionally, assuming suicidal intent can be inferred from the lethality of methods also assumes an individual understands the risks associated with their behaviour. This is not however always the case and research has demonstrated that some people do not fully understand the potential lethality of their behaviour (Hawton et al, 2003). This has specifically been shown amongst some individuals with intellectual disabilities, and those with low IQ (Hawton et al, 2003). Consequentially, it is quite possible that an individual could enact self-harm using potentially lethal methods but do so without suicidal intent and without understanding the potential risks.

Therefore, understanding method selection is one of the most important factors for informing self-harm and suicide risk, as individuals who engage in self-harm and suicidal behaviour using potentially lethal methods are at greater risk of dying by suicide (Huang et al, 2014). However, whilst suicidal intent appears to be a major influencer on method selection amongst suicidal populations, the presence of suicidal intent alone is not able to explain fully the complex decision-making process of method selection in populations who enact NSSI or near-lethal self-harm without suicidal intent. This is because the literature base exploring what makes an individual choose a specific method from a range of low lethality methods is scant. There is however evidence to suggest understanding why people chose lower lethality methods may serve to improve our understanding of suicide risk, as individuals who enact repetitive self-harm with low lethality methods often change methods over time, meaning the pathway to using higher lethality methods could be explored (Hueng et al, 2014).

In addition to suicidal intent, the availability of methods is one the most significant influencing factors on method selection (Biddle et al, 2010; Hawton, 2005). Literature demonstrates individuals often adopt methods that are easily accessible and reject methods that are not readily available (Biddle et al, 2010). This is because it is understood that in most instances, the period in which an individual is at high risk of engaging in near-lethal self-harm, or attempting suicide is relatively short (Florentine & Crane, 2010). In fact, literature has

suggested that for some, the time lapse between contemplating suicide and acting on their thoughts is as little 10 minutes, meaning they enlist methods that are readily available and require little planning (Diesenhammer et al, 2009). Internationally, these findings are well evidenced, with trends in national suicide rates showing an increased use of readily available means. Such studies include the disproportionate use of firearms in American suicides (Kellerman et al, 1992; Brent, 2003), high toxic coal poisoning (Kreitman 1976), and paracetamol overdose within the United Kingdom (Hawton, 2001), pesticide ingestion in areas of high agricultural activities, and jumping from heights in cities whereby the majority of residents live in high-rise buildings (Wu et al, 2012).

Collectively, the aforementioned body of literature has been used to inform national suicide prevention strategies, which enlist 'means restrictions', in a bid to limit population wide access to self-harm methods that pose high risk to life (Florentine & Crane, 2010).

2.6.3 Restricting access to means

Restricting access to means, or means restrictions, are terms commonly used to describe the removal or restriction of items that can be used to inflict harm on oneself (Hawton, 2009). Means restriction can come in many forms, including; making access to means more difficult, substituting high-risk means with ones that pose lower risk to life and limiting the volume or quantity of means available (Yip et al, 2012). Underlying the process of means restrictions is the fundamental assumption that self-harm and suicide can be prevented by removing access to means, as it may delay the process of thinking of harming oneself and acting on such thoughts (Florentine & Crane, 2010; Hawton, 2002). Restricting access to lethal methods is said to change the context of a potentially fatal incident, by precluding one's actions, or 'forcing the use of a less lethal method' (Yip et al, 2012). Throughout the last decade, restricting access to means has featured in many public health initiatives with an aim to reduce the lethality of self-harm and suicidal behaviour (WHO, 2010). Whilst predominantly placed within suicide prevention policies such as Preventing Suicide in England (Department of Health, 2012), it is thought that affective means restriction may also positively influence the ability for individuals to enact self-harm.

Within community populations, means restriction has been shown internationally to be effective at reducing suicide rates. Notably this has been demonstrated within the UK with the removal of toxic gas within the home (Kreitman, 1976), the introduction of catalytic

converters which limited access to harmful carbon monoxide (Kendell, 1998), and the introduction of blister packs for analgesics which limited the amount of pain killers individuals could purchase (Department of Health, 2002). Through controlling access, means restriction has also successfully reduced the number of suicides involved firearms within the UK, (Haw et al, 2004), Australia (Ozanne-Smith et al, 2004), Canada (Bridges, 2004), and the USA (Ludwig & Cook, 2000) and the number of suicides caused by pesticide ingestion within Asia (Gunnell & Eddleston, 2003; Mohamed et al, 2009). In light of these findings, Hawton (2005; 2007) concluded means restriction is able to reduce the risk of suicide and works most effectively when the method restricted is highly lethal, commonly used and widely available.

2.6.4 Method substitution

As with all self-harm and suicide prevention strategies, restricting access to means is not without its downfalls. A common concern related to means restriction is the possibility that when faced with limited or restricted access to a method of harm, individuals will replace the intended method with an alternative (Florentine & Crane, 2010). This is known as method substitution. Whilst the risk of replacing one lethal method with another is considered low (Yip et al, 2012), method substitution does occur (Lester, 1990; Rich et al, 1990; Lester & Abe, 1989). Method substitution was evidenced by Cantor & Salter (1995), and Rich et al, (1990), who noted an increase in the use of hanging, strangulation and jumping from height following increased restrictions on firearm access. Such findings suggest that whilst restricting access to methods can hinder a specific attempt, in the presence of alternative lethal methods, it does little to prevent suicidal behavior in the longer term, (Florentine & Crane, 2010). Instead such initiatives may delay an event until an alternative method is sought (Florentine & Crane, 2010). Despite some literature that evidences method substitution, generally the benefits of method restriction have been well evidenced and more often than not, when method substitution does occur, it results in the use of lower lethality methods (Yip et al, 2012; Diagle, 2005).

2.6.5 Critical Reflections

2.6.5.1 Method selection and means restriction within the context of secure forensic mental health hospitals

To help create a safe environment and prevent self-harm, unlike community populations, those receiving forensic care have impeded access to many common forms of self-harm. This is inclusive of both potentially lethal methods, such as rope or ligature points, and low-lethality items including glass, medication, or razors. It is common for additional restrictive steps to be taken when an individual's risk heightens, including limiting access to every day items that could be used for self-harm, including but not exclusively, pens, bra under wiring, hair clips, clothing, and paper (Tromans et al, 2019). If risk cannot be safely managed within the main ward areas, individuals may be nursed within sterile environments, which are free from objects that could be used to cause harm. As a result, the available means for self-harm within forensic services is limited, meaning self-harm often involves methods that require little external means (e.g. occluding the airways with bodily byproducts, and prolonged head-banging) (Tromans et al, 2019). Importantly, many of the items removed from those considered to be at increased risk are their own personal possessions and not the property of the forensic mental health service. This differs significantly to means restriction in the general population, whereby access to means that are readily available to the public are restricted, not an individual's personal possessions.

While means restriction has proven internationally to be an effective initiative amongst the community (Yip et al, 2010; Hawton et al, 2002), there is little research that directly tests the effects of means restrictions on people within secure environments. Instead, our understanding of means restrictions in community samples has been generalised to secure environments, including forensic mental health hospitals and prisons. Whilst this may seem logical considering the positive impact of means restrictions on community suicide rates, it is important to question whether community literature is valid amongst the FMHP, as FMHHs rely heavily on restricting access to means to help uphold safety and security (Vollm et al, 2017). Considering the literature presented in Chapter 2 (near-lethal self-harm), that provides conflicting evidence surrounding the motivations and functions of near-lethal self-harm, exploring the impact of means restrictions on forensic mental health populations may provide important explanatory information regarding why people enact near-lethal self-harm without suicidal intent. This highlights a clear need to explore this topic within forensic populations, where despite the effects being poorly understood, the restriction of means underpins a key

element of the self-harm and suicide prevention strategy across all forensic pathways in the UK (Care Quality Commissioners, 2017).

Reflecting on the aforementioned literature (section 2.6.4), which shows that some individuals substitute methods of higher lethality for those of lower lethality in the presence of means restrictions, I began questioning what might happen to the severity of self-harm when access to both high and low lethality methods are restricted. In searching for an answer to this question, it became apparent that we know little about the impact of restricting access to lower lethality means, and early studies have either been unable to conclude what happens when low lethality methods are restricted (Gunnell & Miller, 2010), or have evidenced method substitution to those that pose greater risk to life such as hanging and ligating (Spice & Miller, 2000). This felt concerning considering FMHHs restrict access to both low and higher lethally methods and made me question whether there is sufficient evidence to support such a restrictive practice, or whether it could inadvertently increase the lethality of future self-harm.

When searching for an answer, Dyke et al (2014) questioned the effectiveness of restrictive practices within secure environments and claimed that restrictive interventions might result in further episodes of self-harm. Furthermore, Runeson (2010) argued a key difficulty of restricting access to 'usual methods' is that forensic mental health patients will seek out other, more creative methods. Therefore, according to Sarkar (2011), seeking out creative methods often results in more physically harmful injuries for example swallowing batteries or cleaning fluid when access to paracetamol or blunt objects to cut with is restricted. In doing so, patients in secure forensic services tend to be more secretive about their self-harm behaviours (Uppal, 2009), and many use high-risk methods and refuse to be helped (Sakar, 2011). I wondered whether suggestions from Dyke et al (2014) and Klein (2012) might in part explain why more unusual, potentially dangerous methods of self-harm are found within the forensic mental health population compared to their general population counterparts (Tromans et al, 2019; Robertson, 2018; Klein, 2012; Gitlin et al, 2007; Abraham & Alao, 2005). This includes methods such as ingesting and insertion foreign objects, and occluding of the airways (Klein, 2012). It may also explain why literature has found less incidents of potentially lethal, 'creative' self-harm within open wards (non secure hospitals), compared to secure services as arguably, those nursed within secure services have less opportunity to engage in

common forms of self-harm because of restrictions (Sarkar, 2011).

Having thought about the aforementioned literature in chapters 1 and 2, relating to method selection, restricting access to means and method substitution, I began to consider more seriously that for some individuals, near-lethal self-harm could be motivated by non-suicidal intentions. From my own practise, I know that should this be true, understanding and raising awareness of alternative reasons why forensic mental health patients may engage in unusual, potentially fatal forms of self-harm for reasons other than a desire to die would have significant clinical implications. Despite this, I was unable to find any other research studies that specifically explored the reasons for near-lethal self-harm, and/ or the relationship between restricting access to means and near-lethal self-harm within secure forensic mental health services. Consequently, the scope of the current research was refined, and it became a key aim to address the gap in current literature and understanding. In investigating the reasons for less common, more lethal forms of self-harm amongst the forensic mental health population, I hoped that this thesis could help to guide clinical practise, inform care planning and bolster academic understanding of near-lethal self-harm.

Chapter 3
Why do people self-harm, and how do people die by suicide? Theoretical Frameworks

In an attempt to explain why people engage in near-lethal self-harm this chapter will review widely accepted theoretical frameworks. It is however important to note that currently there is not a specific model that acknowledges or explains life-threatening self-harm as a behavioural construct in its own right. Therefore, to try and make sense of the conflicting evidence presented in the previous chapter regarding the role of suicidal intent in near-lethal self-harm, this chapter will describe three key models and discuss the current literature that evaluates whether they can be applied within a forensic mental health context to explain near-lethal self-harm.

3. Overview

Amongst scientists and philosophers alike, there is a basic assumption that like other animals, human beings possess an innate drive for self-preservation (Nock, 2009). For many, preservation entails living a healthy lifestyle, avoiding dangerous situations, and protecting their bodies from physical harm. Whilst this is true for the majority, there is a subset of people who have a need or a desire to overcome the instinct to protect their bodies and instead enact self-harm (Nock, 2009). The reasons for such behaviour are multifaceted and appear to be the result of an accumulation of ineffective, or maladaptive coping mechanisms, adverse life events, persistent mental illness, and traumatic experiences to name but a few.

The consequences of self-harm and suicidal behaviours are far reaching, which for many, can be felt for a lifetime. Whilst self-harm and suicide have been documented throughout history and much research aimed to explore the functions of and pathways to such behaviour, there remains gaps in our understanding of why self-harm and suicidal behaviours manifest in different ways, or how to effectively predict and prevent them (Nock, 2009). So as academics, clinicians, and members of the wider society, we are left with the challenge of unearthing the answers to the following questions; who are the individuals most likely to overcome such an ingrained instinct to protect and preserve their own lives, why do people engage in behaviour which is often brutal, self-loathing, and dangerous, and how can we best help them to remain safe and desist from such behaviours. These questions are complex but necessary to answer due to the life-long individual, societal, and financial implications of these behaviours.

To try to answer the aforementioned questions, a number of theories have been offered to explain why people engage in non-suicidal self-harm (NSSI), and/or attempt, or die by suicide.

This chapter therefore explores theoretical models as explanatory frameworks for NSSI and suicidal behaviour and reviews research evaluating their validity. In reviewing such theories, the chapter also aims to determine whether such theories can adequately explain why people enact near-lethal self-harm. For the purpose of this chapter only three theories will be discussed at length. This is because many theories are not well validated, only explain one aspect of self-harm and suicidal behaviour, or relate to subgroups, meaning the theory cannot be easily generalised to wider populations. Therefore, this section presents the most influential, well validated working models for NSSI and suicide and determines whether they adequately explain near-lethal self-harm.

3.1. Non-Suicidal Self-Injury

The first theory, The Four-Functional Model (FFM) (Nock & Prinstein, 2004; Nock, 2009; 2010), provides an explanation for why people engage in non-suicidal self-injury (NSSI). The FFM will be discussed within this thesis as in recent years there has been a call for the separation of self-harm and suicidal behaviours. This is on account of literature that supports there are distinct differences between self-harm and suicide, including the motivations underpinning the behaviours (i.e. suicidal intent), and the frequency, severity and lethality of methods (see chapter 2, defining self-harm and suicide). Whilst there is a considerable evidence base to support NSSI and SB as a separate behavioural constructs, as outlined within Chapter 2, there is also growing evidence to suggest some behaviours do not align seamlessly with a dichotomous separation. This includes SB enacted with ambivalence, NSSI that results in death despite being enacted without suicidal intent, and near-lethal self-harm. Therefore, whilst it is still unclear what drives near-lethal self-harm, as literature has shown not all near-lethal self-harm is motivated by suicidal intent, it is important to explore a theory which explains why individuals may harm themselves without wanting to die. The FFM is therefore appropriate to discuss, as within its theory, NSSI is understood to occur without the desire to die. Instead the FFM is rooted within the tradition of behavioural psychology and as such adopts the standpoint that behaviours are caused by the events that immediately precede and follow them (Nock, 2009), i.e. the presence of reinforcing stimuli that increases behaviour, and the removal of reinforcing stimuli that reduces behaviour (Bentley et al, 2014). It is therefore understood that individuals enact NSSI for a range of different reasons including but not limited too, managing emotional distress, to get a response from another person, to elicit feelings during times of numbness, self-punishment, anger, and to achieve a desired goal (Nock, 2009).

Considering these reasons, the FFM posits NSSI is motivated and maintained by one of four reinforcement processes: intrapersonal-negative reinforcement, intrapersonal-positive reinforcement, interpersonal-social-negative reinforcement, or interpersonal-social-positive reinforcement (Nock, 2009). According to the DSM-5 (American Psychiatric Association, 2013), NSSI will be frequent and occur 5 or more times, will involve methods that post low risk to life and will result in injuries that require little or no medical attention. In other words, people will choose to enact NSSI for a reason other than to die, will select methods that they are unlikely to die from, and will inflict injuries that are unable to cause death.

Table 5: The Functions of NSSI (Informed by Nock, 2009)

Function	Reinforcement Process
To alleviate negative internal emotional or cognitive states	Intrapersonal-negative reinforcement
The generation of positive or desirable internal emotional or cognitive states	Intrapersonal positive-reinforcement
Escape from or cessation of social situations and interpersonal demands	Interpersonal-social negative reinforcement
To elicit care or obtain a positive response from others	Interpersonal-social positive reinforcement

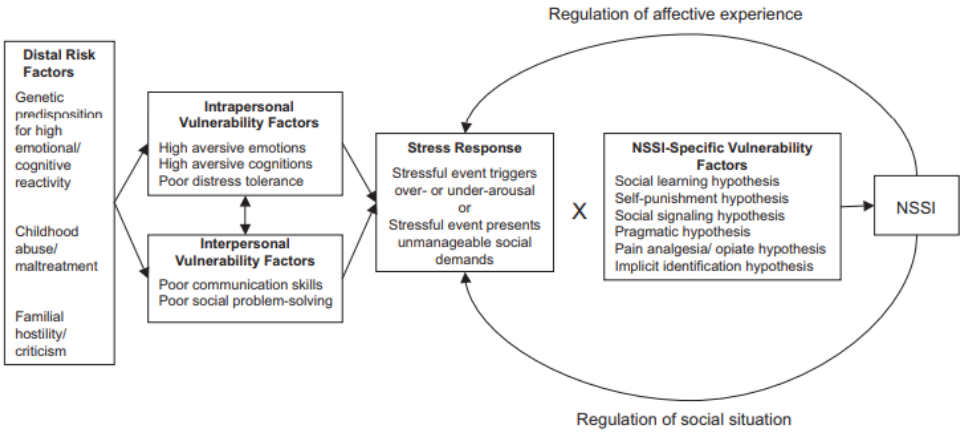
The FFM suggests there are a number of intrapersonal and/or interpersonal vulnerabilities that predispose an individual to NSSI. Literature suggests it is likely such vulnerabilities develop via exposure to early stressors and adverse live events (Nock, 2009). Such experiences include childhood maltreatment (including physical, sexual abuse and emotional abuse and neglect), genetic predispositions, physical hyper-arousal, and parental hostility or criticism (Bently et al, 2014; Klonsky & Moyer, 2008; Weierich & Nock, 2008; Nock et al, 2008c). Arguably, the consequences of such predisposing factors limit an individual's ability to cope with stressful events in an adaptive way, and as a result, some engage in NSSI to manage emotional and/or cognitive experiences (Nock, 2009). Therefore, the vulnerabilities thought to increase the likelihood that someone will engage in NSSI are said to map on to the functions for the NSSI. For example, research shows individual's who use NSSI to reduce negative internal emotions are likely to demonstrate high levels of stress and decreased ability to effectively manage distress (Nock, 2009; Nock et al, 2008c, Najmi et al, 2007). Likewise, an individual who engages in NSSI to elicit care may have experienced parental neglect and as a result demonstrate poor communication and problem-solving skills (Nock, 2009; Hilt et al, 2008a;

Nock & Mendes, 2008). Furthermore, there is evidence to support the relationship between childhood abuse and dissociative symptoms, and NSSI can be used to generate positive or desirable emotional and cognitive states (Intrapersonal positive reinforcement) (Ralis et al, 2012).

There is a significant evidence base to support the FFM of NSSI, (Bentley et al, 2014; Klonsky et al, 2014; Muehlenkamp et al, 2012; Turner et al, 2012; Nock 2008), however to date, much of this research has been conducted within adolescent samples (Zetterqvist et al, 2013; You et al, 2013; Nock et al, 2009; Heilbron & Prinstein, 2008). This is likely due to the increased prevalence of NSSI found amongst young people (Nock et al, 2009), however the lack of validation amongst other populations makes generalising the findings from adolescent populations hard. This includes the forensic mental health populations, where current literature testing the FFM is scant. In fact, to the authors knowledge only one study has directly test facets of the FFM in female forensic patients. The study was supportive of aspects of the theory and found non-suicidal self-injury in female forensic patients was associated with 'active coping' with distressing, or overwhelming emotions associated with childhood trauma and lack of social support (Chapman et al, 2013).

Comparably, the FFM has however been tested more widely amongst the prison population. A systematic review of the prison literature concluded NSSI serves similar functions for adult and young prisoners as it does for members of the general population (Dixon-Gordon et al, 2012). As cited within Nocks FFM (2009), literature most commonly associates NSSI amongst prisoners with regulating emotions, (to alleviate negative emotions, or elicit positive ones), and for social reinforcement (either to elicit a social response from others, or to escape social situations) (Dixon-Gordon et al, 2012). There are however differences in the functions of NSSI between the prison and general populations, and compared to the general population, NSSI is cited far more commonly as occurring with the intention of eliciting a social response (Siebery, 2012; Klonsky, 2007; Power et al, 2005; Whittle, 1997) or influencing their environment (Holmqvist, 2008; Klonsky, 2007). Such findings may be explained by the high prevalence of Personality disorders amongst offending populations, which are characterised by a need for validating responses from others (Fallon, 2003). This research highlights the differences between the general and forensic mental health population, and acts as evidence to support why literature from the general population may not be valid when generalised to forensic mental health patients.

Figure 4: Integrated theoretical model of the development and maintenance of NSSI (Nock, 2009b)



In addition to presenting theory in terms of the functions of NSSI, the FFM also offers a preliminary explanation as to why individuals may select NSSI over other behaviours. Each of the below hypothesis have been generated based on previous literature, although it is advised that further research tests the hypothesis presented within the FFM. Nock (2009) considers there to be six potential explanations for how NSSI develops.

1) Social Learning Hypothesis (individuals learn from other people that NSSI offers a viable way to overcome emotional or cognitive distress and is an effective way to elicit a response and care from others).
2) Self-punishment hypothesis (individuals engage in NSSI as a way of punishing the self – this is particularly true for those who have experienced physical, emotional or sexual abuse and is closely linked to self-hatred, and self-deprecation).
3) Implicit attitude/identification hypothesis (when choosing from a number of possible behavioural responses to a situation, it is suggested that people select behaviours based on their attitudes about, or identification with a certain behaviour. In other words, how an individual identifies with, or what they believe about certain behaviours determines how they react. An example of this is how people choose to cope with stress; some individuals may opt to go running to help alleviate feelings of stress if they identify with this behaviour and believe it to be an effective and viable option. Conversely, an individual who engages in NSSI may possess the attitude that self-injury is the most viable and effective option to alleviate stress).

4) Social signalling hypothesis (individuals learn that engaging in NSSI is an effective form of social communication and eliciting help from others, more so than other methods of communication such as talking, shouting, or crying).
5) Pain analgesia/opiate hypothesis (people who engage in NSSI may have increased tolerance to the pain associated with self-injury. Although Nock (2006) states this area is particularly under researched, it is suggested that individuals who engage in NSSI are either born with, or develop an increased threshold to pain, meaning they can withstand self-injury more easily than others. Additionally, it has been suggested that an increased level of endogenous opiates (endorphins) are found within those who self-injure, which can lead to feelings of euphoria (Van Ree et al, 2000). This may explain why people engage in NSSI find it is effective for escaping negative feelings and inducing positive ones).
6) Pragmatic hypothesis (this hypothesis suggests people engage in NSSI as it provides an effective, and rapid option to assist in the regulation of cognitive and emotional distress, which is easily accessible. Arguably, this is most applicable to adolescent samples however Nock (2009) suggests it is also suitable for individuals with less access to alternative methods of regulation such as alcohol, drugs, or communicating their problems).

As presented within Chapter 2 (table 5: Reasons for Near-Lethal self-harm), all of Nock's hypothesised reasons for NSSI, have also been cited as reasons why people enact near-lethal self-harm. This is interesting as it acts as conflicting evidence for near-lethal self-harm being solely motivated by suicidal intentions and lends support to literature that highlights the shared functions and reasons for both NLSH and NSSI (see chapter 2, defining self-harm and suicide). This is important as currently the majority of literature pertaining to the prison population posits that NLSH is in fact a failed suicide attempt, enacted with the intention and desire to end life.

Considering the literature presented above, it would appear aspects of the FFM may provide an adequate explanation of why some women would engage in NSSI whilst in the care of forensic mental health services. However, despite providing a well evidenced explanation for why people enact NSSI, the FFM fails to explain why and how some people who engage in NSSI go on to die by suicide, despite NSSI being proven to be the strongest predictor for future attempts and suicide above all other known risk factors (Bergen et al, 2012). This is because the FFM does not account for the fact that some individuals may employ more lethal methods despite not being driven by suicidal intent (see Chapter 2, defining self-harm and suicide). This

is particularly true for women receiving forensic mental health care as it is difficult to be sure whether these women are suicidal as their access to many means of lower lethality self-harm is restricted (see chapter 2, section 2.7). This may mean that for some, they enact NSSI but do so using methods that are available, (e.g. occluding the airways with hair) which pose higher risk to life (Sarkur, 2011) (see chapter 6, section 6.5).

Despite this, some women do enact suicidal behaviour with the intention of ending life. Therefore in the presence of near-lethal self-harm using methods that pose high risk to life, to try and make sense of why one may enact near-lethal self-harm it may prove helpful to consider theories of suicide.

3.2 Theories of Suicide

In light of the evidence that suggests that for some NLSH occurs with suicidal intent, it is important to consider how and why people engage in behaviour that is lethal enough to bring about death. If NLSH is underpinned by suicidal intent, exploring theories of suicide may prove helpful in understanding the pathways to NLSH, which in turn is advantageous for appropriate targeting and preventing future behaviour.

Over the last three decades, academics and clinicians alike have offered many theories of suicide, which have influenced our understanding of both the etiology, and development of suicidal behaviour (O'Connor et al, 2016). Amongst these, cognitive, biological, and social explanations have been provided to help clarify the pathways between suicidal ideation and suicidal behaviour. Notably, Durkheim (1897) published one of the first theories of suicide, claiming suicide was a result of social and structural factors. Such factors are conceptualised in two domains, social integration (the social ties one has to others), and moral regulation (the way societal rules and norms affect an individual) (Stanley et al, 2016). According to Durkheim, individuals who are not meaningfully tied to other members of society experience depression and feelings of meaninglessness, which can ultimately lead to suicide (Stanley et al, 2016). Durkheim's theory of suicide (1897) has been praised for its ability to conceptualise suicide as a societal issue and explain phenomena such as seasonal variation in suicide (Christodolou et al, 2012), increases or decreases in the number of suicide during crisis or 'times of coming together' (Joiner et al, 2006; Joiner, 1999), and cross-cultural differences in suicidal behaviour (Shah et al, 2007). Despite this, whilst Durkheim's theory was without doubt influential, clearly it does not capture the highly individualised nature of suicide (Stanley et al, 2016).

Table 6: Durkheim's Types of Suicide (adapted from Stanley et al, 2016).

Type	Description
Altruistic	When an individual believes their suicide would contribute to the society they are highly integrated in.
Egoistic	When an individual is lacking social bonds and integration and ties with other people.
Anomic	Suicide occurs during times of hardship when there is not adequate social regulation (e.g. during financial crisis).
Fatalistic	Suicide is the result of excessive social regulation and oppressive discipline (e.g. prisoners)

Considering the individual nature of suicide, other theories emerged that considered the role of cognitive vulnerabilities and stress (Diathesis-stress-hopelessness model of suicidal behaviour, Schotte & Clum, 1987) and psychological pain (Psychache, Schneidman, 1993). Between them, the theories encompass a plethora of risk factors, cognitive processes, personality traits and trigger events, known to increase the risk of suicidal behaviour. Such theories are however critiqued as they overemphasise the individualised nature of suicide and simplify the role of society and relationships (Stanley et al, 2016). Therefore, whilst seminal theories were helpful, more recently the most credible theories of suicide are those that aim to combine the idea of societal influence and individual risk factors and consider the impact of both on suicidal behaviour. Such theories include Baumeister's escape from self model (1987), Williams Arrested Flight Model (2001), The Cry of Pain Model (Williams & Pollock, 2001) and Joiner's Interpersonal-Psychological Model (2005).

Whilst individual elements of the aforementioned theories have been linked to suicide, (e.g. hopelessness, psychological pain, negative effect), O'Connor (2011) argued that none are able to combine the individual and social processes into one informative model, to comprehensively explain how suicidal ideation develops and translates to suicidal behaviour. This is concerning as theoretical frameworks are used to inform public health initiatives, suicide prevention policies, and clinical practise. Furthermore, without fully understanding the transitional period between suicidal thoughts and suicidal behaviour, arguably we are unable to fully understand or explain behaviours that lie somewhere between self-harm and attempted suicide, including near-lethal self-harm.

As a result, in order to achieve a broader theory, new models often adapt, or extend older theories and integrate them into updated versions. One such example of this is the Integrated

Motivational-Volitional Model of Suicidal Behaviour (IMV) (O'Connor, 2011). The IMV draws influence from a number of models, including the Diathesis-Stress Model, (Schotte & Clum, 1987), the Arrested Flight Model, (Williams, 2001), the Theory of Planned Behaviour (Ajzen, 1991), which posits, "the proximal predictor and any behaviour is one's behavioural intention or motivation to engage in the behaviour" (O'Connor, 2016, p.223), and The Interpersonal-Psychological Model of Suicide (Joiner, 2005). In short, the IMV posits a range of social norms, attitudes and behavioural control influence one's intention, and these factors are likely to inform the distinction between suicide ideation and enacting suicidal behaviour. As the IMV integrates aspects of the Interpersonal-Psychological Model of Suicide (Joiner, 2005) (IPMS), to be able to fully understand the IMV it is important to review the literature that supports of refutes the IPMS. This is because the IMV may offer some helpful ideas, which may help to explain how NLSH develops as the IMV describes the development of suicidal behaviour as a progressive process, whereby self-harm behaviours can escalate and change into suicidal behaviour. Arguably this supports the idea of NSSI and SB existing upon a continuum of behaviours, upon which NLSH can exist.

Table 7: Predominant models of suicidal behaviour, adapted from The International Handbook of Suicide Prevention, (2016).

Author	Model	Summary
Beck and Colleagues (1985)	Hopelessness Theory	Core reason for suicide is hopelessness (negative and fatalistic views about the future and an inability to see a way to improve the future).
Schotte & Clum (1987)	Diathesis-stress-hopelessness model of suicidal behaviour	Cognitive vulnerability (e.g. poor social problem solving) accounts for the relationship between stress and suicide risk
Baumeister (1990)	Suicide as escape from self	Fundamental reason for suicide is to escape painful self-awareness
Schneidman (1993)	Suicide as Psychache	Suicide is caused by 'psychache' or intense psychological pain, anguish and hurt, caused by unfulfilled, frustrated or thwarted psychological needs.
Williams (2001)	Arrested Flight Model	Suicide risk is greatest when defeat and entrapment are high, and the potential for rescue is low
Williams & Pollock (2001)	The Cry of Pain Model	Suicide should be seen as a 'cry of pain', resultant from a strong perception of entrapment, and a desire to escape one's situation.
Joiner (2005)	Interpersonal-Psychological Model	Suicide ideation is the result of high levels of thwarted belongingness, and burdensomeness. Translates to suicidal behaviour only when the individual has the capacity (facilitated by overcoming fear of death through habituation to pain)
Wanzel & Beck (2008)	Differential Activation Theory of Suicide	Diathesis-stress model with 3 main constructs: dispositional vulnerability factors, cognitive processes associated with psychiatric disturbance, and cognitive processes associated with suicidal acts
O'Connor (2011)	Integrated Motivational-Volitional Model of Suicidal Behaviour	Diathesis-stress model, which posits specific pre-motivational, motivational and volitional phases of suicidality.
Klonsky & May (2015)	The Three Step Theory (3ST) of Suicide	Suicidal ideation can translate to suicidal behaviour in the presence of pain, hopelessness, and disconnectedness

3.2.1 The Interpersonal-Psychological Model of Suicide (IPMS)

To make sense of the Integrated Motivational-Volition Model of Suicidal Behaviour (IMV), there are three fundamental concepts that one must understand. These are: thwarted belongingness (an extreme disconnection to others), a high sense of burdensomeness (feeling you are a burden to others), and the capacity to enact suicidal behaviour (the ability to attempt suicide). Each of these factors are important facets of the IMV, and their relationship with suicide was initially outlined, explained and tested within the Interpersonal-Psychological Model of suicide (Joiner, 2005). According to the IPMSS, for suicide to occur, an individual must experience thwarted belongingness and high-perceived burdensomeness simultaneously, and the same individual must have the capacity, or capability to attempt suicide. In summary, thwarted belongingness, paired with high burdensomeness can cause suicidal ideation to develop, and having the capacity to enact suicide facilitates the translation of suicidal ideation into suicidal behaviour. As a result, very few people who think about suicidal actually want to die by suicide, and even fewer people who want to die by suicide actually have the capacity to do so (Van Orden et al, 2010).

According to the Interpersonal-Psychological Model of Suicide (IPMS) (Joiner, 2005), thwarted belongingness (an extreme disconnection to others), is a multifaceted concept, which develops through feelings of loneliness and a perceived lack of reciprocal care (Van Orden et al, 2010). Typically, people who experience thwarted belongingness are those with few social connections, such as marriage, children, or friends, are likely to have experienced domestic, childhood abuse, or familial discord, and may have spent time in custody (Mae et al, 2016; Cukrowicz et al, 2013; Szanto et al, 2012; You et al, 2011; Van Orden et al, 2010; 2008; Hill, 2009; Joiner, 2005). The separation from others, and the genuine belief that there is no one to offer support during times of distress or difficulty, result in extreme feelings of isolation and loneliness (Joiner, 2005). Thwarted belongingness is thought to be a dynamic cognitive state, due to its dependence on both interpersonal and external influencers, meaning it can change in intensity over time (Cacioppo et al, 2006). It is possible that thwarted belongingness may play a role in the development of suicidal ideation as often women in forensic mental health services have few lasting social connections (Mandracchia & Smith, 2015). This is firstly because due to the very nature of incarceration and detainment, being in forensic mental health hospitals thwarts belongingness through physical separation from social support, which is known to contribute to feelings of loneliness (Brown & Day, 2008). Furthermore, prior to their inpatient stay it is common for women in forensic services to have spent time in prison,

meaning many will have experienced long periods of separation from their family and friends (Mandracchia & Smith, 2015).

Burdensomeness, particularly the feeling of being a burden to one's family, has been shown to be fundamental in the etiology of suicide (Van Orden el al, 2010). The IPMS posits individuals who experience unemployment, homelessness, physical illness, and have spent time within custody, are most likely to develop feelings of burdensomeness. The relationship between burdensomeness and suicidal ideation is well evidenced amongst adult, adolescent and undergraduate populations (Hagen et al, 2016; Buchman-Schmitt et al, 2014; Cukrowicz et al, 2013; Bryan et al, 2012; Kanzler et al, 2012; Conner et al, 2007; Joiner et al., 2002; Van Orden et al, 2006; Van Orden et al, 2008). Amongst incarcerated populations, perceived burdensomeness has also been shown to be particularly relevant to suicidal behaviour, based on the personal, familial and societal costs of offending (Mandracchia & Smith, 2015). Arguably, the costs of incarceration are felt most amongst one's social network as being in prison places financial and emotional burdens upon close family and friends (Mandracchia & Smith, 2015). For women, such burdens are felt particularly strongly as detainment means mothers are unable to care for their children (Corston, 2008). For some, this may mean family members or older children taking responsibility of young ones, or sadly in many cases, children are adopted or looked after by the state (Corston, 2008). Considering the evidence, it is therefore clear to see how incarceration and detainment promotes perceived burdensomeness (Mandracchia & Smith, 2015) and how it might play a role in the development of suicidal ideation amongst women receiving forensic mental health care.

Interestingly, recent findings from two systematic reviews (Ma et al, 2017; Chu et al, 2017) conclude that perceived burdensomeness is likely to be a more robust indicator of suicide risk than thwarted belongingness. However, according to the IPMS, the intensity of thwarted belongingness is no greater than when experienced simultaneously with high levels of perceived burdensomeness (Hagen et al, 2016; Christensen et al, 2014; Pettit et al, 2013; Leopoulos & Vincent, 2013; Van Orden et al, 2008), as concurrently experiencing thwarted belongingness and perceived burdensomeness can contribute to as sense of hopelessness about ones ability to overcome and manage their external situation (i.e. homelessness, unemployment or incarceration). This is important as Chapman et al (2013), found hopelessness to be strongly associated with suicide attempts amongst the forensic mental health population. Therefore, for some, suicide can become the only viable option for resolving their interpersonal and external problems and many believe their death will be beneficial for others (Brown et al, 2002; Joiner et al, 2002; Filiberti et al, 2001).

Whilst the concurrent occurrence of thwarted belongingness and burdensomeness are sufficient to facilitate suicidal intent, according to the IPMS, these factors alone are not enough to cause a movement between intent and suicidal behaviour. For this to happen, an individual must possess the capacity to enact suicidal behaviour. Therefore, whilst some may wish to end their lives, the pain and fear associated with suicide prevents individuals from engaging in behaviour that is serious enough to bring about death (Joiner, 2005). As a result, an individual must acquire the capacity to enact lethal self-harm, which is thought to occur through repeated exposure to painful or fearful experiences. The IPMS posits that during repeated exposure, the fear and pain associated with death diminishes, and an individual's pain tolerance increases (Hagen et al, 2016). Only when an individual experiences suicidal intent (facilitated by thwarted belongingness and perceived burdensomeness) and has overcome the fear and pain associated with suicide does a suicide attempt occur (Joiner, 2005).

Acquiring capability is thought to occur in a number of ways, including engaging in repetitive NSSI and exposure to events whereby there was the potential for serious injury or death, including physical, sexual and emotional abuse and domestic violence (Bryan et al, 2013; Van Orden et al, 2010; Riberio & Joiner, 2009). Literature has also proven a pathway to acquired capability for suicide via frequent NSSI and suicide attempts (Glenn et al, 2014; Joiner et al, 2012; Van Orden et al, 2008). In fact, the IPMS conceptualises the main role of NSSI as building the acquired capability for suicide (Assavedo & Anetis, 2015). Both pathways to acquired capability are of particular relevance to the female forensic mental health population, as it is well known the rates of childhood adverse life events and sexual, physical and emotional abuse are high (see chapter 1, risk factors for suicide). This may mean that women with trauma histories and previous NSSI are more capable of engaging in dangerous forms of self-harm.

Interestingly, despite the IPMS emphasising capacity to enact lethal self-harm as the key factor facilitating the transition between suicidal ideation and behaviour, literature suggests it is the least evidenced part of the model (Ma et al, 2016). Furthermore, when capability has been explored, the findings have been mixed. In a recent literature review Chu et al (2017) found 100% of prospective studies examining acquired capability and suicidal behaviour reported a significant association, yet only 40% of cross-sectional studies report significant associations with suicide (Chu et al, 2017). Such findings may be explained by the overrepresentation of undergraduate students (Chu et al, 2017; Zurmoski & White, 2015; Wong et al, 2011), and military veterans (Silva et al, 2017; Monteith et al, 2013; Bryan et al, 2010; Selby et al, 2010),

meaning findings may be skewed towards a population who are likely to have fewer provocative experiences, or towards those who are known to be at greater risk of suicide (Chu et al, 2016).

Whilst aspects of the IPMS appear useful in explaining how women in forensic services may enact suicidal behaviour, the IPMS has been criticised with two large systematic reviews claiming there is insufficient evidence supporting the relationship between the theory's main constructs (Ma et al, 2016; Wachtel & Tesimann, 2013). Instead, Ma et al (2016) and Wachtel & Tesimann (2013) argue there is more evidence to support the independent relationships between thwarted belongingness, perceived burdensomeness and acquired capability with suicidal behaviour than there is for the theory as a whole. Considering such evidence, this may mean that whilst together under the right circumstances the three facets of the theory can contribute to suicide risk, each facet may also work independently of suicidal intent. This may explain how women in forensic mental health services develop the capacity to enact near-lethal self-harm but do so without suicidal intent.

The IPMS is also limited in that it fails to specify why some people who possess all of the components for suicide do not go on to attempt, or indeed die by suicide. Arguably, this is because the IPMS does not fully explain the pathway from suicidal ideation and suicidal behaviour. Chu et al (2017), Ma et al (2016) and O'Connor, (2011) suggest this may be because the IPMS does not consider the likelihood that other factors mediate this transitional period, including many of those outlined in Chapter 1 (risk factors for suicide), including anger, major depression, PTSD, adverse childhood experiences and abuse, maladaptive perfectionism and negative coping style (Ma et al, 2016). This is an important oversight as arguably understanding moderating factors between suicidal intent and behaviour is an essential part of being able to not only distinguish between individuals who will experience suicidal intent and those who will go on to attempt suicide, but better identify when such behaviour will occur (Chu et al, 2017; Ma et al, 2016).

3.2.2 The Integrated Motivational-Volitional Model of Suicidal Behaviour (IMV)

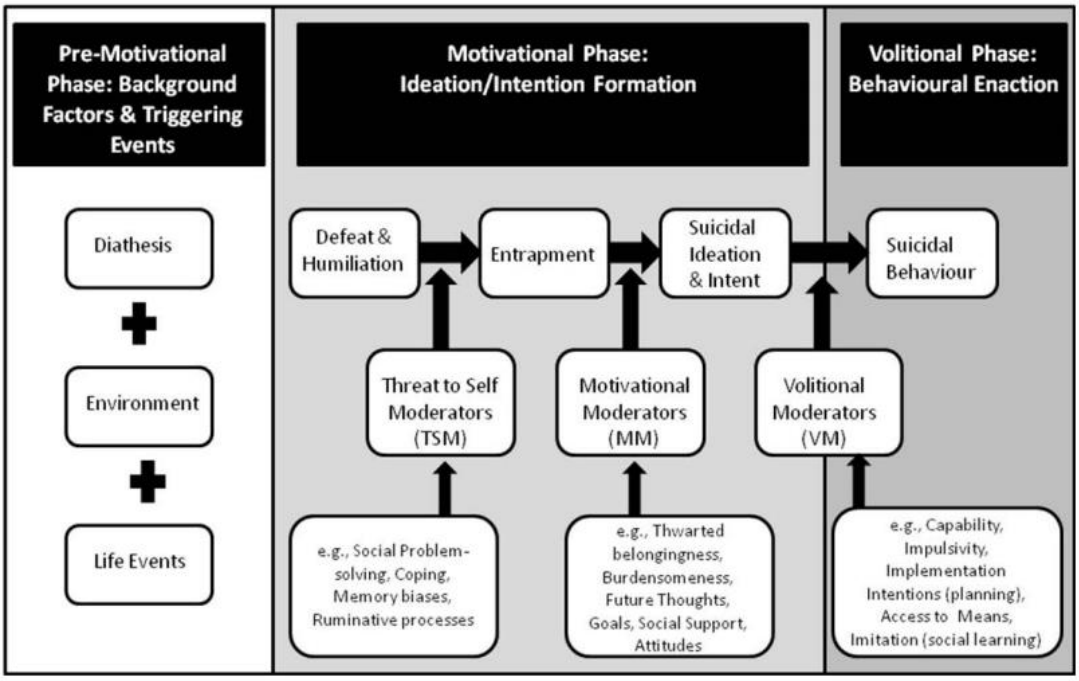
Considering the limitations of the IPMS, and its overlooking of predisposing factors that may moderate the transitional period from suicidal intent to behaviour, O'Connor et al (2011) developed the Integrated Motivational-Volitional Model of Suicidal Behaviour (IMV). The IMV is three-phase model, which explains how individuals develop suicidal ideation, (the motivational phases), and how suicidal thoughts and ideation can translate into suicidal behaviour (volitional phase). A crucial underpinning of the IMV is the notion that suicidal

ideation and suicidal behaviour develop separately, meaning both elements are distinctly differently (O'Connor et al, 2016). Through offering the IMV, O'Connor (2011) hoped that it would provide a basis to improve the identification of those at risk of suicidal ideation, and those at risk of engaging in suicidal behaviour. This is important as our ability to predict who will think about suicide, and those who will go onto enact suicide is limited (Klonsky & May, 2014; O'Connor & Nock, 2014).

The IMV is important to consider within this thesis as it conceptualises suicidal behaviour as something that develops over time, and occurs as a result of predisposing vulnerabilities, and social, environmental and individual factors. It also acknowledges that as suicidal behaviour develops over time, the lethality and severity of self-harm incidents can escalate as the capacity to enact life-threatening behaviour develops. Although it has never been directly tested, the idea that self-harm and suicidal behaviour develops, changes and escalates with time means it may be possible to use the IMV to try and explain how near-lethal self-harm may develop without suicidal intent.

The IMV posits that there are a number of background factors and trigger events that predispose an individual to developing suicidal intent. This is known as the pre-motivational phase and relates to many of the proximal and distal risk factors outlined in Chapter 1 (contextualising the research), including external social stressors and prominent life events. These can include poor mental health, deprivation, relationship breakdowns, bereavements, loss of employment, and detention within custodial, or forensic mental health settings. Combined, the pre-motivational vulnerabilities form the basis from which suicidal ideation can develop. Without these, individuals are unlikely to move through the phases of the model, meaning they will not enact suicidal behaviour (i.e. behaviour that has the potential to bring about death). As a result, the factors detailed within this phase can provide a useful predictive grounding to identify those who may be at risk of suicide (O'Connor, 2011). Whilst the aforementioned pre-motivational factors are known to be significantly related to suicidal intent within community populations, it is important to question how likely such factors will help distinguish which women in forensic mental health services are at risk. This is because whilst amongst the general population such risk factors are less common, such predisposing factors will feature in the histories of almost all women in forensic mental health services. This therefore questions how effective the IMV is to inform our understanding of who is at risk within secure environments.

Figure 5: The Integrated Motivational-Volitional Model of Suicidal Behaviour (O'Connor, 2011)



The motivational phase, (or the 'thinking' about suicide phase), incorporates three main factors or feelings, which assist in the development of suicidal ideation. The first factor is the feeling of defeat and humiliation, which according to the IMV develops because of acute external stressors (loss of employment, incarceration, relationship breakdowns etc.). Having been influenced by the Cry of Pain Theory (Williams & Pollock, 2001), according to O'Connor (2011), the strength to which an individual feels defeat or humiliation is determined by background factors, including what we think others expect from us. In the presence of 'threat to self-moderators', (which include poor coping strategies, lack of problem solving abilities, and ruminative processes), for some, the feelings of defeat and humiliation (caused via an external social stressor or change in existing stress levels) can trigger feelings of entrapment. Entrapment relates to the perception that an individual is trapped by their circumstances and feeling there is no way to resolve life issues. Several motivational moderators can exacerbate the perception of entrapment, including being unable to conceive the possibility of a positive future and not being able to set future goals, which is related to suicidal ideation and intent (O'Connor, 2011). In line with the Interpersonal-Psychological Theory of Suicide, thwarted belongingness (extreme disconnection to others, loneliness, and not feeling supported by others), and burdensomeness (feeling that you are a burden to your family, and your social network) are both important motivational moderators. In light of the feeling of entrapment and in the presence of negative motivational moderators, for some people, suicidal behaviour

becomes a valid solution to resolving their personal and external circumstances, resulting in suicidal ideation.

The translation of suicidal thoughts to suicidal behaviour is explained within the volitional phase, whereby the capacity to enact suicide (as explained by the Interpersonal Theory of Suicide, Joiner (2005)), impulsivity, fearlessness about death, exposure to self-harm by family and friends, access to means, and planning all play important roles. These factors are known as volitional moderators, and as with threat to self-moderators and motivational moderators, each factor facilitates, or obstructs the likelihood of the movement from the motivational stage to the volitional phase. O'Connor (2011) defined a volitional motivator as "any factor that bridges the suicidal intention-behaviour gap, i.e. any factor that renders it more or less likely that an individual will act on their suicidal intent".

Whilst the volitional phase incorporates theory from the Interpersonal-Psychological Theory of Suicide (Joiner, 2005), unlike the IPMS, the IMV provides more detail into the factors that moderate the transition between suicidal intent and suicidal behaviour. These factors are important to understand, as large-scale studies have found the factors associated with the volitional phase are independent from those in the earlier phases of the model (O'Connor et al, 2012; Dhingra et al, 2015). In other words, only the factors present in the volitional phase are able to distinguish between those who desire suicide and those who will attempt suicide. Specifically, impulsivity has been shown to distinguish between adolescents (Madge et al, 2011; O'Connor et al, 2012) and adults, as were exposure to self-harm by friends and family, and fearlessness about death (Dhingra et al, 2015). These findings have important implications in terms of prediction, and indeed prevention, however, as with all theories in their infancy, further testing is required to validate the IMV across a range of alternative populations, specifically in terms of which other volitional moderators have predictive power for distinguishing which individuals that think about suicide will enact it (Kirtley et al, 2016). This is important as many women within forensic mental health services meet the necessary requisites for suicidal behaviour, yet not all women will attempt or die by suicide.

Despite the need for further validation among the forensic mental health population, if NLSH is enacted with suicidal intent, the IMV may provide a well-evidenced explanation for why individuals enact NLSH. Considering the literature outlined in Chapter 2, Defining Self-harm and Suicide, this is however not the case. Therefore, the IMV only works on the premise that individuals want to end their lives and does not account for situations where people enact behaviour that looks similar to a suicide attempt but do so without suicidal intent or with

ambivalence about living or dying. It is therefore important to clarify the functions for and pathways to near-lethal self-harm prior to understanding fully whether the IMV can adequately explain such pathways.

3.3 Concluding thoughts and reflections

In general, our understanding of how and why self-harm and suicide occurs is respectable. Many theories have been presented and tested in a variety of community populations and have adapted as academic and practical knowledge has advanced. Despite this, there is a shortage of testing of such theories within the forensic mental health population (FMHP). In total, I only found two studies that directly tested current theory, specifically in forensic mental health services (Kene & Hovey, 2014; Champan et al, 2013). Both studies offer support for various aspects of current theoretical frameworks, however further work is required to rethink current models and incorporate factors known to be specific to the forensic mental health population (Ireland & York, 2013; Dear et al, 2000). This includes the impact of psychiatric disorders and restricted access to means. Instead, the majority of research testing psychological theories of suicide with offending populations (albeit limited in itself) correlates almost exclusively to prisoners detained within the custodial estate (Slade et al, 2014; Slade & Edelman, 2013; Ireland & York, 2012; Pereira et al, 2010). This means it remains unclear whether current theories appropriately explain self-harm and suicidal behaviours within the female forensic mental health population. This highlighted an important gap within the literature as current theories have been designed and tested on populations that are far less risky than the FMHP. This means the behaviours amongst the forensic mental health population are more common, making it harder to identify people at risk. Therefore, without adequate testing within the forensic mental health population, it is questionable whether current theories can be appropriately translated to the FMHP.

Despite all three theories presented within this chapter offering valid reasons as to why someone may enact NSSI or suicidal behaviour, currently the theories require a dichotomous split between either behaviour being NSSI or SB. This means that due to their rigidity and reliance on a 'with or without' suicidal intent approach, currently none of the aforementioned theories account for self-harm and suicidal behaviour enacted by people experiencing ambivalence, or for people who enact NLSH without suicidal intent. This therefore highlights an important need for research to explore the functions of and pathways to near-lethal self-harm amongst the female FMHP, in a bid to inform a specialised theoretical model that better explains near-lethal self-harm.

Chapter 4: Methodological Framework

4. Overview

This chapter will describe and provide a rationale for the overarching methodological research framework. It will review the current literature that supports Participatory Action Research (PAR) and discuss its place within health and psychological research. This chapter will also outline the epistemological standpoint of the research and provide a critical reflection on designing and conducting a PAR design project within forensic mental health services.

4.1 Methodological Framework: Participatory Action Research

Qualitative research integrates observation, documentation, analysing, and interpreting characteristics, patterns, attributes, and meanings of human phenomena (Gillis & Jackson, 2002; Leininger, 1985). Through qualitative inquiry, it is possible to broaden understanding into complex human behaviours, as it places importance on human experience as a whole and the meanings that individuals place upon living such an experience (MacDonald, 2012, Mason, 2006; Lincoln, 1992). Gilbert (2001) posits that the role of a qualitative researcher is to uncover the world through the eyes of other people, without manipulating or influencing the findings (Leininger, 1985). Participatory Action Research (PAR) originates from the work of Kurt Lewin, who was concerned with helping minority groups seek and achieve "independence, equality, and co-operation" (Lewin, 1946). Maguire (1987) described PAR as "a method of social investigation of problems, involving the participation of oppressed and ordinary people in problem posing and solving" (p.29). At its core, PAR is democratic, equitable, liberating, and life changing (Kach & Kralik, 2006), and is underpinned by two fundamental assumptions. Firstly, people who live and work within their communities are capable of participating actively in research. Secondly, the research being conducted ought to make a concerted effort to bring about change and make improvements to the current practises within the communities that the research participants find themselves (Kemmis et al, 2014; Creswell et al, 2007; Gillis & Jackson, 2002).

Unlike many other frameworks, Participatory Action Research (PAR) facilitates research in a way that plays close attention to nurturing equal power relationships between the researched and the researcher (Gibson, 2002). PAR emphasises that in order to achieve community informed change, researchers must prioritise the power balance and blur the boundaries between the researcher and the researched, by immersing those with pertinent life experiences in the research design, procedure, and analysis (Baum et al, 2010). PAR achieves

this through fostering the capacity, empowerment, social justice, and participation of individuals and groups within the community (Vollman et al, 2004). This is achieved by the researcher remaining open and responsive to feedback, criticism, and suggestions from the community to maximise the involvement of everyone throughout the research process (MacDonald, 2012; O-Brian, 2001). This approach chimes seamlessly with the notion of patient and Public involvement (PPI), which now features heavily in government initiatives, including those from NICE and Public Health England. The involvement of service users and the public can be mutually beneficial for those affected by the research and the hosting organisations. Many service users report feeling valued as a consequence of taking part in research that is meaningful for their communities, (Newell & South, 2009), which has been shown to result in feelings of empowerment (Nierse et al, 2011; Walmsley & Mannan, 2009; Cotterell, 2008; Hewlett et al, 2006; Couplan et al, 2005). PPI can also improve the relationships between service users and care providers, with many citing improved trust in care organisations as they view them as honest and transparent about the issues affecting them (Minogue et al, 2005; Dickson et al, 2001).

In keeping with PPI, those who seek to use a PAR framework must adopt the standpoint that community members have a unique ability to participate in research because those who live within the realms of the phenomena being studied have first-hand, pertinent lived experience, which outsiders do not possess (Kemmis et al, 2014; Baum et al, 2010). It is through this valuable insight into the challenges faced by members of underrepresented or disenfranchised communities, that PAR enables researchers to understand and change the world in which the participants live (Sullivan & Skelcher, 2017; White et al, 2004). Whyte (1991) posits such change can only occur when problems are identified, defined and resolved within the community, as typically researchers are outsiders of the community meaning they are unlikely to possess firsthand knowledge of the problems the community face (Greenwood & Levin, 1998). Therefore, PAR seeks to empower members of their communities to act as experts in their own lives (Livingston & Nijdam-Jones, 2013). Through doing so, PAR projects can facilitate the generation of new, rich and deepened understanding to facilitate socially relevant change and improve the issues affecting the daily lives of the community under study (Livingston & Nijdam-Jones, 2013; Schneider, 2012; van Der Velde et al, 2009; Minkler & Wallerstein, 2003; Birbich, 1999; Whyte et al, 1989).

According to Selenger (1997), there are seven fundamental components to research using PAR.

- Any problem that forms the basis of research must originate within the community in which the problem arises. Through the generation of knowledge, the problem must be defined, analysed, and solved by the community.
- PAR must seek to improve the lives of the individuals under study and change the social reality of its participants for the better.
- Research using PAR must involve the participation of the community it seeks to understand in each stage of the project.
- A project that uses PAR must embark on research that involves a range of disempowered people, including the oppressed, marginalised, exploited, and the impoverished.
- Research that adopts a PAR approach must lead to the development of self-confidence and self-reliance of individuals within the community.
- PAR facilitates the generation of authentic, accurate analysis of social reality.
- The researcher must be committed to their participation in the research, and be passionate about learning, developing and facilitating change.

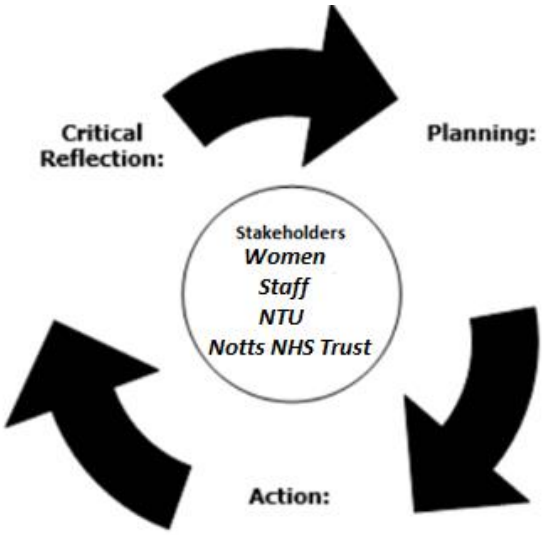
According to Kelly (2005), PAR makes use of standard research techniques and provides an overarching framework for engaging a community under study (Kidd & Kral, 2005). Typically, qualitative methods are employed for PAR projects, and an inductive approach is taken (Smith, 1997). However, quantitative methods also have a valuable place within a PAR projects (Smith, 1997) and the framework does lend itself to the deductive approach whereby the findings of a PAR research project (theory, and relationships) can be tested. This is important as it bolsters the validity of PAR as a research method framework.

PAR is conducting using a cyclical approach, and takes place over three key phases - planning, action, and critical reflection (Ward & Bailey, 2013). The planning phase of PAR involves the identification and initial assessment of the community, finding a community partner or hosting organisation and liaising with as many individuals and groups within a community (Kelly, 2005). The planning phase is essential for building relationships and facilitating the community's involvement in the research (Kelly, 2005). During the planning phase of a PAR project the meetings, discussions, and interviews assist in the identification of the problems faced by the community, and shape how the research is led (Kidd & Kral, 2005).

The action phases of a PAR project are less focussed on determining the research questions or the answers being sought and is instead focussed on solving the original problem (Kidd & Kral, 2005). During the action phase the researcher aims to ensure all participant voices are

represented and seeks to create the knowledge and understanding to create social change (Kelly, 2005). Action can take many forms however it essentially encompasses "any efforts to remove some impediment that hampers the growth of a group of people" (Kidd & Kral, 2005). PAR researchers are urged to be continually critically reflective throughout the project and encourage the community to assess the progress of the research (MacDonald, 2012). During the critical reflection stages the group should collectively decide how the outcomes of the research and any health promotion efforts are disseminated within the community (Kelly, 2005). A research project is likely to go through many PAR cycles as the research develops, refines and targets specific problems or challenges faced by the community under study.

Figure 6: The Participatory Action Research Cycle



4.2 Rationale for Participatory Action Research

Over the last decade, support for the utility of PAR within health research has grown. This is in part because it aligns seamlessly with the underpinnings of public and patient involvement (PPI) - an internationally widespread focus for health research (Gillard et al, 2010). The foundations of PPI mirror those of PAR and stem from the concept that those with first hand, lived experience of the phenomena under study are able to provide unique insight and enrich our understanding in a way which is otherwise unavailable from those not directly affected (Rose, 2003). PAR has proven to be a successful research approach across a number of disciplines including health, psychology, education, community development, and social work (Young, 2006; Varcoe, 2006; Greenwood et al, 1993; Selener, 1997; Maguire, 1987). PAR has also demonstrated its suitability amongst many marginalised populations including; young people (Jervis et al, 2015; Kornbluh et al, 2015; Cammarota, 2010), women (O'Neill et al, 2017;

Kempadoo et al, 2015; Gretzinger et al, 2015), ethnic minorities (Sinclair, 2018; Corrigan et al, 2015), and refugees and migrants (Gilhooly & Lee, 2017; O-Reilly-de Brun et al, 2015). Whilst previously PAR featured more commonly in physical health research, more recently it has been shown to be an effective methodology to engage prisoners (McInerney et al, 2013; Giblin et al, 2012; Hatton & Fisher, 2011; Martin et al, 2009; Fields et al, 2008) and community and inpatient mental health samples (Michalak et al, 2016; Speers et al, 2015; Tambuyzer et al, 2014; Issacs et al, 2010; Gillard et al, 2010; Knightsbridge et al, 2006; Lipscomb et al, 2006; Linhorst, 2002). In particular, using the first-hand insight of service users for the planning, delivery, and evaluation of mental healthcare has received attention (Hitchinson & Lovell, 2012; Collier & Stickley, 2010; Warner, 2010; Linhorst, 2002). This being said, the application of PAR in forensic mental health settings remains largely absent (Livingston et al, 2012).

Having conducted an extensive literature review, to the best of the authors knowledge there are only six research studies that adopt a PAR methodology to engage the forensic mental health community within secure hospitals (Livingston & Najidam-Jones, 2013; Livingston et al, 2013; Livingston & Najidam-Jones, & Brink, 2012; Gill et al, 2010; Cook & Inglis, 2008). Of these studies, five used a mixed sample of males and females and one used a female only sample (Long et al, 2013). In each case, the studies included either patient only, or staff only participants. None of the studies involved both patients and staff. The focus of each PAR study in forensic mental health services was to explore perceptions of care, evaluate current practice, services, or treatment and identify ways to improve engagement of patients in research and recovery treatment. None of these studies explicitly used PAR to study a particular behaviour, nor did they use it to inform a new approach for assessing behaviours. One further study emerged from the literature review; however, the study took place using forensic patients who were cared for within the community (Jacobs et al, 2010). Evidentially, there is a dearth of research using PAR with women and staff from secure forensic services.

The author conducted a second literature search to explore how PAR had previously been used to study self-harm and suicidal behaviour. Although the use of PAR in relation to the study of self-harm and suicide is scarce (Ward & Bailey, 2013), amongst the literature that does exist, young people and those from aboriginal, or indigenous communities feature most commonly. Such studies highlighted the vital contribution people with experiential knowledge can contribute to self-harm and suicide prevention strategies (Bruck, 2017; Farrely, 2007; Cochrane et al, 2006; Wexler, 2006). PAR also proved to be a useful methodology to identify new risk and protective factors for self-harm and suicide, through the combined understanding of those who are directly affected by the behaviours (Cox et al, 2014; Barlow et al, 2012;). These

findings chime with a recent statement made by the World Health Organisation (2017), who posit that active community participation is essential from the start of any self-harm and suicide prevention strategy. PAR has also been used to evaluate the current services available to those who self-harm, both within primary (Bailey et al, 2015), and secondary healthcare services (Walker, 2018). Bailey et al (2015) reported PAR fostered positive feelings of helping others and those involved in the research to stop self-harm, through their involvement within the research. Despite a growing body of literature demonstrating the successful use of PAR to study self-harm and suicide, the author was unable to identify any research studies that employed PAR to study these behaviours within forensic services.

The literature search did however identify one study that employed PAR to study self-harm within a prison setting. Ward & Bailey (2012; 2013) demonstrated how different stakeholders (including women prisoners who self-harmed in custody and members if staff) can be brought together and work collaboratively to improve healthcare outcomes for the women. In the case of Ward & Bailey (2012; 2013), the PAR process led to the production of self-help materials that women prisoners created, which were then used to help them, and others manage their self-harm in custody. Additionally, along with the researchers, the women co-designed and co-led a staff-awareness training package on working with self-harm in custody. Despite being a hard to access population, (Livingston et al, 2013), Ward & Bailey (2013; 2012) evidenced how women and staff can be engaged at all stages of the research process and how the sharing of their knowledge and experience can led to a culture change. Furthermore, Ward & Bailey were able to evidence a reduction in the frequency and severity of women's self-harm and savings in healthcare costs. Their application of PAR within the prison environment provides positive encouragement for its utility with forensic services, as women in prison share many characteristics with women in secure forensic settings in terms of both demographics, self-harm and suicide prevalence, and the restrictive milieu of these establishments. The use of research that involves women within forensic settings appears to be supported Chandler & Torbert (2003) who argue in order to appropriately understand and address the issues faced by women in prison and forensic care, it is essential to conduct research that includes their testimony and uses it to facilitate positive change.

Therefore, in an novel approach, PAR was chosen for this thesis based on its ability to engage and empower underrepresented, marginalised women, who due to their self-harm and offending behaviour, are likely to have experienced social rejection, and stigmatisation (Ward & Bailey, 2013). Not only do the women in forensic services import a range of vulnerabilities (including historical trauma, disruptive childhoods and separation from their support

networks), once in receipt of secure forensic care, the very nature of such services can further confound the social rejection and stigmatisation so many have previously experienced. This includes being segregated from society and being viewed as dangerous, or unmanageable, which can be reinforced by the increased media attention associated forensic services, particularly when patients are detained on account of a high-profile crime. Coupled with this, women receiving forensic care lack freedom and are largely powerless over their care, the situation they find themselves in, and the ability to influence change. It is well documented that women in forensic care experience health disparities compared to their general population counterparts, and have higher rates of serious mental illness, adverse traumatic experiences (including physical and sexual abuse, and childhood neglect), and a history of self-harm and suicide (see chapter 1, defining self-harm and suicide). Additionally, many women receiving forensic care are likely to have spent time in prison during adulthood, meaning they will have experienced long periods of absence from their families, social support networks and children, further adding to their social disenfranchisement (Glaze & Maruschak, 2010). Considering these findings, it is clear to see that there are many challenges faced by women receiving forensic care, including some known to increase and prolong the risk of self-harm and suicidal behaviours. Adopting a PAR approach may therefore help to address these challenges as through being heard, the process of PAR can be liberating and empowering for powerless people and can inform crucial understanding of less well-known topics (Greenwood & Lewin, 1998; McTaggart, 1997; Greenwood et al, 1993).

The second justification for using PAR is grounded in the emphasis it places upon the importance of multiple stakeholders collaborating and working together to achieve a wider goal (Reason, 2001). This was important for the project outlined in this thesis, as there are a number of different stakeholders who experience self-harm and suicidal behaviour and make decisions on the policies and procedures in place to help manage it. These include the women, front line staff, senior management, the NHS, Public Health England, and The Ministry of Justice. Adopting a PAR framework to engage multiple stakeholders therefore addresses the dearth of literature that integrates both staff and women within a project exploring self-harm and suicide.

The final justification for adopting a PAR framework is grounded in its ability to provide a flexible, reflective method of engaging participants. Both these factors are essential elements when working with those in receipt of forensic care. Due to the complex mental health challenges such women experience, for a successful research project there are numerous additional elements, which must be accounted for - all of which can extensively change both

the timeline and the scope of the research. To name but a few such circumstances may include; increased distress, patients being transferred to other services, loss of capacity to consent, lack of staff resources to facilitate the research, and heightened security measures. Due to the emphasis placed upon critical reflection, PAR provides a framework to conduct research from which allows modifications to all stages of the research process, as new insight, information, and perspectives arise. In light of these considerations, it is the view of the researcher that a traditional methodological framework would not have been suitable for the project detailed within this thesis, as all others provide limited scope to truly involve, and be responsive to the needs of women in forensic services, and the staff who care for them.

4.3 Epistemological standpoint

The debate between quantitative and qualitative researchers has been widely documented therefore it would not be prudent to discuss these at lengths within this thesis. However, to summarise, the epistemological underpinnings of the positivist and constructivist paradigms conflict (Cresswell & Plano-Clark, 2007). Positivism states that only one reality or truth exists: and that the one truth is available and ought to be discovered using the scientific evidence that is available to the senses (noise, smell, touch, and taste) (Feilzer, 2010). Positivist research should be value free and places importance upon linear cause and effect inquiry (Chandler & Torbet, 2003). In contrast, constructivism provides a research framework that considers the contexts of people's lives (Young, 2006; Kelly, 2005; Gray, 2004), and argues multiple or shared realities exist, which can be discovered and understood through research, (Kelly, 2005; Gray, 2004). Constructivists believe the language and signs used by individuals are accurate representations of the external world, which can be used to inform our understanding of the world that exists around us (Gray, 2004). These representations do however differ between people, as reality is constructed from the individual meanings people form through personal experience and interaction with the world (Gray, 2004). Even though many contradictory perceptions can exist for the same phenomena, the constructive epistemological approach concludes each account is equally valid.

Despite many researchers remaining committed to one paradigm, arguably research that mixes methods and paradigms offers "a response to the long-lasting, circular, and remarkably unproductive debates discussing the advantages and disadvantages of quantitative and qualitative research" (Feilzer, 2010, p.6). Mixed, or multiple methods research, offers a recognised, viable option to explore an underlying phenomenon using both quantitative and qualitative techniques, or a mixture of different qualitative only methods (Leech &

Onwuebuzie, 2007). Arguably, using a mixed, or multiple method design allows a researcher to answer questions that may not be possible to answer using one method alone (Leech & Onwuegbuzie, 2007), and combines the strengths and abates the weaknesses of singular methods (Johnson & Onwuegbuzie, 2004). Therefore, projects that utilise the benefits of mixed or multiple methods align with a third paradigm, which accepts the standpoint that there are singular and multiple realities, which are open to empirical testing (Creswell & Plano-Clark, 2007; Miller, 2006; Johnson & Onwuegbuzie, 2004; Tashakkori & Teddie, 1998). Pragmatism rejects the notion of duality, (Rorty, 1999), and posits that the epistemological and ontological underpinnings of both positive and constructivist research are the same in that they both seek to discover and inquire about the truth (Dewey, 1925, p.47; Johnson & Onwuegbuzie, 2004). Therefore, the pragmatic paradigm is less focused on the need to prescribe to singular methods. Instead, pragmatism posits that as there are multiple realities and different layers to phenomenon, it is essential that such truth is unearthed pragmatically, using the most *appropriate* research methods available, which in many cases includes a multiple method approach (Feilzer, 2010). In other words, pragmatists adopt the most suitable, sensible and beneficial research approach, based on both the needs of the population under study and the phenomena being explored. This makes pragmatism particularly suitable for conducting research amongst populations with specific or complex needs, whereby flexibility and adaptations are key (Feilzer, 2010; Rorty, 1999).

In the context of the current research, a pragmatic epistemological approach was adopted as it aligned with the overarching project aim, which was to enlist the lived accounts of those who engage in self-harm and suicidal behaviour and those who care for them, to help develop a more nuanced understanding of self-harm and suicidal behaviour within forensic mental health services. In doing so, it was hoped that a pragmatic approach to the research design and methodology would offer the flexibility required to engage a range of stakeholders from the forensic mental health community (each of whom will hold different views regarding their own reality). This supports the pragmatic approach that there will be multiple realties regarding the truth behind self-harm and suicidal behaviours, each of which will be valid and meaningful. This is important as whilst there are many shared features of risk for and pathways to self-harm and/or suicide (see Chapter 1), the reasons for enacting such behaviour are highly individualised (NICE, 2013), meaning what is true or reality for one person may not be true for another. Therefore, by adopting qualitative methods it was possible to involve individuals within the research who possess expert experiential knowledge (Gray, 2004; Crotty, 1998). It was however important to recognise the unique nature of the forensic mental health

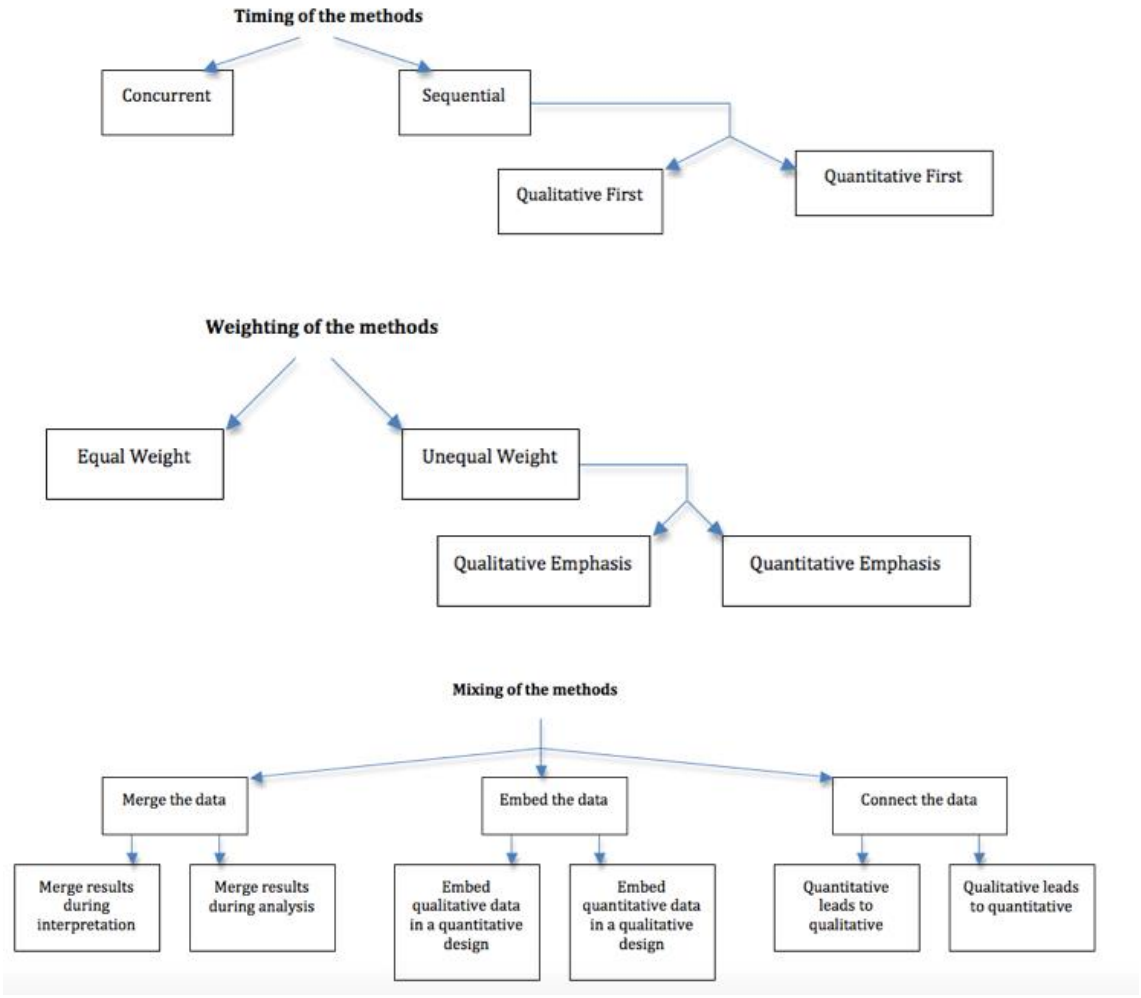
population, both in regard to the complex mental health and social needs of the women, the employment needs of staff, and of the restrictive nature of the environment. Consequentially, it was important that the research design and methodology was reflective of the population under study and of the environment and allowed the researcher to respond flexibly to the dynamic nature of forensic mental health services. Therefore, the most pragmatic approach was taken, and a multiple, embedded, methods design was employed.

4.4 Rationale for an embedded multiple mixed methods design

An embedded mixed methods research design offers an approach to studying a phenomenon where one type of data (qualitative or quantitative) is intended to support the other (Creswell, Plano & Clark et al, 2003). Embedded designs are suitable when the findings from one data set are not adequately able to answer the proposed research questions, or where researchers wish to use one type of data to inform the analysis of the other (Creswell, Plano & Clark et al, 2003). When planning an embedded design research project, one type of data will be "embedded within a methodology framed by the other type of data" (Caracelli & Greene, 1997). In other words, quantitative data can be collected and embedded within a qualitative methodological framework (or visa versa) and can be used to inform the analysis of the overarching qualitative data.

When designing embedded research, it is important to consider timing, weighting and mixing (Creswell, 2006), as depicted below in figure 7 Firstly, Creswell (2006) suggests that whilst timing is often discussed in terms of the order in which qualitative or quantitative data is collected, timing actually refers to the order in which the data are analysed and used to inform the interpretation of the other. Secondly, Creswell (2006) posits a weighting decision must be made during the design phase, whereby the researcher determines whether qualitative or quantitative data will feature more prominently within the project, based on its importance and ability to answer the research questions. According to Morgan (1998), this stage is known as the "priority decision" and will be informed by the epistemological standpoint of a research project. Finally, Creswell (2006) states researchers must decide how their data will be mixed, which can be done by merging, embedding or connecting the data.

Figure 7 – Decision tree for mixed methods design criteria for timing, weighting, and mixing (based on Creswell, Plano & Clark, 2003; Hanson et al, 2005 and Plano Clark, 2005).



For the current research, a concurrent, unequally weighted, embedded design was employed, where quantitative data was embedded within a qualitative design. Such a design was selected as the primary research aim was to collate the experiential knowledge and lived experience of women service users and staff, to help develop a nuanced understanding of self-harm behaviours across one forensic mental health pathway. Therefore, a qualitative methodological framework was employed. However, to help inform and enrich the analysis process of the qualitative data, quantitative data (word frequencies) was collected concurrently during the individual interviews to supplement the qualitative data. The quantitative data was analysed first (see chapter 5, section 5.6.3), and was used to compare patterns between the data from the women and staffs and inform the rationale behind whether their qualitative data would be analysed together as one experience, or as two separate experiences. A concurrent, unequally weighted, embedded design aligns with participatory action research (PAR), as it lends itself to the critical reflection stages of PAR,

whereby each stage of the design, data collection and data analysis is informed by the findings of the previous one. Furthermore, PAR is able to facilitate the generation of both qualitative and quantitative data and suggests its use can help improve the validity of the findings (Gillis & Jackson, 2002). The research design and use of quantitative data to inform the analysis of qualitative data aligns with the notions of pragmatism, whereby any design and analysis decisions ought to be made based on what is most practical and helpful for answering the research questions.

Figure 8 – A concurrent, unequally weighted, embedded research design (adapted from Creswell, Plano & Clark, 2003).

4.5 Improving Validity and Stages of Critical Reflection

Across-methodological triangulation (AMT), or using mixed or multiple methods, involves employing a range of methods to study one phenomenon (Bekhet & Zauszniewski, 2012; Casey & Murphy, 2009). AMT is an effective way to enhance, widen, and enrich understanding of a topic under study, and improve the validity of the findings (Bekhey & Zauszniewski, 2012; Halcomb & Andrews, 2005). AMT seeks to compare findings from different methods number and validates the findings if the results and conclusions are similar or the same in each study. Arguably, in addition to improving validity, combining methods has the potential to neutralise the limitations of singular methods, and strengthen the benefits of both (Hussein, 2009). This is important as the findings from singular qualitative methods are often criticised for having limited reliability and validity (Bekhey & Zauszniewski, 2012; Halcomb & Andrews, 2005).

To help improve the validity of the findings and critically reflect over the findings from each stage of the current thesis, the process of triangulation was used in three ways. Firstly, quantitative data (word frequencies) were used to identify and compare patterns amongst the testimonies of women and staff regarding self-harm and suicidal behaviours. This was achieved by asking all participants the same research questions, (albeit in a slightly different manor to account for the high prevalence of intellectual disabilities and low IQ amongst forensic populations) and comparing the most commonly cited words relating to the reasons

for life-threatening self-harm. In doing so, it was possible to establish consistency amongst the findings and improves validity, as the stories told by the women and staffs were congruent. Secondly, to bolster the validity of the comparisons between the women and staff, a member of the supervisory team checked the accuracy of a proportion of data. This not only assisted in validating the findings, but also added depth to the scope of the findings, which in turn helped to produce a comprehensive account of life-threatening self-harm in women's forensic services. Finally, to ensure the women and staff remained active in all phases of the research, and to improve and validate the findings, the women and staff acted as 'member checkers'. This involved women and staff participating in a focus group (staff), or 1:1 individual feedback session (women), and acting as 'member checkers' for the findings (see chapter 5, section 5.4).

Thesis Aims and Research Questions

4.6 Research Aims

The discussions of literature in the earlier chapters highlight a dearth of literature relating to self-harm that poses high risk to life. In comparison to the general and prison populations, the lack of evidence is even more evident for women receiving forensic mental health care. This means whilst a picture is forming in relation to the reasons for life-threatening self-harm amongst the prison population, currently we do not understand why and how this behaviour occurs within forensic mental health services. This means our ability to prevent or treat life-threatening is limited.

It was suggested by Rivln, Fazel Marzano & Hawton (2011) qualitatively interviewing those individuals who survive life-threatening self-harm and suicidal behaviours may be far more superior when trying to understand the motivations behind life-threatening behaviour compared to other quantitative methodological approaches. Therefore the current study collected the lived experience of women service users who had enacted life-threatening self-harm and suicidal behaviours and members of staff from three forensic mental health hospitals to explore the differences between self-harm and suicidal behaviour, and to better understand the functions of and pathways to life-threatening self-harm. To the authors knowledge, this is the first time life-threatening self-harm has been explored specifically within women's forensic mental health services.

4.7 Research questions

The present study aimed to explore the differences between self-harm and suicidal behaviour in women with complex mental health needs, and describe staff and women's' experience of

living amongst, or working with, women who engage in life-threatening self-harm. In particular, the research aims to focus developing a better understanding life-threatening self-harm. It is hoped that by better understanding why women enact life-threatening self-harm, and how the behaviour develops, the findings detailed within this thesis may serve to assists with the identification of those at risk and offer practical clinical recommendations to help with prevention. The aim of this research is further explored through addressing the following research questions

- What are staff and women's experiences of living amongst, or working with, women who enact life-threatening self-harm?
- Why do women enact life-threatening self-harm?
- Is life-threatening self-harm enacted with suicidal intent?
- What are the pathways to life-threatening self-harm?
- Does restricting access to means of self-harm play a contributory role in the development of life-threatening self-harm?

4.8 Critical Reflections

4.8.1 Using PAR with women receiving forensic mental healthcare

According to the ethos underpinning the PAR framework, to fully investigate a topic within a community, it is essential for researchers to immerse themselves into the community under study. Being involved with the community is required at all stages of the project; however, it is of particular importance during the initial planning and design of a study. This is advocated as it is seen to be an effective way of sourcing first-hand knowledge of the phenomena as it unfolds (Gillis & Jackson, 2002), meaning the researcher has a better understanding of what problems are faced by the community (Streubert & Carpenter, 1995). There are however a number of practical and security issues relating to research with the forensic mental health population (FMHP) (see chapter 1, section 1.8.1), which made engaging all members of the community challenging. In particular this related to women from the FMHP, and because of the security protecting them and their complex mental health needs, sadly, it was not possible to observe the community of women during the planning stages or involve them in the initial design process. Notably, this is due to the stringent ethical constraints, which rightly prevent people accessing vulnerable individuals without vetting, or research being undertaken without ethical approval.

Reflecting on this, I wondered whether this may explain why previous literature has already argued that the forensic mental health population is one of the most challenging groups to engage in research (Livingston et al, 2013). Having worked within forensic mental health hospitals and prisons, I knew first hand it would be challenging, and whilst I understood it was possible that ethical constrains could prevent the women being involved in the initial planning phases of the project, I couldn't help but feel somewhat disappointed that I wasn't able to fully integrate the underpinnings of PAR in all aspects of my research. Arguably, this highlights a challenge with using PAR within forensic services. In particular, I feel this highlights a slight incompatibility between ethical restrictions and creating 'grass-root' research studies. I wondered whether the valuable steps taken to protect vulnerable populations in some way reinforces their marginalised status and limits their ability to make choices about participating in research. I also wondered whether not being able to contribute to the design and planning phase of research that directly affects their lives could mean that, as with other aspects of their lives, other people are making the assumptions about what is important to them. This could mean that the staff and wider stakeholders made decisions for the research based on what they believe were the key problems affecting the women's lives and their community, without understanding if their assumptions were true. In turn I wondered whether the voices of the women I sought to understand were actually heard or represented.

Being aware of the limitations of adopting a PAR framework with the FMHP, I took a three-fold approach to try to overcome the challenges of not being able to observe or involve the women in the initial stages of the research project. Firstly, drawing from my experience of working in similar forensic services with women who self-harm, I felt I had an informed idea of some of the problems faced by the women under study. Secondly, I also considered the lived experience of members of the community who I could approach, including the staff working within the forensic pathway and wider stakeholders. I believed that in the absence of the women, through combining my own experience and that from direct nursing teams and senior management, collectively we would be able to establish key problems and understand what new knowledge needed generation from the research. I did however recognise that there was important insight lacking, therefore, to try to involve the women, I organised for key contacts at the research sites to relay research specific information to some of the women and asked for their feedback and suggestions. This included suggesting ways to improve documentation such as information sheets and consent forms.

On balance, whilst these efforts managed to mitigate some of the limitations of being unable to involve the forensic community in totality in the grass-roots design of the project, the total

involvement of the women during the early design stages of the research was limited. I feel this highlights a limitation of using a PAR framework when the researcher is not a direct member of vulnerable or hard to access communities. In doing so, I believe this identifies that clinicians are particularly valuable for clinical research, as they have access to vulnerable populations due to their staff status. As a result, I believe that using clinicians to conduct research with hard-to-reach populations offers an opportunity for the design of real grass-roots projects, and to involve the participants at all stages of the research design. Whilst there are limitations to using a PAR framework, I feel passionately that the findings from my research evidence the ability of women in forensic mental health populations to contribute to research. The findings from my research are testimony to the women's ability to articulate their experiences and use their unique, expert opinions to help generate new knowledge, and enrich our understanding about complex behaviours. Furthermore, the understanding they have demonstrated about their own behaviours reaffirms my belief that service users can, and should, be allowed to participate in discussions and decisions about their care, even when they engage in high-risk behaviours.

4.8.2 The Scope of the Research - Changing Aims

When I initially embarked upon the research detailed within this thesis, one aim was to use the findings to develop a draft assessment tool to assess for risk of near-lethal self-harm. The aim of designing a draft assessment tool was originally outlined in the funding application for the PhD I undertook, and the focus of the tool was refined during the initial scoping and planning exercises with the staff and wider stakeholders. This was because the staff felt that there was not currently an assessment tool that could help them to determine who would enact life-threatening self-harm – a problem they felt was serious and prevalent amongst the forensic mental health community.

Therefore, to achieve this aim of the research, data was collected during the interviews to help develop an understanding of what the women and staff thought ought to be included in an assessment (including details of what they believed were risk factors for life-threatening self-harm) and how they believed the assessment ought to be conducted. When discussing how an assessment of risk could be improved during the interviews with the women and staff, an assessment was frequently referred to as a 'learning tool', or a 'process of getting to know a woman', and great emphasis was placed upon the importance of understanding each woman as an individual in order to understand the function of their self-harm. When discussing the best way to assess risk, both women and staff told me how they felt current assessment tools

were flawed in that they tried to condense a complex and detailed set of behaviours into an arbitrary value, whilst failing to understand their meaning. In fact, many participants believed that conventional risk assessments (such as psychometric tools) were for the benefit of the service (i.e. they helped them to make decisions on levels of care and observation), but they did little to help unpick the complicated stories that contain the meaning and function of life-threatening self-harm.

Whilst it was anticipated that the research would be able to fulfil the aim of designing a new assessment tool, due to the challenges faced whilst researching within the FMHH (see section 1.8.1), in the third year it became apparent that it was not possible to achieve within the time constrains of the PhD. When realising this, I held discussions with the staff and women and unsurprisingly, the women and staff emphasised the importance of focussing on developing a rich account of the functions of and pathways to life-threatening self-harm, the experience of what it was like to live amongst or provide care for women who enact life-threatening self-harm and the impact of restricting access to means on life-threatening self-harm. It was concluded that a new assessment tool would likely become as flawed, (like the tools they currently used), if there was not an in-depth understanding of why the behaviour occurs. Therefore, the aim of producing a draft assessment tool within the parameters of this PhD was postponed for future research plans (see chapter 9, section 9.6). In particular, I recall a woman telling me that she believed that if people understood why she self-harmed when she was young, she would not have found herself in a FMHS, nor would she engage in life-threatening self-harm. For me, this highlighted the importance of documenting and sharing the women and staffs understanding of why people enact life-threatening self-harm in the hope that it can assist other clinicians to support women in a more productive way to help reduce their self-harming behaviour.

When reflecting on the change of aims for this research, I feel it is also important to return to the fact that the aim of designing a new assessment tool featured in the preliminary funding agreement for the PhD, which was set prior to being awarded the scholarship. I find it interesting to consider whether the original aim of designing of an assessment tool actually represented the agenda of external organisations outside of the FMHP, and highlights that what we believe to be a problem within a community (or indeed what we think may offer a resolution to a problem) can differ from the understanding of those who live alongside a problem. This, I would argue, summarises the main benefit of using a PAR approach, whereby research can be flexible and adaptive to incorporate the lived experience of those we seek to

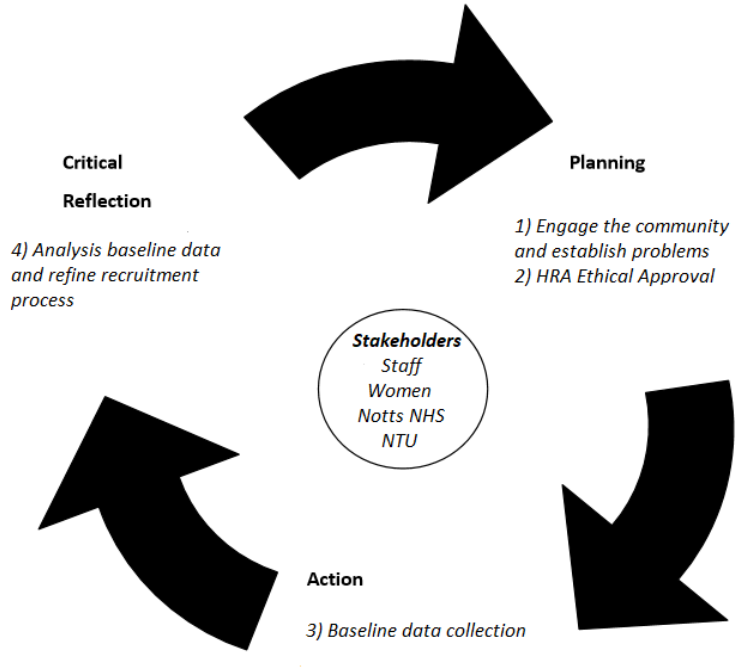
understand, and allows researchers to truly co-produce new knowledge in a way that reflects their expert experience.

Chapter 5: Methodology

5. Overview

Chapter 5 describes the methodology of the current research. It outlines data collection methods, provides details of the recruitment process for the staff and women participants, and describes the data analysis. The chapter also reports on ethical considerations and provides a critical reflection of the methodology, participant screening and recruitment and the ethical constraints of the research. To address the gaps in our current understanding of self-harm and suicidal behaviours in women with complex mental health needs, a Participatory Action Research (PAR) framework was adopted (see Chapter 4, Methodological Framework). As illustrated below in figure 7, the current research took place over three key phases – an audit of incident reports, semi-structured interviews, and one focus group, or individual sessions to feedback the findings of the project. These three phases formed the overarching PAR cycle of planning, action, and critical reflection. Within the overarching PAR cycle, in line with the critical reflection element of PAR, each stage went through numerous smaller cycles to help refine the project and ensure it was responsive to the needs of the participants and the forensic mental health hospitals. 15 members of staff and 7 women took part in individual interviews, and 6 members of staff took part in a feedback focus group and 7 women engaged in individual feedback sessions.

Figure 9: Overarching PAR Cycle for the Thesis Research



5.1 Ethical Clearance

Before commencement of the study, ethical approval was obtained from the Health Research Authority on behalf of the National Health Service (NHS), and Nottingham Trent University (see Appendix A and B). Ethical considerations and safeguards were also discussed with the Clinical Directorate Team at each NHS Forensic Mental Health Hospital where the current research took place.

5.2 Procedure

5.2.1 Data Collection Summary

In keeping with the fundamental underpinnings of a PAR framework, it is important the methods selected for data collection align with the principles of involvement and knowledge co-production. In doing so, PAR posits that any data collection methods must provide an opportunity for stakeholders to participate fully in the collection and generation of new knowledge, and ensure they are able to critically appraise the way in which it occurs (Ward & Bailey, 2012). Additionally, stakeholders ought to have the ability to contribute their ideas and knowledge on how best to obtain data, and where possible, take part in stages of analysis and validation. Many methods of data collection are therefore able to fulfil the requirements of PAR including; interviews, field observations, focus groups, diary and personal logs, questionnaires, and surveys (McNiff & Whitehead, 2006; Stringer & Genat, 2004; Gillis &

Jackson, 2002; Greenwood & Levin, 1998). To overcome the limitations of each of the cited data collection methods, Streubert & Carpenter, (1995); advocate the use of at least three types. This relates to a process of data triangulation, which aligns with the PAR framework, and helps to increase the validity of research findings through the collection of multiple sources of information relating to the topic under study (see Chapter 4, methodological framework). Therefore, as previously detailed in Chapter 4, (section 4.4), based on its ability to engage participants in a range of different ways and its ability to bolster the reliability and validity of research findings, a concurrent, unequally weighted, embedded design was employed, where quantitative data collection was embedded within a qualitative design. Data collection took place during the initial planning phase via an audit of current incident reports (used for the recruitment of women), during the action phase via individual interviews, (which were first analysed quantitatively to inform the qualitative analysis), and during the critical reflection phase, where participants acted as member checkers for the findings via staff feedback focus groups, and individual feedback sessions with the women. In keeping with the cyclical nature of PAR (Ward & Bailey, 2012), each phase of the project went through additional cycles of planning, action, and critical reflection.

5.2.2 Initial Planning Phase

5.2.2.1 Scoping Exercise and Early Preparations

In line with PAR, an initial scoping and planning phase took place to help the researcher observe, investigate and become immersed within the community under study. A key aim of the early preparation phase was to develop a rich understanding of the forensic mental health population, establish collaborations with the stakeholders of the research, and identify the main problems faced by the forensic community in relation to self-harm and suicidal behaviour. Initially, the scoping phase consisted of three meetings (one at each of the research sites), which were used to generate support and source the knowledge and expertise from healthcare professionals regarding the practical requirements of conducting research in secure forensic mental health services. Having secured support for the research and established key contacts at each site, additional meetings were arranged to discuss the current problems faced by women and staff in relation to self-harm and suicide and refine the topics for the project. To ensure the focus of the research was reflective of the challenges faced by the wider forensic mental health population, active engagement was sought from various wider stakeholders (women, ward staff and senior management) and the ideas from the preliminary meetings were presented at a research proposal at each hospital research seminar programme, at senior

management meetings. Importantly, where possible, the key contacts discussed the research proposal with women in their care and encouraged them to provide feedback. In doing so, a continual process of critical reflection allowed members of the community to critically evaluate the research until they felt the aims adequately targeted the problems faced by the forensic mental health community. The key questions identified during the scoping and planning phase were:

- What are staff and women's experiences of living amongst, or working with, women who enact life-threatening self-harm?
- Why do women engage in near-lethal self-harm?
- What increases risk of enacting near-lethal self-harm?
- Does near-lethal self-harm occur with suicidal intent?
- Are women who engage in near-lethal self-harm ambivalent about living or dying?
- Does restricting access to means of self-harm affect near-lethal self-harm?

Due to the complex security and patient protection procedures in place across secure forensic mental health hospitals, it is a necessary requirement of hospital staff to act as 'gatekeepers' for all research projects, (HRA, 2018). Notably, this includes staff carrying out the initial steps of patient identification and recruitment and accessing any records or identifiable information to protect patient confidentiality and anonymity. Furthermore, to ensure security is upheld, until the researcher has undergone the appropriate vetting procedures, a member of staff must escort the researcher at all times around the non-secure side of the hospitals (areas where patients do not access), and researchers are unable to access any secure areas. Consequentially, the initial scoping and early preparation phase also included organising and clarifying the responsibilities of the key contacts within each hospital and confirming the requirements of the hosting hospitals to facilitate the research. This included identifying a member of administrative staff to complete the incident report audit as part of the recruitment phase (see below), establishing who would complete the vetting application and book the researcher onto mandatory training (a requirement of the honorary contract) and identifying who would facilitate interviews with the women and staff. This included planning who would book appropriate rooms, who would liaise with wards managers to enable staff to take part, (whilst ensuring the wards remained appropriately staffed), and who would help facilitate interviews with the women around their current treatment sessions and activities.

Once the aforementioned steps had been completed, and the project aims and procedures defined an application for ethical approval was submitted to the Health Research Authority

(HRA). On receipt of ethical approval, a meeting was held with the Responsible Clinicians (Psychiatrists from each hospital ward) to confirm which doctors would complete the screening process (see section 5.8.1.3 below), for the women identified as potential participants during the audit of incident reports, and when the researcher would be able to begin data collection.

Whilst the initial scoping exercise informed the research design and procedure, due to the complex nature of forensic mental health hospitals (including mental health needs, staff shortages, security measures and external pressures), the process of continuous critical reflection resulted in adaptations to the research design. Furthermore, at various stages the research was adapted in response to the critical reflections of staff, women and wider stakeholders, which are discussed below at the stage of the methodology where they occurred.

5.2.2.2 Incident Report Audit

To identify a potential sample of women service users, the planning phase also consisted of an audit of NHS incident reports pertaining to self-harm and/or suicide attempts. In line with requirements from the Heath Research Authority (HRA) ethical approval, to uphold patient confidentiality and anonymity, the incident reports where accessed by a member of administrative staff who was employed by the high secure hospital. The audit took place at the high secure hospital because of its ability to access care records from across the forensic pathway. Incident reports were only accessed, reviewed and anonymised if they corresponded to a woman at one of the three nominated research sites. An identifiable patient list was created and kept by one forensic psychologist at the high secure hospital, which the researcher did not have access to at any time.

To gauge the number of self-harm incident reports, the nominated member of administrative staff completed an initial scoping exercise. The first search (which included all incident reports ever recorded for each woman across the three specified research sites) revealed over 20,000 incident reports. As a member of NHS staff was gatekeeping the initial audit, it was important to consider ways to try to reduce the number of incident reports and aid manageability. Consequentially, as part of a critical reflection stage, a literature review was conducted for guidance, and an inclusion criterion was set to only include women who had five of more documented incidents of self-harm within a one-year period (November 2015 - November

2016). The inclusion criteria were set as Hawton et al (2014) suggest women who have enacted self-harm on five or more occasions within a 12-month period are at increased risk of future self-harm and suicide. Furthermore, incident reports pertaining to women who threatened to self-harm but did not enact self-harm behaviours were excluded. The exclusion criteria was set in accordance to Joiners Interpersonal-Psychological Theory of Suicide (2005) (see Chapter 3, Theoretical Frameworks), which posits women who self-harm repetitively have an elevated risk of suicide, as they acquire the capacity to enact behaviour dangerous enough to bring about death due to the habituation of pain and fear associated with potentially lethal methods of self-harm. Therefore, women who threatening but did not act meet were considered less likely to have lived experience of self-harm behaviours compared to those who frequently enact self-harm, and due to their increased risk of suicide, were considered more likely to self-harm using methods that pose greater risk to life.

Having applied the inclusion and exclusion criteria, the audit of NHS incident reports revealed 2505 incident reports, which corresponded to 53 women who were considered suitable for the research. Again, to respond to the needs of the forensic mental health pathway (see chapter 1, section 1.8.1), to make the audit manageable to complete, 5 incident reports were randomly selected and anonymised (by the administrative staff), for each of the 53 women. Incident reports that contained details of more than one act of self-harm/ suicide attempt within a single report were separated, meaning in total, 272 incidents reports were included within the audit of NHS incident reports. To help build an informative picture of self-harm and suicidal behaviours amongst the women identified as suitable for the research, each incident report was anonymised and information was extracted relating to; date, time and location of each incident, the methods used, injury type and the body part to which harm occurred, and the means of self-harm. The NHS categorisation coding was also documented which categorises incidents as either 'self-harm', 'self-harm without suicidal intent', 'self-harm with suicidal intent', or a 'suicide attempt', as was the level of harm caused during each incident. The NHS rate level of harm as either '0 – near miss, harm prevented by action', '1 – no harm, including natural cause death', '2 – minor/low: minimal harm', or '3 – moderate/serious: short/medium term harm'. Once all data was extracted and anonymised, the audit of incident reports was saved in a password-protected document and exported to the author. The incident report was then saved to the Nottingham Trent secure one-drive Internet portal, which only the researcher has access to. The demographic information extracted from the incident report audit can be found below in section 5.5.2.4.

5.2.3 Interview topic guide design

The final stage of the initial planning phase and early preparations for the current research, was designing the interview topic guides for data collection. Two flexible interview topic guides were developed to ensure the interviews were able to adequately address the aims of the project and answer the overarching research questions. To take into consideration the high prevalence of intellectual disability and low IQ amongst the forensic mental health populations, separate interview guides were designed for the women and for the staff members who care for them (see appendix I and J). Although both interview guides covered the same topics, the duration and delivery of the interviews differed to ensure the questions were suitable and appropriate for each sample. Using open-ended questions, the semi-structured interviews explored their personal experience of self-harm within forensic settings, the functions of and pathways to life-threatening self-harm, assessing risk, and the impact of restricting access to means on life-threatening self-harm.

The interview topic guides were informed by three main sources:

1) A review of the current literature (specifically relating to what is currently known about risk factors for self-harm and suicide, restriction of means, environmental influences on self-harm, assessing self-harm and suicide risk, and the relationship between lethality of self-harm and suicide risk).
2) Consultation with healthcare professionals and the clinical directorate team at each research site to discuss what they felt was important to explore when trying to better our understand life-threatening self-harm in forensic services.
3) Current psychometric tools used across the forensic pathway to assess risk of self-harm and suicide and known associated risk factors for increased risk.

5.2.3.1 Literature review

The literature review identified a gap in our current understanding about the functions of near-lethal self-harm (NLSH) amongst women receiving care in secure forensic services. Whilst a study conducted by Marzano et al (2011) addresses the issue of identifying the functions of, and risk factors for NLSH within female prisoners, little is known about whether the same understanding is applicable to the female forensic population. Being aware of factors that are likely to increase risk of NLSH and having a more comprehensive understanding of why women engage in such behaviour is crucial for the identification of those at risk and implementing the most appropriate prevention and treatment strategies. The current research aims to address

these gaps in the literature and develop a more nuanced understanding of why women engage in NLSH and establish whether it is enacted with suicidal intent. As discussed in chapter 2, (section 2.7.2), the literature review revealed a deficit in research exploring the relationship between restricting access to means and NLSH within forensic mental health services. Whilst some studies have demonstrated method substitution as a result of restricting means within community samples (Yip et al, 2010), the effects of such initiatives within forensic services remain unclear, and therefore require further exploration. The literature review also revealed a lack of validated assessment tools, designed and tested on women receiving forensic care. Therefore, considering the deficit in literature, the interview schedule was tailored to discuss how the best way to assess women in forensic care for risk of self-harm and/or suicide.

5.2.3.2 Consultation with health professionals

Throughout the early planning stages of the research, the study was presented at numerous meetings and site-specific research forums. Such events provided a valuable opportunity for staff that would not take part in the interviews to play an active role in the design and refinement of the project. In doing so, the process allowed important stakeholders to identify the things they felt the research needed to cover in order to better understand NLSH. A recurring theme emerged amongst the staff related to the severity of the self-harm behaviours seen amongst the women's services. The staff expressed a desire to better understand why women engaged in NLSH, and to establish whether it was related to a desire to end life. Whilst many were incredibly knowledgeable about self-harm behaviour, they often described a sense of urgency in being able to better understand the social, environmental, and situational factors that influence NLSH, to help better predict who would enact such behaviour. The interview guide therefore tried to incorporate these suggestions, and as a result, intent behind NLSH was addressed, in addition to trying to establish how the environment, and situational factors can affect the pathways to NLSH.

5.2.3.3 Current assessment tools

Current psychometric measures used to assess risk of self-harm and suicide across the forensic pathway was obtained from a lead practitioner at the high secure hospital. Each question from all 8 measures were printed on separate flash cards, laminated and used to conduct and activity related to assessing risk within the interviews. Whilst all questions were laminated, a random selection (picked by the participants) were used to discuss the current process of assessment and to identify both the positive things about what is currently used and suggest improvements they would like to see. It is important to note that none of the psychometric

tools were used to perform assessments on any participants, nor were they tested or validated. Questions were extracted from the following psychometric measures:

- Functional Assessment Screening Tool (Iwata & DeLeon, 2005)
- Brief Symptom Inventory (Derogatis, 1993)
- Cognitive Distortions Scale (Briere, 1998)
- Major Depression Inventory (Cuijpers et al, 2007)
- State Trait Anger Expression Inventory 2 (STAXI-2)
- Posttraumatic Diagnostic Scale (Foa, 1996)
- Mindful attention awareness scale (Brown, 2003)
- UPPS-P Impulsive Behaviour Scale (Whiteside, 2001)

5.2.4 Pilot Interviews

In order to test the effectiveness of the interview topic guide, pilot interviews took place with two participants from the staff sample, and one woman from the women's sample. Pilot interviews were conducted to ensure the topic guide generated information that met the research aims and was able to help answer the research questions. In particular, throughout these interviews, feedback was sought from participants in relation to the interview delivery, and the ability of the questions asked to better the current understanding of risk factors associated with NLSH for women receiving forensic care. Where suggestions were made, amendments were made accordingly. Initial feedback from the pilot interviews was positive, and participants felt as though the design allowed them to speak freely about their experiences and share their understanding of self-harm and suicidal behaviour. A key finding was the need to reduce the length of the interviews, as staff felt they could not be away from the ward for longer than an hour. In response to this, the risk assessment activity was shortened. From the pilot interview held with the women sample key feedback related to the length of the questions that were asked. In response to this, questions were shortened, and the language used was simplified to aid clarity.

5.3 Action: Data Collection - Semi-Structured Interviews

Individual interviews were employed to "enable participants to describe their situation" (Abdulla & Stringer, 1999, p.68), and share their stories, thoughts, and ideas of their reality in their own words (Kvale, 1996; Kaufman, 1992). A semi-structured interview topic guide (see section 5.2.3 and appendices I and J) was used to cover four overarching topics. These

included; exploring the personal experience of working with, or engaging in, self-harm and suicidal behaviours, clarifying the functions of, and pathways to NLSH (with aim of clarifying whether the behaviour is enacted with suicidal intent), assessing risk of NLSH and exploring the impact of restricting access to means on NLSH.

Semi-structured interviews align with the PAR framework as they are flexible and responsive in nature and value the capability of using first-hand poignant experiential knowledge to generate new information. In line with guidance on conducting PAR research, Stringer (1999, p.70), suggests open-ended questions ensure participants are given the freedom to discuss what they believe to be important to the research and help to maximise the opportunity for them to share their experiences in their own way. In doing so, it is thought that researchers can "increase participant involvement and ensure all knowledge generated is co-produced and reflective of the lived experiences of the population under study" (Stringer, 1999, p.70). Therefore, each interview began with initial orientation questions to help build rapport (e.g. 'tell me a bit about yourself', 'what sort of things do you like or are you interested in?', 'Tell me about what made you want to take part in this research?') and was followed by 'so, tell me about your experiences of working with/living amongst women who self-harm'. For the women, when sufficient trust was established for it to be appropriate, the initial question was followed up with 'and what about your experiences of engaging in self-harm, can you share your own experience with me?' Although the structure of each interview differed, the following topics were then covered: language; the difference between low and high lethality self-harm; functions of and risk factors for life-threatening self-harm (LTSH); pathways to LTSH; assessing risk; and the impact of restricting access to means. Throughout the interview, clinical interviewing skills were employed to help the author check understanding and facilitate a collaborative process of knowledge generation. This included Socratic questioning (e.g. what do you mean by that?, can you give me an example of why you think that is true?, how do you think someone else would see this – do you think they are likely to agree or see it in another way?), summaries (e.g. 'so correct me if I am wrong but I think I have heard that from your own experiences you think…'), and check-ins (e.g. 'so just to be sure, you think it is this?', 'Have I understood that correctly?').

A card sorting activity took place in order to make the interviews engaging and assist with understanding how the women and staff believed was the most appropriate way to identify those at risk of life-threatening self-harm. This included asking women and staff to sort a random selection of laminated questions, taken from the current self-harm and suicide assessment tools used by the forensic mental health pathway (see above, section 5.2.3.3). The

women and staff were asked to sort the cards into piles of questions they thought were either helpful, somewhat helpful' or unhelpful in understanding whether a woman was at risk of enacting life-threatening self-harm, and how their behaviour self-harm had developed or changed. Staff and women were then asked to describe how they thought an assessment of risk should occur.

Prior to the interview, all participants had been provided with an information sheet and had been given the opportunity to discuss the research with the author and ask questions about the project. Additionally, where appropriate, the women were assisted with reading the information sheet with a named member of staff. Written informed consent was obtained for each participant. For the staff this was obtained on the first point of contact and for the women informed consent was taken on the second point of contact. Each woman and member of staff were given a 7-10 day cooling off period between providing informed consent and taking part in their individual interview. At the beginning of the interview, an additional information sheet was provided to the women and staff and a unique identifier was given to each participant. The women and staff were reminded of their right to withdraw and of the procedure to do so. They were asked to confirm for a second time that they were happy for the interview to be recorded.

Fifteen members of staff and seven women took part in individual interviews. All interviews took place at the hospital in which the staff worked, or in which the women received care. For staff members, interviews at the high and low secure service took place in a private office within the psychology department. At the medium secure service, staff from the WEMS service were interviewed in the family room on the non-secure side of the hospital. Due to staffing pressures, interviews with the staff from the standard medium secure ward took place on the secure side of the hospital, in side rooms on the ward. Whilst the duration of each interviews varied, all staff interviews lasted between 49 – 90 minutes. The women were interviewed in a private side room located on their ward and all women's interviews lasted between 25 – 45 minutes.

To facilitate critical reflection and ensure the interviews were responsive to the needs and suggestions of the participants (MacDonald, 2012), feedback was obtained throughout regarding the questions, topics and delivery, and amendments were made accordingly. Additionally, at the end of each interview the women and staff were asked to provide feedback on the interview, and to suggest any other questions that may have been helpful to assist with better understanding their story. Such questions included 'can you share with me

what you think I have missed out during our discussions that might help me to better understand life-threatening self-harm?' 'What other questions could I have asked?'' From the questions I have asked, what ones seemed irrelevant or were hard to understand?' According to Ruben & Ruben (1995) assists with ensuring the interview is flexible, iterative and continuous in design.

5.4 Critical Reflection - Feedback Sessions

Unlike quantitative studies, the validity and reliability of qualitative studies is often contested on account of the interpretive nature of qualitative analysis (Bradley, 1993). To help bolster validity and reliability, Lincoln & Guba, (1985) suggest researchers ought to engage in a process of on-going observations of the population under study, peer debriefing and member checking. Such activities are also in keeping with the emphasis PAR places upon co-production of knowledge, and stakeholder involvement in as many stages of the research as possible. Therefore, to aid validity of the findings from the current research, a process of 'credibility checks', (Bradley, 1993, p.446; Lincoln & Guba, 1985) took place.

In the first instance, throughout the process of data analysis, the author continued to visit the research sites and spend time on the wards with women and staff. This allowed observations of the forensic mental health population to continue, and for peer debriefing and informal conversations to take place regarding the progress of the research and the emerging findings. It was originally intended that a focus group would take part at each of the participating hospitals to present the initial codes, themes and preliminary conclusions to the women and staff. Focus groups were selected as previous literature has noted their ability to provide a useful opportunity to generate knowledge from a group of people who share similar characteristics and have a relevant place within the community under study (Marshall & Rossman, 2006). However, due to the continued complex needs of the women who took part, the security measures of the participating hospitals and pressures on staffing, this was not possible. For the women, the inability to hold a focus group was largely due to numerous 'non-mix' procedures that existed within the hospitals, whereby some women were not allowed to participate in groups or interact with certain other women. Typically, such measures are introduced where previous offending histories, or mental health needs of women would necessitate a separation from certain other women. In relation to staff, it was not possible to hold focus groups at each research site due to staff shortages and sickness and demands on the hospital due to on-going health regulatory checks.

Therefore, in response to the care, security and organisational needs of the women, staff and hospitals, one staff focus group and seven individual women's' feedback sessions were held with those who took part at the high secure hospital. In line with PAR, the focus group and feedback sessions offered an opportunity for the women and staff to discuss whether the findings were reflective of the stories they had told during their interview, and to consider whether they felt the findings captured their lived experiential knowledge. The women and staff were encouraged to discuss and evaluate the main themes of the findings, and to consider whether they felt the subcategories aligned with the overarching themes. This included the quantitative data (word frequencies), which the women and staff were asked to review whether the most commonly cited words reflected their understanding of the risk factors for, and functions of life-threatening self-harm. The overarching themes from chapter 6, (experiencing life-threatening self-harm), the findings found in Chapter 7, (functions of and pathways to life-threatening self-harm) which where presented using a visual representation of the findings, and the findings from chapter 8 (the impact of restricting access to means) were also presented. Where discrepancies were identified, or the women and staff did not feel the findings were representative of their interview, the original transcripts were reviewed and reconsidered. Whilst it has previously been noted that a decision was made which deemed it inappropriate to continue with the design and validation of a draft assessment tool, a conversation was still held regarding the authors interpretation of how the women and staff believed an assessment ought to take place and what should be included. As stated in Chapter 9, (section 9.6), it is planned that this information will be used for future research plans.

6 members of staff took part in the focus group. The focus group lastedfor 75 minutes and was held in the Psychology department of the high secure hospital. Each of the individual feedback sessions took place in a private room on the ward where the women lived. With permission, a named nurse sat in on each feedback session (to facilitate appropriate levels of observation required as part of each women's care plan), and each session lasted approximately 20-30 minutes. In line with suggestions from PAR literature that advocate the importance of minimising power dynamics between the original researcher and participants, the focus group and feedback sessions were not recorded. This decision was made to help blur the boundaries between the researcher and the researched (Baum et al, 2010; Vollman et al, 2004), and to promote a sense of autonomy amongst the participants to critically evaluate the findings, and to help them view themselves as equal researchers who were part of a co-production of knowledge (Macdonald, 2012; O-Brian, 2001).

Feedback sessions are in line with the PAR framework as they allowed the women and staff to act as member checkers, which helped facilitate the process of validating the findings. Also, in line with the PAR framework during the feedback sessions, the women and staff were asked for suggestions on how best to disseminate the findings from the research. We discussed the importance of publishing the findings in academic journals, and also presenting the findings to the NHS senior management team. Three members of staff and five of the women expressed an interest in taking part in presenting the findings back to the management team. A more detailed plan for disseminating the findings and future research plans can be found in Chapter 9, (section 9.6).

5.5 Participants

5.5.1 Staff

Eighteen members of staff from the three secure services self-selected and provided consent to take part in a one-to-one interview. Three members of staff later withdrew. One withdrew because of a family bereavement, one left their employment with the hospital, and one was seconded to another hospital for their Nursing training. Interviews were completed with 15 members of staff. Six members of staff were employed in the high secure hospital. Four were employed on the WEMS ward at the medium secure service, and a further three were from the standard medium secure wards. The remaining two members of staff were employed at the low secure service.

Table 8: Staff sample

Job Title	N	Gender		Ethnicity			Age			
		Female	Male	White British	Black British	British Indian	18 - 30	31 - 40	41 - 50	51 - 60
Healthcare Assistant	3	2	1	2	1	0	2	1	0	0
Registered Nurse	4	3	1	4	0	0	0	3	1	0
Registered Psychologist	2	2	0	2	0	0	0	1	1	0
Trainee Forensic Psychologist	1	1	0	1	0	0	1	0	0	0
Assistant Psychologist	1	1	0	0	0	1	1	0	0	0

Clinical Team Leader	1	1	0	0	0	1	0	1	0	0
Speciality Psychiatric Doctor	1	0	1	1	0	0	0	1	0	0
Clinical Nurse Practitioner	2	2	0	2	0	0	0	0	1	1
Total	15	12	3	12	1	2	4	7	3	1

5.5.1.1 Staff Sampling Strategy

A staff sample was identified through self-selection, via an invitation to research email. To uphold staff anonymity and to ensure the ward could suitably facilitate any participation, an invitation email was sent via the senior Psychologist at each research site, who forwarded this to the appropriate ward managers. Ward managers were then asked to distribute the email among their staffing teams, and to provide each member of staff with an information sheet. Those who self-selected and expressed an interest in the research gave permission for the ward manager to provide their contact details to the Psychologist, who in turn passed these to the researcher. The researcher contacted the staff directly via an introductory email to allow the staff to ask any questions. Each staff member was given a week to reflect on the information sheet and the conversation with the researcher, before being contacted to schedule an interview. Each ward manager was consulted to ensure they would support the staff member to take part and facilitate time off the ward to attend the interview.

Recruitment Inclusion Criteria

- Direct clinical experience of treating or intervening with women's self-harm behaviour

And be

- A member of staff from either the direct nursing team, the psychology team or the psychiatric medical team.

Recruitment Exclusion Criteria

- No experience of directly delivering care to women who self-harm and/or have attempted suicide.

5.5.2 Women

5.5.2.1 High Secure

Of the 29 women identified during the planning and recruitment audit, 5 patients were no longer receiving treatment within service. The RC's and PP's excluded 13 women as they were deemed high risk of imminently attempting to end their lives or were being nursed on 1:1 observation in sterile or segregated environments. 11 women remained and were available to approach for the individual interviews. Nine women consented to take part in the research, however two of these later withdrew. Seven women were interviewed from the high secure service.

5.5.2.2 Medium and Enhanced Medium Security

Of the 14 women identified during the planning and recruitment audit, 5 patients were no longer receiving treatment within the medium secure service. It was not possible to approach two of the remaining women as they were receiving care within general hospital, having been admitted for self-harm related injuries. The Responsible Clinician and Principle Psychologist excluded one woman, as she was due for imminent discharge from the service. Six women remained and were available to approach for individual interviews. Unfortunately, on approaching the women, all six chose not to take part.

5.5.2.3 Low Security

Of the 10 women identified during the planning and recruitment audit, five patients were no longer receiving treatment within the low secure service. Four women had been transferred to a different medium secure service and one had been discharged to the community. The Responsible Clinician and Principle Psychologist excluded two women as they were assessed as high risk of imminently attempting to end their lives and were receiving 1:1 nursing in sterile or segregated environments. Three women remained and were available to approach for interviews. On approaching the women, one declined to speak to the Principle Psychologist due to her increased levels of distress, and the remaining two women declined to take part in the study.

5.5.2.4. Women's Sampling Strategy

To identify a potential sample of women, an audit was conducted to review incident reports pertaining to acts of self-harm and/or suicide attempts (see chapter 5, section 5.2.2.2). In total, 53 women met the inclusion criteria.

Inclusion Criteria

- Aged 18 years old and above
- Women detained under the Mental Health Act and receiving forensic care within the forensic pathway in Nottinghamshire NHS trust.
- A history of 5 or more incidents of self-harm behaviour between November 2015 and November 2016
- Women with all diagnosis, and offending histories

Exclusion Criteria

- Those with less than five documented incidents of self-harm or suicidal behaviours (as documented on the NHS incident reporting system)
- No documented incidents of self-harm and suicidal behaviour
- Those who threatened, but had not enacted self-harm on five or more occasions

Table 9: Potential sample distribution across the forensic pathway

Hospital	Number of women
High Secure Hospital	29
Medium Secure Hospital (including WEMS)	14
Low Secure Hospital	10

Unusually, it was not possible to obtain demographic information for the women who took part in the current research. This was attributable to a decision made by the HRA Ethics board, to help ensure confidentiality and anonymity due to the high-profile status of many women within secure forensic mental health services. However, demographic information was available within each incident report of self-harm and/or suicide attempt used for the audit of incident reports (see section 5.2.2.2 above), including time and location of the incident and the method of self-harm. Therefore, to help generate a working model of self-harm and/or suicide

attempts within secure forensic mental health hospitals, and to form a better picture of the women who took part, the demographic information has been presented below.

Of the 272 incident reports were reviewed, (relating to 53 adult women receiving forensic care in the high, medium, or low secure hospital), 55.7% (n=151) of the total incidents occurred in the high secure setting. 22.7% (n=62) of incidents corresponded to women receiving care in the medium or enhanced medium secure service, and 21.6% (n=59) related to incidents that occurred in the low secure service. The highest rates of self-harm were noted in the latter hours of the day, specifically between the times of 16.00 and 23.59 (n=164). This pattern was noticed at each individual hospital. The fewest incidents occurred between 00.00 and 07.59am (n=15). Incidents of self-harm took place in a variety of locations across the three forensic hospitals and is illustrated in Table 10. Across the pathway, in general, self-harm was more common in private parts of the wards (52.4%) and was less common in public spaces such as communal areas (47.6%). Very few incidents occurred in external areas away from the wards, such as gardens or hospital grounds. 59% of self-harm incidents occurred in patient bedrooms, 13.6% occurred within seclusion suites, and 6.6% took place in patient bath/shower rooms. In 127 incidents (46.5%) staff witnessed the act of self-harm. In 51 incidents (18.7%) women had disclosed their staff, and in 2 incidents (0.7%), a peer disclosed the self-harm on behalf of another woman patient.

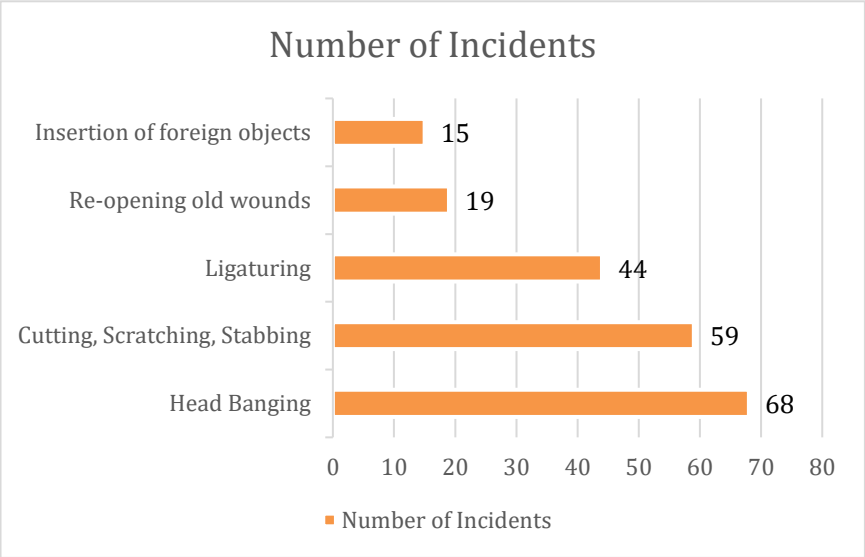
Table 10: Location of self-harm incidents

Ward Location	**Frequency**
Patient Bedrooms	59%
Seclusion Suites	13.6%
Patient bathroom/shower room	6.6%
Ward Corridors	2.6%
Day rooms	1.1%
Dining rooms	0.7%
External areas of the ward	0.7%
Clinic Rooms	0.4%

Across the three forensic mental health hospitals, 19 different methods of self-harm were used. These methods ranged from cutting, biting, deliberate choking, food refusal, head

banging, hitting the self or hitting an object, ingestion objects, insertion of foreign body, ligaturing, vein-popping, occluding, and re-opening old wounds. Head banging was frequently used across the Trust and was the most common form of self-harm in the high and medium secure hospitals. The methods least frequently used were food refusal (0.4%), and vein-popping to allow bloodletting (1.1%).

Figure 10: Most frequent methods of self-harm across forensic pathway



5.5.2.5 Screening

Prior to inviting the women to take part in the interview phase of the project, in line with HRA ethical requirements, a screening process took place to assess the capacity and risk status of the women identified during the audit sampling strategy. The Responsible Clinician (Psychiatrist) and Principle Psychologist at each research site completed capacity screening and assessed women for

1) Capacity to provide informed consent
2) Current self-harm risk status
3) Stage of treatment

Women who were deemed to not have capacity, or to pose a heightened or imminent risk of engaging in self-harm were excluded. Women were also excluded if the RC or PP felt that they were in a stage of their treatment whereby participation would be detrimental to their recovery

5.5.2.6 Recruitment Method

To protect anonymity, the principle psychologist (PP), or clinical nurse practitioner (CNP) at each research site approached the women during 1:1 psychology or nursing sessions and discussed the research project. The PP or CNP provided the women with information booklets, which gave an in-depth description of the study, detailed what their participation would involve, and explained how the information they shared during their interviews was going to be used. To ensure the information sheets were visually engaging and used language that was accessible to women in the forensic community, feedback collected from some of the women was used to refine the supporting documentation during the ethical approval stages of the project. To ensure the women were able to provide informed consent, where required, the staff assisted the women to read the information booklets and answered any initial questions. All the women who were approached were given the information sheets to keep or was kept and made available for those who due to risk had limited, or supervised access to paper. When a woman expressed an interest in the research project, individual meetings were arranged with the researcher to facilitate an initial contact conversation and discuss any questions about the research. To ensure each woman suitably understood the research and was able to voluntarily provide informed consent a member of their direct therapeutic team attended the initial meeting with the researcher. Participants were asked if they wanted to participate and written consent was taken if appropriate. Having given informed consent, each woman was given a 7-10 day cooling off period prior to their interview to ensure they still wished to take part in the research project.

5.6 Data Analysis

5.6.1 Transcription

To protect the anonymity of the women and staff, the researcher transcribed all interviews. The interviews were transcribed verbatim, meaning all interviews were transcribed as they were heard. Transcription took place in a designated office within the Psychology departments at each corresponding research site. Participants were allocated a pseudonym and any identifiable information that could be used to identify participants or research sites was removed. The allocated pseudonyms were used to reference all quotes within the findings chapter of the thesis. Anonymised transcripts were saved to a password-protected document and were uploaded to a secure personal storage drive that was safeguarded by the Nottingham Trent University firewall. After transcription, recordings of all interviews were

deleted. Printed copies of all transcripts were stored in a lock filing cabinet, which was located in a secure smartcard protected office.

5.6.2 Analysis

To undertake data analysis, summative content analysis (SCA) was employed. Content analysis is regarded a flexible method for analysing large volumes of text data (Cavanagh, 1997), which comes from interviews, focus groups, open-ended survey questionnaires, diaries, media print, and observations (Hsieh & Shannon, 2005; Tesch, 1990). The aim of content analysis is to "provide knowledge and understanding of the phenomenon under study" (Downe-Wamboldt, 1992, p.314). Content analysis condenses large amounts of information into smaller, refined categories that reflect the data and its meanings (Weber, 1990). There are three forms of content analysis - conventional content analysis, directed content analysis, and summative content analysis (Hsieh, 2005). Depending on the aims of the research, the most appropriate method is selected. Whilst opting for either qualitative or quantitative content analysis can be helpful, Webster (1990) argued that the best forms of content analysis are those that can operate both quantitative and qualitative data, as together, they provide the richest level of understanding from within a collection of texts. This is known as Summative Content Analysis (SCA).

Unlike many other forms of qualitative data analysis, content analysis places more emphasis on directly extracting meaning from text and less on researcher interpretation. Patton (2002, p.453) describes such a process as "any data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings". In doing so, SCA is thought to be particularly useful for uncovering new knowledge and understanding as it allows the direct extraction of meanings, themes and patterns within both manifest and latent text (Zhang & Wildemuth, 2009). Therefore, arguably SCA facilitates a rich understanding of a community's reality in a subjective yet scientific way (Zhang & Wildemuth, 2009). Considering the design of the current research, (a concurrent, unequally weighted, embedded design, where quantitative data was embedded within a qualitative design), summative content analysis was chosen on account of its compatibility with both quantitative and qualitative data.

In addition, SCA was favoured due to its emphasis on extracting direct meaning from the text, and less interest in complex interpretations. Adopting a SCA would therefore facilitate the direct extraction of the voices of the women and staff who took part in the current research and would not favour the voice of the researcher. This was crucial for the current research for

three reasons. Firstly, little is known about life-threatening self-harm in forensic mental health services, meaning the expert testimony of those with lived experience needed to guide the generation of new knowledge. Secondly, due to the disenfranchised nature of women in forensic mental health services, it felt important that a method of data analysis was chosen that would not alter or stifle the voices of the women and staff who took part. Therefore, it was essential to choose a data analysis method, which assumed that the truth about a reality or phenomena ought to be found directly within text, and one that places less emphasis on researcher interpretation. Finally, adopting a data analysis method that allowed the direct extraction of knowledge and meaning from the text lent itself to the research outlined within this thesis as it helped facilitate the process of member checking. In accordance with the stages of participatory action research, to help validate the findings, where possible, participants of a research study ought to be involved at each stage of the research, including data analysis (Ward & Bailey, 2012). SCA offered an accessible method of data analysis for the women and staff, (meaning they would be able to confirm or refute the findings), due to its ability to directly extract words, patterns, and meaning from the text. In doing so, SCA offered an opportunity to help co-produce knowledge and develop a shared language and understanding of life-threatening self-harm.

Summative content analysis was also chosen for the current research study as it lends itself to recruitment strategies whereby a selection of purposely selected texts is used to inform the research questions (Zhang & Widemuth, 2009). This is helpful for the current study as a well thought out recruitment inclusion and exclusion criteria was introduced to ensure that the women and staff who took part in the research had lived experience of caring for or engaging in life-threatening self-harm within forensic mental health services. Consequentially, opting for a data analysis method that required a random sampling strategy or a probabilistic approach (like many quantitative methods of analysis) would have been unsuitable. Finally, SCA was chosen for the current research as previous literature has noted its usefulness in studies that intend to create descriptions or typologies using the direct expressions regarding the phenomena under study, found within participants data (Zhang & Wildmuth, 2009). This is essential for the current study considering one of the overarching research aims was to describe, and better understand the functions of and pathways to life-threatening self-harm amongst women from the forensic mental health community.

5.6.3 Quantitative Data

The first stage of summative content analysis (SCA) enables researchers to analyse data quantitatively by exploring and quantifying word usage within the data. The manifest content analysis stage is focussed solely on exposing word usage and does not seek to infer any meaning (Hsieh, 2005; Potter & Levine-Donnerstien, 1999). A SCA searches the transcripts for the presence of specific words; phrases or sentences and the occurrence of the words, sentence or phrase are counted. According to Morgan, (1993), word counting allows for the identification of patterns within the data, which can then be compared between participants. This approach therefore allows their direct understanding to be extracted from the data, without being clouded, or distorted by the interpretation of the researcher.

A manifest content analysis (MCA) was performed on the data collected from the individual semi-structured interviews to help identify and compare initial patterns within the data. The manifest stage was completed with an aim of informing the qualitative analysis of the data, and supplementing, or validating any findings in the qualitative analysis. In the first instance, MCA was used to inform whether the findings within the data from the women and staff ought to be told together as one coherent story, or if it was necessary to present and compare the lived experiences of the staff and women separately to develop a better understanding of self-harm and suicidal behaviours in forensic mental health services.

To achieve this, the MCA stage required the author to become immersed within the data by reading each transcript at least twice. During each reading of the transcript, the author noted by hand words that were used frequently by the women and staff in relation to the functions of, and risk factors for near-lethal self-harm, and a list was collated. The MCA was then performed electronically and the 'find function' was employed within Microsoft Word (the programme which hosted the transcripts), to quantify the usage of the most commonly cited functions and risk factors for near-lethal self-harm. Using Microsoft Excel, a record was made of the number of times each participant mentioned the frequently cited word. The word frequencies for the women and staff were kept separate. This process was completed for each transcript and when a new frequently used word emerged, the author went back through each transcript and completed an electronic search. Where the word was cited in the correct context, the author updated the excel spreadsheet.

Once the MCA had been completed by hand and electronically, the word frequencies from the women and staff were reviewed and a sort filter was applied so that the commonly cited words could be put into order according to their usage frequency. Where words were similar

or represented the same meaning in a specific context (e.g. trauma and abusive, or significant life event, bad news and anniversaries), the word frequencies were combined. The word frequencies were then compared between the women and staff to determine how their lived experiential knowledge ought to be analysed. As can be seen in table 12 (chapter 7, section 7.3), as the word frequencies between the women and staff were similar. Therefore, the MCA informed that the qualitative analysis of the women and staffs' transcripts ought to occur together.

The word frequencies relating to the functions of, and risk factors for near-lethal self-harm were also used later used to inform and support the findings presented in chapter 7 (functions of and pathways to life-threatening self-harm), and before changing the aims of the research (see chapter 4, critical reflections), were used to directly inform the draft assessment tool. As later described within the plans for dissemination and future research (see chapter 9, section 9.6), the word frequencies will be revisited during the planned finalising of the design and validation of the draft assessment tool.

5.6.4 Qualitative data

A second phase of summative content analysis was then adopted, which facilitates the process of qualitative interpretation of the content found within the transcripts (Holsti, 1969). This is known as latent content analysis (LCA), and was used to provide context to the functions and risk factors identified during the manifest content analysis phase, explore the differences between self-harm and suicidal behaviour and establish the pathways to life-threatening self-harm and inform understanding of the role of restricting access to means on life-threatening self-harm. Previously, LCA has been evidenced as being a useful form of analysis to develop models relating to the phenomenon under study (Lindkvist, 1981). LCA involves the researcher emerging themselves within the data and identifying codes that capture the key concepts and thoughts within the transcripts (Hsieh, 2005). Each interview transcript was read through at least twice and codes that represented the key concepts and thoughts (themes) within the transcripts were identified (Hsieh, 2005). The process of analysis relies on the researcher continuing to read the transcripts throughout the process of analysis to allow any new codes and themes to emerge. In doing so, meaningful clustering of text is refined into categories, which assists in the development of rich knowledge about the phenomenon under study (Patton, 2002; Coffey & Atkinson, 1996). With time, the codes and categories become further refined, and definitions are given to describe the meaning within each theme (Morse & Field,

1995). This process can be found in the tables providing additional quotations for findings in chapter 7.

Typically, the latent stage of content analysis occurs in an inductive way. Through a careful and considerate inductive approach, the meanings and underlying messages are identified from within the data and are not driven by hypothesis testing or coded using findings from previous empirical research (Zhang & Widemuth, 2009). It is important to note that a deductive approach can also be utilised for the latent stage of content analysis, and Patton (2002) suggests that considering previous concepts about the topic under study can play a useful role in the early stages of design and analysis. In relation to the current study, although an inductive approach was taken when analysing the qualitative data, the interview topic guidelines and initial reading of the transcripts were done deductively, on account of the lack of previous literature relating to life-threatening self-harm in forensic mental health services (see chapter 5, section 5.2.3.1).

To aid validity, LCA follows a set of predefined, transparent steps (Zhang & Widemuth, 2009). In line with the participatory action research framework, depending on the goals of the research, the steps of a LCA can be prescriptively or flexibly completed. For the purpose of the current research, as suggested by Zhang & Widemuth, (2009), the LCA adopted the following steps.

1) *Preparing the data*

All audio recordings of individual interviews were transcribed verbatim and anonymised by the author.

2) *Defining the unit of analysis*

The term 'theme' was adopted and was expressed as either; a single word, a phrase or a sentence, and related to an overarching 'expression of an idea' (Minichiello et al, 1990).

3) *Develop categories and a coding scheme*

As the literature relating to life-threatening self-harm in forensic mental health services was scant, for the first two studies (see chapter 6 and 7), an inductive approach was adopted. As more is known about the impact of restricting access to means within the community, but little is known about its application within forensic mental health services, for the final study (see chapter 8), a deductive approach was adopted, whereby previous literature was used to

inform the data analysis. As reported in chapter 4, this included exploring the impact of restricting access to means on the lethality of self-harm and suicidal behaviour, seeking to understand whether method substitution occurs, and if so, understanding how it impacts the lethality of self-harm and suicidal behaviour.

In line with suggestions from Glaser & Strauss, (1967), to ensure the analysis unearthed the original insights within the data, and to make the differences between categories apparent, a constant comparative method was used. The constant comparative method firstly involves systematically comparing each sentence or quotation assigned to a category or theme with the sentences or quotations that already exist within the category or theme. This helps to ensure each sentence or quotation aligns with the emerging meaning of the category.

In the case of the current research, the process of the constant comparative method was recorded on an excel spreadsheet, and sentences or quotations were allocated to a tab (one for each emerging theme). Throughout the process of analysis, the names of the themes developed, and quotations and sentences were moved around the different tabs until they resided in what appeared to be the most appropriate theme. Each time a sentence or quotation was moved, it was compared to those already residing within the theme to ensure they aligned with and bolstered the meaning of the theme. This helped to ensure that the themes were as internally homogenous as possible whilst being externally as heterogeneous as possible (Lincoln & Guba, 1985).

4) Test the coding scheme on a sample of text

To ensure the coding scheme being used was appropriate and representative of the data, the supervisory team reviewed the coding on a sample of data. This involved using the interpretive memos and the quotations and sentences within themes aligned with a sample of data from various transcripts. The meaning of the themes was discussed and refined when discrepancies were identified.

5) Code all of the text

Having reviewed the coding system, all the transcripts were coded.

6) Assess the coding consistency

It is known that throughout the process of coding, there may be subtle changes in the meaning and understanding of themes (Miles & Huberman, 1994; Weber, 1990). Therefore, to ensure there is still consistency amongst the coding system, having coded the entire data set, the

themes and the quotations within the themes were reviewed to check they continued to represent the appropriate meaning of each theme.

7) Draw conclusions from the coded data

Having coded and assessed all data, the relationships within and between themes were explored and conclusions about the findings were drawn. Key to the validity of the findings of a SCA is the verification process, whereby researchers are able to check their findings with their participants (Lincoln & Guba, 1985). This process is known as member checking, and took place during one staff focus group, and individual feedback sessions with the women (see section 5.4 above).

8) Report the findings

As qualitative analysis does not produce statistical comparisons like quantitative data analysis, it is important to provide evidence to support the findings of qualitative research. To do this, Schilling (2006) emphasises the importance of presenting quotations that help support and justify the researcher's conclusions. Furthermore, it is recommended that tables or graphs are included that illustrate the refinement process of theme development. Consequentially, for the current research, quotations were used within the body of text to evidence and support the conclusions drawn from the data, and tables have been included that show the refinement process of quotations, the meaning behind the quotations, coding and finally, the allocation of quotations to themes.

5.7 Considerations for alternative data analysis methods

As PAR offers a research design framework, many methods of data analysis are compatible. Therefore, to review whether content analysis was the most appropriate data analysis method to employ for the research detailed within the current thesis, it was important to consider alternative methods.

5.7.1. Grounded theory

Charmaz (1996) described grounded theory as the "logically consistent set of data collection and analytic procedures aimed at developing theory". According to Glaser & Strauss (1967), grounded theory is appropriate for 'every kind of data', and is suitable for studying individual processes, interpersonal relations, and iterations between individuals and larger social processes. Grounded theory ought to be selected when the researcher seeks to gain a deeper understand of a psychological process, of a specific group of individuals, and not that of a

whole population (Charmaz, 1996). Grounded theory makes no pre-determined assumptions about what knowledge or theory might be tested, rather the theory is allowed to emerge from the data. Grounded theory is therefore compatible with a PAR design as it facilitates the potential for theory to emerge from a research project that is informed by the experiences of the stakeholders taking part. However, considering its emphasis on theory generation, grounded theory was not considered the most appropriate method of data analysis, as its fundamental aim does not align with the aims of the current research. Instead the primary aim of the project was to better understand the differences between self-harm and suicidal behaviour, in a bid to clarify the role of, and reasons for near-lethal self-harm. On balance, content analysis appeared more suitable to facilitate the generation of data to inform a draft assessment that better captures the specific risk factors for women receiving forensic care.

5.7.2 Interpretative Phenomenological Analysis (IPA)

Underpinned by the phenomenology that posits the central concern of research ought to be exploring the meanings individuals assign to events, (Biggerstaff & Thompson, 2008), IPA assumes researchers are able to access the cognitive inner world of individuals through the engagement of text. According to IPA, such access is only available through an interpretative process (Potter, 1996), and focuses on subjective experience and personal accounts (Allport, 1953). IPA is therefore a suitable research method when adopting a PAR design. Like a PAR framework suggests, IPA enlists a semi-structured interview design, offering flexibility to facilitate participant's voices, understanding and experiences. However, unlike PAR which values participation and the co-produced knowledge, IPA places importance on the researcher designing and leading the interviews, and on their interpretations of the meaning assigned to experience by those being studied (Biggerstaff & Thompson, 2008). Therefore, IPA appears incompatible with a PAR project that values stakeholder involvement and the ability of a community to share their knowledge about a topic explicitly. Furthermore, the heavy reliance on researcher interpretation made IPA less favourable for the current research, which aimed to understand self-harm and suicidal behaviour using the first hand, raw perspectives of those it affects. Despite advocating service user involvement, research that adapts or changes the testimony of its stakeholders and places it within a framework of language belonging to the researcher, which may not fully represent the words of the community under study. This means participants voices can become hidden, and the experiential knowledge they shared can be lost in translation, or indeed interpretation. Therefore, it appeared more suitable to enlist content analysis for the research, allowing the researcher to directly extract the

experimental knowledge of the stakeholders to enrich our understanding of near-lethal self-harm.

Ethical Approval and Considerations

5.8 Ethical Approval

Prior to the study commencing, the appropriate Research and Development team was approached to discuss the research proposal. Once support was garnered, ethical approval was obtained from the Health Research Authority (project approval ID: 199758), East Midlands NRES Committee (REC reference: 16/EM/0364) (see Appendix A), and Nottingham Trent University (see Appendix B). Ethical approval was provided for the author to approach and interview staff and women from three secure hospitals in one NHS forensic pathway in the United Kingdom. Permission was granted to hold one-to-one interviews and staff feedback focus groups and individual women's feedback sessions to discuss self-harm and suicidal behaviours in women's secure services. Agreement for access to patients was also provided by the clinical directorate team at each of the three sites involved in the study, and the author was placed on an honorary contract for four years with the NHS trust. By involving women with complex mental health needs, the research was designed to explore the differences between self-harm and suicidal behaviour in adult women receiving forensic care within Nottinghamshire NHS trust. In addition to ethical approval, permissions were sought from each clinical directorate team for access to incident reports (IR1 forms) pertaining to incidents of self-harm and suicide attempts and interviewing women and staff.

5.8.1 Ethical Considerations

Given the sensitivity of the research topic, the vulnerability of the client group, and the secure nature of the research sites, there were a number of key ethical considerations. Throughout the process of applying for ethical approval, the researcher sought input from the clinical directorate at each research site and the supervisory team, to ensure each stage of the application had been appropriately thought through, and any risks were suitably contained and managed. All research sites agreed that the ethical approval process fully considered all risks to service users, staff, and service security.

5.8.1.1 Psychological health and well-being

A fundamental ethical consideration associated with the research was the psychological wellbeing of those taking part. Given the discussion of sensitive and often traumatic incidents

that can act as triggers to self-harm, it was accepted that there was a risk that some participants may become upset, or find it distressing to revisit difficult memories. To minimise distress and to provide appropriate support, a number of safeguards were put in place. Firstly, due to the author's experience of working with women who engage in self-harm and suicidal behaviours whilst cared for in secure forensic services, it was accepted that the author could provide low level support to participants if they felt upset. Additional support was offered from the Principle Psychologist (PP) and Named Nurse (NN) at each research site, and a network of support was put in place to assist both the women and staff should an increased level of distress occur. Participants were informed of the support available to them, and the direct care team and staff managers agreed to liaise with participants to check on their wellbeing. For the women who chose to take part, with consent, their responsible clinician (RC) was informed to ensure the staffing team could provide a collaborative, supportive approach in the eventuality that it was needed. For the staff participants, their managers were notified to ensure they were offered supervision if necessary.

5.8.1.2 Author's Psychological Well Being

In light of the sensitive research topic, the supervisory team was available to provide psychological support and guidance should the author experience any upset or distress. The supervisory team consisted of a Chartered and Registered Forensic Psychologist, a Professor of Mental Health and a Qualified Social Worker. As the research was conducted as part of a PhD degree, the author also had access to the university student counselling services if necessary.

5.8.1.3 Informed Consent and Capacity

Staff

An invitation to research was distributed by ward managers to the staff on each of the women's wards. Each member of staff received an email containing an information sheet relating to the project. When a member of staff expressed an interest in taking part, a meeting was scheduled one week after receiving the information sheet to allow them to ask questions regarding the research. If they wished to participate, the researcher obtained written consent for the staff sample on the first point of contact after reviewing the information sheet, consent form, and withdrawal process. Participants were reminded that participation was voluntary and taking part would not affect their employment rights.

Women

Having conducted an audit of NHS incident reports and identified a group of women who met the inclusion criteria, the RC's and PP's at each research site screened the list of potential participants to ensure they had capacity to provide informed consent. The RC and PP excluded women who in their clinical judgement lacked capacity, or those they believed wellbeing or treatment would be detrimentally affected by taking part. Once completed, the researcher provided the lead psychologist with an invitation to research letter and an information sheet, which was provided to the women who remained on the list. Taking into consideration the increased prevalence of intellectual disability within the forensic population, the information sheets and consent forms were tailored accordingly, using suitable language and visual descriptions to aid understanding. To ensure the patient sample was supported to provide informed consent, where necessary, staff assisted the women to read the information sheets during 1:1 nurse session, or psychology sessions. In order to further aid understanding, when a woman expressed an interest in participating, a meeting was scheduled with the author one week after receiving the information sheets to allow them to ask questions about the research. After reviewing the information sheet, the consent form, and reminding participants of their right to withdraw from the study, the researcher obtained written, informed consent for those who wanted to participate. All women were reminded that participation was voluntary and taking part or declining would not affect their medical or legal rights.

In accordance with Regulation 3 of the Mental Capacity Act 2005, (Loss of Capacity during Research Project) (England), Regulations, 2007, in the event that a participant lost capacity, any data that was collected with informed consent during a previous stage would be kept and used for the research project. To ensure participants fully understood, when completing the consent form, this was discussed verbally, and the women were asked for an additional signature to indicate their understanding.

5.8.1.4 Confidentiality

Confidentiality, security and anonymity were recognised as key ethical considerations during all stages of the research. In order to ensure these ethical issues were managed, the following procedures were followed.

Recruitment for Women

In order to identify a potential suitable sample of women who met the inclusion criteria, an audit took place to review incident reports (IR1 forms) held on the computerised reporting system (see chapter 4, section 5.2.2.2). To protect patient anonymity, a member of

administration staff at the High Secure Hospital collated incident reports and anonymised them. The administrative staff member gave each participant a unique identifier and an identifiable list was created and stored at the High Secure Hospital. Only one psychologist at the hospital had access to the list. The compiled, anonymised audit was exported to the researcher in a password-protected document, which only the researcher and the supervisory team had access to.

To ensure the identity of the women identified during the audit remained confidential during the recruitment process, all initial contact with the women occurred via the psychologist from within the service. Their identity was only revealed to the researcher after a woman expressed an interest in taking part in the research on the day the initial meeting was scheduled.

Recruitment for Staff

To maintain the confidentiality of the staff members at each research site, an invitation to participate in the research was sent out indirectly through the principle psychologist. The PP sent the information sheets along with the invitation email to the ward managers of each of the women's wards. They were then distributed accordingly to their staff. Staff who responded, expressing an interest to participate were asked to give consent for their email address and name to be provided to the researcher. In receipt of the contact details, the researcher made contact with staff participants.

Transcription and Dissemination

To protect their identity, participants were allocated pseudonyms during the transcription process. The pseudonyms were used within the thesis, and any dissemination of findings. All interviews and focus groups were transcribed on site by the researcher. Any names of people and/or services were removed. All recordings were deleted once transcribed and any notes made during interviews or focus groups were destroyed. Any information that could help to identify an individual, for example physical characteristics or unique offending histories, was omitted from the transcripts.

Safeguarding

Both staff and women were informed that their one-to-one interviews were confidential, unless they disclosed information that identified or indicated a risk of harm to either themselves, their peers, members of staff, or threatened the security of the hospital. This included active plans to harm themselves, or knowledge of another person's active plans. Participants were advised that should they report plans for harm, then confidentiality would

be broken. Confidentiality would not be broken in instances where participants reported old incidents of self-harm, even if they had not been reported.

5.8.1.5 Data Protection

The researcher was governed by the Data Protection Act (1998), (now the GDPR, 2018) and the Nottingham Trent University data protection requirements.

All electronic data generated from the research was saved in password-protected documents and was uploaded to a personal electronic one-drive, that was safeguarded by the Nottingham Trent University IT network. Any hard copies were stored in locked filing cabinets at Nottingham Trent University. Throughout the duration of the research project, only the researcher and the supervisory team had access to the electronic one-drive and the filing cabinet.

5.8.1.6 Payment

In line with recommendations from the Health Research Authority (2015), to reduce the risk of coercion, undue inducement, or financial vulnerability, no offer of payment was made to the women or staff in return for their participation.

5.8.1.7 Conflict of interest

During the duration of the research project, there were no conflicts of interest. At the time of the research, the author and all members of the supervisory team were employed by Nottingham Trent University, and none practised within any NHS organisation, or had a prior affiliation with Nottingham NHS Healthcare Trust.

5.8.1.8 Compliance Check

In order to monitor the compliance of the ethical protocol associated with this research, the NHS Research and Development team conducted a compliance audit in 2017. All data protection laws, and aspects of the ethical protocol were upheld (see appendix F).

5.9 Critical Reflections

5.9.1 Audit and participant recruitment

A key ethical consideration for this project was protecting the anonymity of the women across the forensic pathway. This required careful planning to ensure I was able to identify a

potential sample whilst ensuring I did not have access to any patient information prior to obtaining informed consent. To achieve this, together with the clinical team leaders and the local Research and Development Team, it was decided that a member of NHS administrative staff would undertake the initial process of the recruitment audit (see section 5.5.2.6). This entailed reviewing patient information and NHS incident reports for woman receiving care in one of the three research sites, applying the inclusion and exclusion criteria, and anonymising information. As a result of these necessary steps, it was important to acknowledge time constraints around the audit and consider how this would impact the workload of the individual undertaking the audit. To help ascertain the feasibility of an audit, an initial scoping exercise took place to review the number of incident reports pertaining to the women understudy. 20,000 reports met the initial criteria, which included reports over a five-year period. Clearly, this number of reports was unmanageable and unreasonable for the admin staff to anonymise.

Consequentially, it was necessary to refine the audit search criteria to reduce the number of incident reports. Unfortunately, in doing so, the number of potential participants also reduced. Whilst the introduced inclusion and exclusion criteria (5 or more incidents of self-harm in a one year period, and excluding women who made threats but did not enact self-harm) was grounded in literature, the need to refine the number of incident reports (and therefore the number of potential women) undoubtedly affected the size of the final sample of women. Reflecting on this, I think this highlights a challenge with staff acting as gatekeepers for NHS research, as conducting the audit in the aforementioned way prevented some women from taking part. I also considered how the need for staff to act as gatekeepers may conflict with NICE and NHS guidelines, (which advocate public and patient involvement in research that affects their lives), as the gatekeeper policy meant that some women were excluded from the study, despite meeting the original inclusion criteria. I feel at odds with this on an ethical level, as I believe all service users ought to be given the same opportunity to take part in research. Therefore, in an attempt to avoid this occurring again, if time-constraints allowed, in future I would ensure I obtained an honorary contract at an earlier stage and perform the sampling audit myself to ensure the number of potential women remained as large as possible.

5.9.2 Screening

The aforementioned reflection also resonates with the process of patient screening, whereby the Responsible Clinician (RC) and Principle Psychologist (PP) screened the women identified as suitable in the audit. The women were assessed for their capacity to consent, mental

wellbeing, stages of treatment, and risk of self-harm and suicide. Whilst reflecting on this process, it was interesting to consider how many women were excluded from the research and to think about the reasons provided by the RC and PP. Whilst it is natural to expect both the women's directorate and the staff who care for them to want to uphold and protect the safety of their patients, I was surprised at the number of women who were excluded from the research before being asked if they were willing, or felt able to participate. It was apparent that there was a discrete battle between some of the RC and PP's paternalistic risk adverse nature, and the evidenced benefits of encouraging vulnerable people to participate in research.

Whilst I appreciate there will be some women who would be unable to participate due to the acute nature of their mental illness, or instability of risk, I was curious to consider whether some decisions were made based on protecting the women or protecting the service. This is because of literature demonstrates participation in research improves the relationships between service users and caregivers, and helps to foster a sense of purpose, control and ownership (Minogue et al, 2005). It was particularly interesting to observe the disparity between the exclusion of the women from the potential participant list across the services. In the case of the low secure service, all but two women were excluded prior to being approached despite the fact the women in low secure services would be deemed the least risky, compared to those in the medium and high secure service. In contrast, the medium secure service adopted a positive approach to risk managaement and only excluded one woman based on imminent risk. This resulted in the rest of the women from the identified list being given the choice whether to take part. This approach was also taken at the high secure hospital where all women were approached unless they were on the intensive care wards, or in segregation due to risk of harm to staff. Where exclusions were made, the RCs believed participation would be near on impossible due to their reduced level of engagement, acute mental illness, and risk of harm to themselves and others. Considering the ability of the high secure hospital to facilitate patient choice, I wondered whether the differences between the services exists either because higher security hospitals are more accustomed to life-threatening self-harm behaviour, meaning they feel able to manage such incidents, or whether there are lasting memories from the low secure service whereby serious incidents have created a risk adverse environment.

Thankfully, having completed the research and spoken to clinicians, there were no documented incidents of women who took part self-harming as a result of their participation in the project. Instead staff noted positive mood and the women expressed to me how much

they enjoyed taking part. Importantly, they felt they were helping others, and felt as though they were able to, and were going to make an important difference. This raises questions as to whether more autonomy ought to be given to mental health patients, who quite clearly can take part in meaningful research that has the potential to impact their lives.

There is one woman in particular that I continue to reflect on, which I think reinforces the discussion above:

Poppy is a young patient, receiving care in the high secure hospital. In most instances she is nursed on 2:1 or 3:1 observation and is considered high risk for self-harm and suicide. *Poppy* is also known to pose a risk of violence towards others and regularly assaults staff. In order to try and prevent her engaging in self-harming behaviours or being violent to others she is often held in mechanical restraint. As a result, *Poppy* was considered highly unlikely to engage in the research. Despite this, the service gave *Poppy* the opportunity to make her own decision and decide whether or not she wanted to take part. Having met with *Poppy,* she decided she wished to take part and provided informed consent. Despite visiting *her* on a number of occasions where she was too unwell to take part, *Poppy* maintained her desire to participate; therefore, I continued to visit her until I was able to interview her. *Poppy* took part in a 45-minute interview and was accompanied by one member of staff. *Poppy* told me that her main motivation for wanting to take part was to "help others", as she believed if someone had helped her to understand and manage her self-harm as a child, she would not be in the position she found herself in. *Poppy* was calm, open and engaged, and presented in contrast to the challenging individual I had seen on many other occasions. She told me she would like to be a part of all other aspects of the research, and regularly offered me feedback or ideas she had when I saw her on the ward. *Poppy* told me taking part made her feel like she was doing something to help other people.

5.9.3 Scope and Size of sample

Whilst originally it was anticipated that 8-15 women from across the three research sites would participate in the research, the final sample size was seven. As it was not possible to recruit the numbers as planned, I felt it was important to reflect on the reasons why this may have occurred. In respect of the number of women who participated, it is clear that the reason for the limited sample size is partly attributable to the need to reduce the size of the planning and recruitment audit. I have also considered how the screening approach is likely to have impacted the size and the scope of the women's sample as only women from the high secure

hospital took part. It was disappointing to have not been able to recruit women from the medium and low secure services, as it would have been be interesting to hear their stories and see if they corroborated those from the women and staff in the high secure hospital. I have reflected over this and considered whether the findings from the current research are limited to women receiving forensic care in high secure services. Whilst it is clear that the women who received care in the high secure services will differ to those in lower secure services in terms of their mental health and security needs, due to the step-wise nature of forensic services (i.e. women can be transferred between higher and lower security hospitals), the women who took part will all have had experiences in both medium and low secure hospitals. Therefore, whilst they are not currently living within medium or low secure services, they will have been able to draw upon their experiences of engaging in, and witnessing, others self-harm and suicidal behaviour in lower security hospitals. Additionally, the voices of staff that work across lower secure services were captured, meaning the findings are representative of the lived experience of medium and low secure services. Whilst this means the ability to generalise the findings to lower secure services is limited, on balance, I feel the findings are likely to be applicable to lower secure services as voices of some members of the medium and low secure community were captured.

Despite the extensive and complex ethical, procedural and organisational constraints for the research detailed within this thesis, I think I have shown how an adapted, flexible version of PAR can be utilised amongst the forensic population and have evidenced how it can be used to better understanding the challenges faced by marginalised groups, and create change. Additionally, I remain confident that women in forensic services, and those who receive care in wider mental health provisions are able and capable of taking part in research.

5.9.4 Data Collection - Interviewing on wards

As previously mentioned in the critical reflection section of Chapter 2, there is many notable pressures on forensic mental health services that impacts research conducted amongst the forensic mental health community. An example of such a pressure relates to staff shortages at the women's enhanced medium secure services (WEMSS). Unlike the other research sites whereby all interviews were conducted on the non-secure site of the hospital, the interviews with the WEMSS staff were conducted in a side room of the ward. This was because despite the efforts of the management teams, staff shortages meant the staff who participated could not leave the secure side of the hospital. Unfortunately, this meant interviews took place in a side room on the ward, and there were a number of interruptions from staff and service users

entering the interview room, and noises, which could be heard from the main areas of the ward. Understandably, it is likely that such interruptions put pressure on the staff, and it is my opinion that three members of staff ended their interviews prematurely because they felt that they ought to go back to work. It is therefore important to reflect on how this might have impacted the stories that the WEMSS staff told, and to consider how staff may have said more, or shared their stories in more depth should their interview have taken place away from the ward.

Having conducted interviews with the WEMSS staff I wondered whether their experience of taking part in research was different to other members of staff, and whether they felt their voice was heard. This is important considering a fundamental aim of participatory action research is to co-produce knowledge, and for the researched to become researchers. I felt this would be an important thing to address with the WEMSS staff during the focus groups, however, unfortunately, due to staff shortages it was not possible for the focus group to happen. Again I reflected on how this may have felt for those who took part in the research and considered whether not having an opportunity to be heard may be reflective of the culture amongst forensic mental health services that contributes to high staff burn out rates and low moral amongst staff.

Chapter 6: Findings
Experiencing Life-Threatening Self-Harm within Forensic Mental Health Hospitals "The Uncontrolled Surgery"

6. Overview

Chapter 6 presents findings from the semi-structured interviews conducted with staff and women from high, medium and low secure forensic mental health hospitals. The findings represent the first-hand experimental accounts of working with or enacting self-harm and suicidal behaviours within secure forensic hospitals. The chapter is broken down into four main themes from the data, language "one size does not fit", the severity of self-harm "some next level shit", being traumatised "witnessing haunting self-harm" and futile efforts "we try and try".

6.1 Introduction

Working within secure forensic environments is challenging. It is well known that the rates of incidents within secure forensic services are high (Uppal & McMurran, 2009), particularly those pertaining to self-harm. This is none truer than within women's secure services, whereby the services themselves have been cited as having 'a reputation within their wider organisational setting as highly stressful and demanding places to work' (Jeffcote & Watson, 2004; p.22). It has been documented that such challenges and demands particularly affect staff within the direct nursing team, who arguably are positioned 'on the front line' (Scalon & Adlam, 2011). There is also evidence that reports women's accounts of receiving care within forensic services, which also highlights that, at times, living amongst other acutely unwell women can be emotionally taxing (Beryl, Davies & Vollm, 2018). Despite literature that documents such experiential knowledge, to date, there is little research that captures the experiences of both women and staff working or living within secure forensic services together. Instead, research has either investigated the accounts of staff (Beryl et al, 2018), or those of the women they care for separately. Additionally, like the research conducted by Beryl et al, (2018), the majority of the literature that does explore the experiences of working, or living within forensic services tends to focus on one aspect of the forensic pathway, (e.g. either high or medium or low secure services) meaning they arguably only capture one part of the story. The current research therefore tried to address this imbalance and record together the lived experiential knowledge of women from one forensic pathway, and the staff who care for

them. Throughout the chapter, whilst some comparisons are made to non-life-threatening self-harm, the accounts shared by the staff and women are to be considered in relation to life-threatening self-harm.

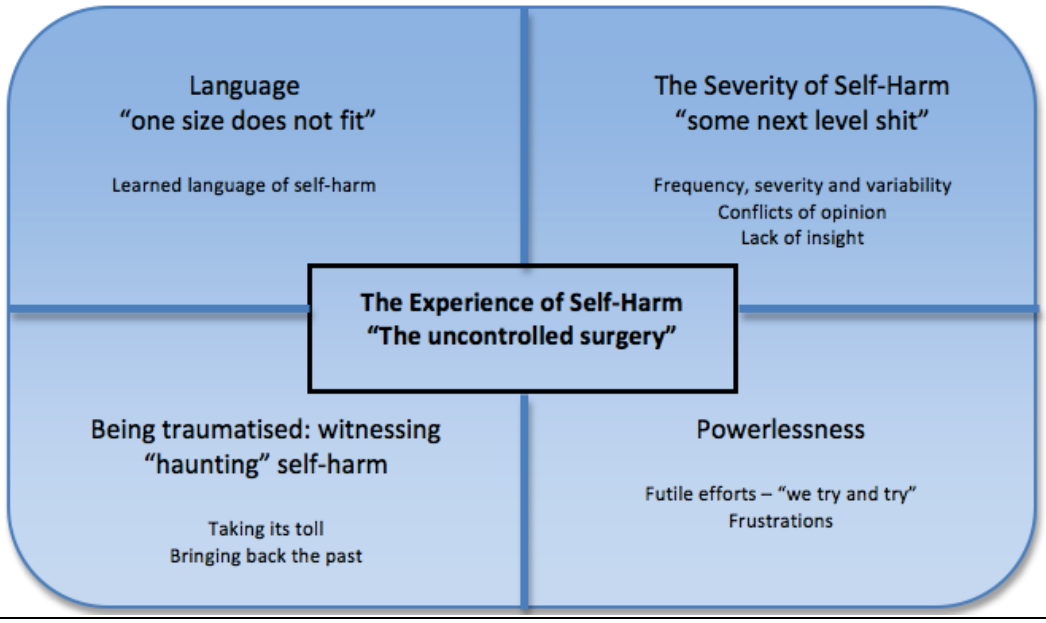
In light of the findings that suggest self-harm that poses high risk to life ought to be referred to as 'life-threatening self-harm', for the remainder of the thesis the term life-threatening self-harm will be used. This replaces the term near-fatal self-harm, or near-lethal self-harm as the women and staff believe these terms are inappropriate for women receiving forensic mental health care.

In line with ethical considerations for confidentiality, none of the names used within the data are the participant's real names. Within the findings, all names that are allocated to quotes represent the pseudonyms that were allocated to the women and staff.

6.2 Findings

There was congruence amongst the stories told by the women and staff, including both the emotional impact of witnessing self-harm and the challenges they faced when trying to cope with such experiences. Based on the similarities found between the accounts of the staff and the women, the themes are discussed together and, where necessary, discrepancies are highlighted. Overall, four main themes emerged from the data relating to experiencing self-harm. These included; language – "one size does not fit", the severity of self-harm, "some next level shit", being traumatised - "witnessing haunting self-harm", and futile efforts – "we try and try"'. Within each of the themes, additional categories were identified, and are described below.

Figure 11: Visual Representation of Themes



6.3 Theme 1: Language – "one size does not fit"

"It's life-threatening or non-life-threatening, it's as simple as that"(Lorraine, RMN)

As mentioned within chapter 2 (defining self-harm and suicide) currently, there is a move to separate self-harm from suicidal behaviour and the most frequently adopted terms are non-suicidal self-injury, and suicidal behaviour (Nock, 2009). Additionally, to try and differentiate between self-harm of differing severities, Marzano and Colleagues have adopted the term 'near-lethal' self-harm to describe self-harm that is likely to result in death without rapid medical intervention. Much literature supports such a separation and the use of the offered language within both community and prison populations. However, to date and to the authors' knowledge, there is yet to be a study that explores the appropriateness of such language to describe self-harm and suicidal behaviours in forensic mental health hospitals. Therefore, one aspect of the interviews consisted of asking the staff and women what terminology they used to describe different types of self-harm behaviours, and what terminology they felt was most suitable for women in forensic services.

"I actually have never even heard of lethality (laughs)… see what we do is group it into two so we have non-life-threatening self-harm and life-threatening self-harm and erm you categorise different things so anything that ermm well you can get patients who superficially cut so that would be non-life-threatening but then you get patients who is digging out their artery and that would be life-threatening... is depends on how much their life is threatened in that moment" (Michael, Speciality Doctor)

In 21 of the 23 interviews (women n = 5, staff n = 16), the term 'life-threatening self-harm' (LTSH) was suggested as the most suitable term to describe serious self-harm that was potentially lethal. Participants also noted the utility of using terms such as 'life altering' or 'life changing' self-harm, which referred to incidents whereby the individual had sustained injuries that would have lasting effects on their life. One staff member gave the example of women who "bite their finger off", or "scratch their eyes out" as life changing. In 17 of the 23 interviews (women n = 4, staff n = 13), participants explained they felt 'non-life-threatening self-harm' (NLTSH) was the best term to describe self-harm that did not pose high risk to life. Additional terms to describe NLTSH included 'superficial', 'minor', or 'not severe' self-harm. When discussing the meaning of the term 'near-lethal', (chosen because of its prevalent use within the discussion of self-harm that poses high risk to life), the majority of the staff (except the medical doctor, and both chartered psychologists) said that they were unsure of its meaning. Responses ranged from having never heard of the term, to knowing that it referenced risk to life. However, all but one member of staff (n=15) stated that they regarded the term 'near-lethal' as inappropriate or uninformative. Some mentioned they did not like the way it sounded, or that they felt it was a judgemental term that would not be helpful when working with women who self-harm. Instead, again the term 'life-threatening' was suggested to be more appropriate.

"We don't particularly use that to be honest I mean we use life-threatening here... I don't think that terminology is very good to be honest for the girls on the wards they know life-threatening and they know self-harm if you put lethal in or lethality in, it isn't a term that is going to register for them... so yeah we have life-threatening self-harm and self-harm that's what we use it is literally as simple as that that's how we do it here" (Sadie, Clinical Team Leader)

"I think there is ermm I think there is a significant difference between low level self-harm and life-threatening self-harm… so yeah its either non life-threatening and kind of that low level stuff and then there is life-threatening stuff the really dangerous stuff" (Olivia, Service User)

The experiences of the staff and women who took part in the current research reinforce the on-going debate within the literature pertaining to defining self-harm behaviours, and support the reality that multiple terms are used interchangeably and inconsistently when describing a single concept (Andover et al, 2012; Silverman et al, 2007). As Andover et al (2012) stated, such disparity between the use of language is concerning, as it can lead to confusion, which has practical implications when attempting to determine who is at increased risk. It is interesting that the term 'near-lethal self-harm', which is readily accepted and used amongst

literature pertaining to custodial settings was less well known and deemed inappropriate to describe women's self-harm behaviours in forensic services.

"Lethality, near-lethal, I mean it is not really a word we use here… Life-threatening that is the best description that would be used here…I mean there are all sorts of things to consider including how it feels to the person who is engaging in that behaviour because the word lethality isn't really nice is it" (Francis, Clinical Psychologist)

Therefore, whilst there have been calls for best practise definitions and terminology for different types of self-harm behaviours, (Silverman et al, 2007), it may in fact be more appropriate to develop and adopt more specific terminology and definitions based on the population under study. It would, of course, be important for such definitions to be disseminated amongst the wider literature to ensure appropriate comparison between populations. However, adopting population specific terminology may serve to improve understanding and consistency among clinicians and academics. This would also ensure that the terminology used is reflective of the needs, views, and understanding of the population being worked with, thereby helping to achieve a more integrated approach to care that is responsive to the needs and understanding of service users, as highlighted as an important element of care by both NICE and the Care Quality Commissioners. Using language which makes sense to the population to which it is applied, may help to foster a more universal understanding, and serve to bridge the gap between language used by clinicians and their patients. In doing so, specific, patient informed language might help women to better articulate their experiences using language that adequately reflects their understanding. It is possible that in doing so, it may become easier for staff to develop a more in-depth picture of the reasons for, or motivations behind self-harm behaviour, thus allowing them to tailor prevention and treatment programmes to the individual needs of those they care for.

6.3.1 Learned language of self-harm

It was also encouraging to see the similarities between the language used to describe self-harm behaviours by the staff and the women themselves, and whilst the overall terms were debated, almost every participant was able to describe what self-harm behaviours they would classify as LTSH or NLTSH. Whilst there were differences in the classification of each method, amongst the staff and between the staff and women, LTSH and NLTSH appeared to offer universally accepted terms whereby all participants understood what type of self-harm was being discussed. It was also interesting to note that whilst many of the staff explained that they didn't like the term 'superficial', as they felt it was 'dismissive', or "laden with

judgement", three of the seven women suggested they thought it was an appropriate term to describe self-harm which did not pose a high risk to life.

Reflecting on the stories of some of the women who took part, it is possible that the use of term 'superficial' came from either; the length of time they have been in contact with inpatient services (i.e. superficial was a term commonly used in the past), or their movement between the prison service and forensic mental health pathway, (where again the term superficial is used). Alternatively, it is also possible that the term 'superficial' may be suitable for women in forensic services, however during the process of their treatment, they are taught to understand and describe their self-harm in a way that is more appropriate or acceptable to clinicians, meaning their terminology changes to reflect terms such as 'non-life-threatening'. This would ring true with the reflections of one participant who said:

"I think patients who you have for a while learn to speak the same language as we do so they will reflect back to us the same terms as we use to talk to them so basically they learn to speak Nurse or Healthcare Assistant… what we are doing is giving them a language to help them understand what they are feeling so it makes sense that patients will talk back to us in that way … so for example they will use the word settled and that is very much a nurse word that we don't use in the outside world... sometimes I do think though is that a form of coercion – are we making them speak like that and are we making them experience things in the way we want them too and am I actually getting them to reinterpret it in the way that we want them too?"(Jamie RMN).

The findings present an interesting discussion, in terms of how clinicians educate their patients to understand and describe their behaviour. An important part of mental health treatment is helping service users to develop an understanding of their difficulties. For many this includes learning professional terminology (for example, low self-esteem or cognitive distortions) to help service users understand what drives or maintains their mental illness. Whilst generally it is helpful in terms of an individual's recovery, considering the discussions held with the staff and women, it is important that professionals develop a shared understanding of an individual's difficulties, to ensure the language and understanding they have is helpful during their transfer to lower security services and ultimately the community. These findings are important, as service users who have previously received care as an inpatient need to be able to articulate their distress or challenges in a way that is also understood by community mental health teams to ensure their community care is appropriate for their needs. It may however be difficult considering the extended duration of forensic mental health placements.

6.4 Theme 2: The Severity of Self-Harm: "some next level shit"

6.4.1 Theme 2, Category 2a: Frequency, Severity and Variability

There was an overwhelming emphasis on how often and how severe the self-harm was across each of the three hospitals. The severity of the self-harm extended not only to the behaviours themselves, (i.e. the dangerousness of the self-harm act), but also the seriousness of the consequences of the women's self-harm in terms of the level of injuries sustained, and the management process that followed. All of the staff were able to recall vivid scenes relating to the aftermath of a severe self-harm incident and described how they have had to clean blood and body tissue.

"We have two ladies in particular that head-bang to a level I have never ever seen before in my whole life… its shocking when you are wiping skull and brain off a door way, it is hard core and it is shocking" (Marie, Assistant Psychologist)

The severity of the self-harm was one of the first things shared within each of the staff interviews, demonstrates how pertinently this aspect of their experience resonates with them. This was also true for the women, whereby each woman shared stories of serious self-harm they had witnessed. They too compared their time in forensic services to other places they have received care, and cited how self-harm was far more prevalent and serious on the wards they currently lived in.

"The severity here in this place… this is some next level shit… I still find it fucked up now that I work in a place where it is near enough an everyday thing" (John, HCA)

When discussing how serious the self-harm was within their service, staff would often refer to other types of mental health services they had worked in and explain how their previous experiences were no comparison to the severity of the self-harm they had witnessed whilst working in the women's forensic services. This was true even for members of staff who had worked in the women's forensic pathway for many years, whereby these participants still spoke of their shock regarding the severity and the frequency of self-harm among the women they cared for. They explain how the extent of the behaviour they witness is unique to women's secure forensic services, noting how they have never seen such things whilst caring for mental health patients in alternative settings. The findings were shared between staff from

all disciplines, and were noted by one Psychiatrist, both the chartered, and the assistant psychologists, two of the nurses, two nurse practitioners, and three healthcare assistants.

"I mean I vividly remember when I first came here from acute and I had seen people self-harming but cutting and ligaturing by inserting, ermm by trying to occlude their airways… but then I came here (laughs) and these women occlude and cut and ligate in ways that you could not imagine" (Rose, Clinical Nurse Practitioner)

Their stories were similar to the women's who also commented on the extent of the self-harm. They too were able to provide graphic details of events that had happened and note how they had never seen similar self-harm prior to coming into forensic services. Sadly, five of the women spoke of knowing peers who had died because of their injuries. These findings align with those from Beryl et al, (2018a) who also noted the 'horror stories' of working with women who self-harm, told by staff who work within women's secure services across the forensic pathway.

"There was this one person who struggled a lot and literally smashed her whole head open" (Poppy, Service User)

In many instances, the extent of the self-harm severity amongst the women was situated within the context of being unable to manage unbearable distress; however, seven members of staff and three women reported there is a perception of a domino effect or a competition related to the severity of self-harm. The staff echoed the women's stories, and one staff member explained how they believed the severity of self-harm sometimes relates idea of achieving status through enacting more serious self-harm. They reported how the service had to respond to the domino effect by moving women to different wards, to try to reduce the risk of self-harm competitions. The motivations and explanations underlying such 'collective' self-harm is however complex and is related to both social and environmental factors of the forensic environment, which are better explained within the context of the pathways to life-threatening self-harm. This discussion can be found in Chapter 7.

It is not surprising that the women and staff highlighted self-harm to be so extreme within forensic services, as findings from James et al (2012), identified more incidents to occur within secure forensic services compared to any other psychiatric inpatient setting. In the same study, women were more likely to self-harm than males, and women most commonly used methods that restricted breathing. An important element of the stories that informed category 2a was the frank description of women using everyday items to enact self-harm. The

staff and women both shared how the methods, or items used to enact harm were often unusual and resourceful. An example of this is self-harm that restricts breathing. Whilst commonly within community settings people may enlist rope to hang oneself, within the forensic services there were many accounts of women using everyday items such as food, excrement, hairbrushes, hair, or toilet roll to occlude their airways (Klein, 2012). Similarly, when the women and staff shared their experiences of women who had cut themselves, they explained how items such as plastic from a watch face, or hairclips have been used to inflict serious lacerations. These findings mirror those from Dyke et al, (2014), Klein (2012), Sarkur, (2011), who all note the use of 'creative' and unusual methods of self-harm within secure forensic services. The findings highlight a clear difference in the self-harm behaviour of women in forensic services compared to community mental health patients, which the women and staff believed is in part influenced by their restricted access to means of self-harm. This will be discussed further in Chapter 8, where the effects of restrictive access to means are discussed.

"I mean just some of the stuff you see like even I have been here for so long and I have never seen or heard some of the stuff the patients were doing or saying over there and I mean I was just like oh my god okay" (Annabelle, HCA)

Another interesting aspect of the interviews was the reference to frequent head banging, which is a behaviour seen more commonly in male psychiatric patients than women (James et al, 2012). Despite previous research suggesting women are less likely to engage in outwardly aggressive self-harm, the women and staff who took part in the current research regularly referenced women 'smashing their heads', indicating head banging may be more prevalent amongst women forensic patients than was previously thought. This finding would support that from Chester & Alexander (2018), who found women and those cared for in higher security environments are more likely to engage in head-banging, compared to males. When discussed with the staff and women in the study, unfortunately the reasons for head-banging remained unclear. The women who utilised head-banging were unable to remember where the behaviour started, or why they decided to use head-banging, and instead two stated it was "just their method".

There were, however, some suggestions that some of the women learn to head bang through exposure to others, the process of which is discussed in depth in Chapter 7, functions of and pathways to life-threatening self-harm. The lack of meaningful explanation is interesting, as despite the recent discussion from Chester & Alexander (2018) that highlights its prevalence

amongst women in forensic services, head-banging is currently a self-harm behaviour that is largely discussed within the context of those who have learning disabilities. Such literature may in part explain aspects of the behaviour as the prevalence of intellectual disabilities is known to be high within those in receipt of forensic care (Livingston et al, 2012), however it does not explain why some women without intellectual disabilities utilise head-banging. This is important as none of the staff made a distinction between women with or without intellectual disabilities in regard to head-banging, nor did they highlight it as a behaviour that was more commonly used amongst women with intellectual disabilities. The findings therefore raise important questions for practise, as if little is known about the motivations for head banging, arguably it would be hard to tailor suitable and specific care plans to try and minimise the behaviour. Considering its prevalence, and the links to numerous adverse outcomes (including brain damage, blindness, bruising, scarring, and loss of hearing and speech, Stein & Niehaus, 2001), it would be prudent for future research to explore hang-banging in more detail to help inform effective care management approaches.

6.4.2 Theme 2 Category 2b: Conflict of opinions

6.4.2.1 2b.1: Perceptions of Severity

Whilst discussing the severity of self-harm across the female forensic pathway, category 2b 'conflict of opinions' emerged. Category 2b represents the disparity between clinicians and the women as to what constitutes life-threatening or non-life-threatening self-harm. Whilst generally, there was some consensus between the women and staff about certain methods (bloodletting and occluding) which they felt would always constitute a life-threatening incident, there remained some discrepancy around other methods. Interestingly, the disparity was evident between members of staff, and between the women and the staff. It was suggested the disparity between staff members could be explained by differences in experience. In this instance, the staff explained how someone new to a service may perceive certain types of self-harm to be more serious compared to another who has for example, worked on the same ward for 20 years.

The findings indicated either staff become desensitised to the severity of self-harm over time, or they become more confidence in knowing what behaviours constitute life-threatening and non-life-threatening self-harm. Staff becoming desensitised to self-harm has been reported elsewhere in the literature, particularly within custodial settings. Walker et al (2017) report after repetitive exposure to self-harm, many members of staff no longer appear to be affected

by the incidents they respond too, and many are able to remain calm and not panic. In the same study, staff discussed how they felt being desensitised could be positive, as it helped to protect their emotional wellbeing, and enabled them to make effective decisions. There was however discussion of desensitisation having more long-term effects and cited many 'store up' the psychological effects associated with exposure to self-harm. In relation to the current research, staff becoming desensitised to the severity of self-harm may offer in part some explanation as to why many incidents of self-harm within forensic services are rated as causing little or no harm (James et al, 2012), despite the women and staff describing self-harm as 'awful', 'shocking' and 'staggering'. As the participant cited above explains, the self-harm that occurs within forensic services may in fact be of a higher lethality than is documented, however as staff become desensitised over time, they may become used to seeing serious self-harm, meaning they may no longer recognise the potential severity of the behaviour witnessed.

"To be honest the person filling in the forms and making those judgements will differ so someone who has been here 20 years and self-harm is normalised for them compared to someone who has been here a week will have very different views probably in the level of severity, if that is the first time someone has ever seen someone ligate to that degree, they will think it is far higher than someone who it is their 8th ligature they have removed this week you know" (Rose, Clinical Nurse Practitioner)

When trying to explore further how staff and women thought of self-harm in terms of severity, there was a recurring idea that the severity of self-harm (i.e. whether it is life-threatening or not) was highly individualised. Staff spoke of the women's individual "skill sets" and described how different people had different capabilities in terms of what they could use to self-harm, or what their bodies could withstand. Additionally, the staff reported that what may be non-life-threatening to one woman (i.e. head-banging) could prove potentially fatal to another, who for example, has a pre-existing head wound, or exposure of the skull because of prolonged banging of the head. In order to assess the potential lethality of self-harm, it was therefore suggested by many that an individualised approach ought to be taken, whereby the individual risks and capabilities are taken into consideration. The staff described the importance of "knowing your patients" when determining the severity of self-harm and suggested the ability to effectively respond came from witnessing their self-harm behaviour over a period of time. Arguably, discrepancies may occur when members of staff who are not directly involved in the daily care of the women, or who work on an ad-hoc basis, do not fully understand the unique nature of individual women's self-harming behaviours. Staff explained how this could lead to

an over or under estimation of risk, or indeed a conflict between staff as to whether an act is life-threatening or non-life-threatening. Indeed, one member of staff reported that when you get to know someone, you are able to predict with a certain degree of confidence how far they are likely to take certain behaviours, and whether for them a particular type of self-harm represents life-threatening or non-life-threatening self-harm. One of the nurses succinctly summarised the need for individual care saying:

"It depends on the patient, but then when you know a patient what I might class as life-threatening some people will turn round and go I can't believe they have classed that as life-threatening but then when you know someone and know the skills they have with certain pieces of just everyday life and you know the damage they can do is second to none you know what is going to happen… so yeah it is individualised, massively individual" (Sadie, Clinical Team Leader)

6.4.2.2 2b.2: Lack of insight

The second conflict of opinions occurred between the women themselves and the members of staff. Conflicts of options were commonly explained by a lack of insight some women have in terms of understanding the risks of their own behaviour. Staff explained how women would often perceive certain methods of self-harm as "minor", or "superficial", despite them being potentially lethal methods. One staff member gave the example of one woman who believed bloodletting was non-life-threatening, because she felt able to control the extent of her injuries, could stop it when she wanted to, and used clean instruments to avoid infection. The idea that the women lacked insight into their behaviour was shared by many of the staff and another offered a memory of one woman who recalled her "surprise" when she realised she was able to "bite right through her arm down to her veins", stating she then discovered "biting can actually be quite deadly".

"We have a lot of disagreements with our patients in terms of that ermm … as to what is life-threatening self-harm because a lot of the time if patients open a vein for example we would class that as life-threatening whereas ermm I am thinking of one women in particular, she would define that as very minor because she is very clean and erm … she can stop it when she wants to stop it ermm… so for her it isn't life-threatening but for us clinicians if you open a vein then that is life-threatening" (Lorraine, RMN)

Although the staff often reported they felt the women lacked insight into their behaviour, stories offered by the women did not necessarily suggest lack of insight, but instead chimed

with the notion of acceptance of how serious their behaviour could be. One woman agreed that some people do not understand how dangerous their self-harm is, however, she also spoke of how she was regularly told her self-harm was life-threatening.

"A lot of people tell me it is very life-threatening, that one more knock to the head could kill you and stuff but the more people tell me that the more I do it… some people don't even realise how actually dangerous it is like I am always told one more hit to the head will kill me but I don't listen because yeah it's my way of self-harming". (Isla, Service User)

Her story was more akin to feelings of defiance, stubbornness and perseverance to enact behaviour she felt necessary, and not that of someone who lacked insight into the potential dangerousness of her behaviour. The findings could be explained by the frequent exposure to life-threatening self-harm described by so many of the participants, and a sense of desensitisation to what goes on around them. Considering the role of self-identity and self-worth may prove useful to consider here, as over time we are inclined to 'accept' who we are and our behaviour and can become defiant to change in light of new information. Sherman & Cohen (2002) explain such a process as 'defensiveness' whereby some individuals allow their beliefs about certain behaviours to evaluate new information negatively (in this instance that certain self-harm is life-threatening), and reinforce their confidence and validity of their beliefs (Lord Ross & Lepper, 1979). It is said that such a response shields one's self-worth and integrity from the reality that their beliefs about something may be misguided (Steele, 1988). Consequently, peoples' self-worth can cause them to resist or reject new information that may help to improve their decision-making, protect them from potentially harmful behaviours, and strengthens their old belief system (Sherman & Cohen, 2002). This may offer some understanding as to why women may hear and quite possibly understand the warnings provided by staff, but despite this continue to believe in their self-harming behaviours

6.5 Theme 3: Being traumatised: witnessing "haunting" self-harm

Throughout the interviews with the staff and women, a reoccurring theme emerged relating to witnessing traumatic events. Both the staff and women spoke of how awful it is to witness either their patient or their peer engaging in self-harm and described how particularly serious incidents can be traumatising. Again, graphic scenes were described, and language such as "haunting", "awful", "difficult" and "terrible" was used to describe incidents they had witnessed. Within the theme 'traumatisation', six members of staff could identify occasions where they have 'taken home' what they saw at work or could describe the lasting effects that witnessing self-harm had on them. For the women, witnessing others self-harm acted as a re-

traumatising experience, whereby they relived their own past behaviours, and the distress they experience when they self-harm. Five of the women also spoke of being able to remember being cared for on a ward at the time of a peer dying because of their self-harm. One staff nurse poignantly said:

"A lot of things that we have seen and dealt with are quite traumatic… and I don't think we have got there yet but some people who work in this environment start showing some trauma symptoms themselves… you can't contain people who are damaged like this without becoming slightly damaged yourself" (Jamie, RMN)

6.5.1 Theme 3, Category 3a – Taking its toll

There was a unanimous description between staff and the women, of how living amongst, or caring for women who self-harm is emotionally challenging. The staff and women shared their emotional reactions ranged from being upset or distressed, feeling a deep sadness, and at times feeling angry or frustrated towards those who self-harm. Such emotional responses are understandable considering the level of exposure the staff and women have to self-harm and have previously been documented within the literature (Taylor et al, 2009). When the staff spoke about their own reflections on particular incidents, they described real sadness when they considered the level of distress the women in their care go through when they self-harm. Three members of staff confessed that despite their efforts to try and understand the experiences of the women in their care, they were unsure whether they would ever truly know what they go through when they self-harm.

"No I don't think we will never understand being in their head and how they react I mean things have happened in their lives that I would probably never have happen to me and will never encounter and its just the stuff they have had to go through" (Lilly, HCA)

"I mean it can be really upsetting you know … erm obviously people on this ward do some horrific things to themselves and when you sort of empathise and you try to think what they must actually be going through to actually do that to themselves, we just don't know what that is like do we" (Lorraine, RMN)

Although some were less forthcoming in saying that they had personally been affected by the trauma of their job, others were open in discussing how, over time, they believe they started to show signs of trauma. They described how attending a medically serious incident of self-

harm was physically and mentally draining, and referenced a range of sights, smells and noises that affect them. The staff described how working in a team that was understanding and supportive can help to alleviate the feelings of trauma, however in some cases, staff described having to move wards or services as they felt the effects of witnessing self-harm was resembling symptoms of PTSD. Some staff described how they take home the things they see at work and gave examples of normal daily activities they find distressing, or unnerving, because of witnessing self-harm at work. These stories were similar to those found by Beryl et al (2018), whereby participants also described the personal costs of working within secure services, particularly relating to how their experiences affected them outside of work. A notable example from the research came from one nurse who explained how she is finds herself on edge when her neighbours do DIY, as the noise of banging against a wall reminds her of head banging. This story chimes with findings from Wright et al, (2006), who evidenced an increased risk of developing symptoms of trauma, or post-traumatic stress disorder amongst custodial staff who experience frequent indicants of self-harm.

"I don't like the noise of head banging… like it goes home with me, if the neighbours are having work done and there is repetitive banging I don't like that I find it irritating because I am instantly on edge" (Faye, RMN)

"It took me probably the best part of a year to realise the emotional and mental impact they were having on me I mean I was going home and taking a lot of stuff with me … it has taken me the last 6 months to realise how much of a toll working on there was having on me... you take so much stuff home and honestly it is physically and mentally and emotionally draining...." (Sadie, Clinical Team Leader)

From the current research, a particularly poignant story was told by the medically trained Psychiatrist whose account echoed the findings from Wright et al (2006). The psychiatrist made a comparison made between surgical wounds created in theatre and those made by women in acute distress, which highlighted not only the extent to which some of the women self-harm, but also how professionally testing witnessing such events can be. The Psychiatrist discussed how surgical training helped to prepare them for the visual scenes of self-harm but noted there was little that could prepare someone for witnessing another human being in an acute state of distress. They spoke of how they try to remain level-headed and controlled, however highlighting that they too struggle at times to execute this. Their use of the word "haunting" brought to the forefront of the discussion how even the most professionally

qualified, and experienced members of staff find witnessing self-harm within forensic settings traumatising.

"In terms of the kind of seeing you know cuts or wounds and those sort of things I guess having been in you know operating theatres or seeing those sorts of things in a medical setting it helps... but there is always a different connotation if someone has done that to themselves like seeing a you know a wound created through surgery that is very clean it's very different to one that somebody may have you know done themselves really deeply and clearly you are seeing the wound in the context of acute distress agitation or anger, and so I think the context is important as it can be very haunting if you kind of see that very vivid kind of ermm yeah expression of someone's distress so it still can be haunting" (Michael, Speciality Doctor)

Figley (1995) described how professionals experience signs of trauma because of working with traumatic incidents, documentation or people. Figley (1995) described the process of trauma accumulation and transmission, (known as secondary traumatic stress (STS), or '*compassion fatigue'),* whereby professionals who are regularly exposed to traumatic incidents, and who feel empathy towards those directly involved in the incident, can develop signs of trauma over time. Compassion fatigue has been applied, and validated with many working professions, including nursing staff, psychologists, and other mental health workers (Abendroth & Figley, 2014). The extent of STS is thought to be affected by the frequency and severity of traumatic events exposure; however, those with insight and training into how to manage such events are thought to demonstrate more resilience to STS (Ludick & Figley, 2016). This being said, those with greater concern, motivation and capacity to empathise with those involved in traumatic events have been shown to have increased vulnerability to experiencing personal distress and STS (Figley, 2002a), particularly when an individual's skills and resources are overwhelmed (Craig & Sprang, 2010). Common responses to prolonged exposure to traumatic events, prior to STS developing include; numbing or withdrawal of empathy (Salston & Figley, 2003); not being able to detach from patient suffering and feeling guilty (Figley, 2002). Applying the theory of compassion fatigue to the staff members interviewed for the current research, may help to provide a valid explanation as to why some staff members develop symptoms of trauma, but also why many appear to have strong emotional resilience to witnessing frequent self-harming behaviours. Additionally, it may also offer an explanation as to why forensic services have a reputation for high levels of staff burn out, and why some staff are reported to have a negative perception of those who self-harm (Garcia, 2017; Happell, Pinikahana & Martin, 2003).

Despite finding it difficult to experience these emotional responses, there was a clear passion amongst the staff to help the women learn to manage and overcome their self-harm behaviour, and many explained how their emotional responses to the situations stemmed from their desire to help. Whilst welcome, the finding appeared to differ somewhat to the experience of staff members who work with those who self-harm, documented within the literature. In a recent literature review, Karman et al (2014), found having a negative attitude towards those who self-harm is common amongst professionals. A range of studies have reported staff frequently report feeling angry, or disgusted at those who self-harm (Hopkins, 2002), and in secure settings specifically, there is a common perception that those who self-harm are attention seekers, or manipulative (Boardman & Rayner, 2018; Dickinson et al, 2009). The feelings of compassion and sadness that emerged within this research, may in part be due to organisational support and supervision held within the individual establishments that took part, which research points to as lacking in studies where staff hold negative perceptions of those who self-harm (Thompson et al, 2008; Wilstrand et al, 2007). The findings may also be explained by the idea that different 'feeling rules' exist between organisations that priories care and well-being, (i.e. forensic mental health services) over punishment (i.e. prisons). Literature has noted that within prisons, there is an expectation that staff will be colder and more punitive towards prisoners (Crawley, 2013; 2004). Because of these feeling rules, Crawley (2013; 2004) argues that staff can perceive prisoners and their adverse behaviours negatively. Comparatively, staffs that work in forensic mental health hospitals are employed to help promote recovery in a caring way. Therefore, it is expected that staff from forensic mental health hospitals will be empathetic and compassionate towards their patients. The findings from the current research and that from Crawley (2013; 2004), may therefore help to explain the differences between the findings of the current research and that within the wider literature.

Considering this theory, and the accounts of the staff across the women's forensic services, it is clear that there is an important need to focus on, and manage staff responses, well being, and trauma. Whilst some professionals within mental health care will receive regular supervision, it may be prudent that services also consider integrating regular trauma-related support, to try and reduce the chances of staff members developing STS, or other trauma related symptoms (Beryl et al, 2018; Davies, 2015).

6.5.2 Theme 3, Category 3b: Bringing back the past

A similar story was shared by the women during their interviews, and they too explained how witnessing serious self-harm can be traumatising. All seven of the women described how difficult it was to try to manage their own mental wellbeing and distress, while witnessing peers going through difficult times. The women also appeared to express a sense of empathy for other women who self-harmed, and while at times this was expressed in terms of being cross, or irritated at others, they described how it is particularly hard to watch someone else go through difficult times, as they know like no other, what that experience is like. The women used words such as "horrific", "horrible", "stressful", and "distressing", suggesting the women experiencing similar emotions to the staff who care for them.

"erm it can be very hard it's horrible when it is someone you are really close to like and they are a really good friend I find that really hard you know what I mean but I always try my best to support them and always tell them I am here if they need me and stuff..." (Evie, Service User)

Unlike the staff, the women described how witnessing self-harm can be a re-traumatising experience, reminding them of past behaviour and their experiences. Sadly, four of the women reported witnessing their peers in distress and self-harming often triggers their own self-harming behaviours as seeing others enact self-harm reminded them of who they used to be, or what made them want to self-harm.

"Just seeing it, it makes me think like about what happens if I go back like that again and like that is what I am scared of" (Chloe, Service User)

"Ermm it is really difficult… especially if you are really trying to sort yourself out and abstain from self-harm when you have got a lot of distress around you…it's just that ermm the distress that is going on and you know what I mean it is difficult to be around you know when one person is struggling and you are trying to pick yourself up it is really hard to pick yourself up" (Olivia, Service User)

The stories the women told were particularly emotive, as they described being re-traumatised in the very place designed to try to help them manage their self-harming behaviours and recover from their past. The re-traumatisation of women within forensic services has been discussed within the literature, most commonly pertaining to the effects of restraint and restrictive practise on survivors of sexual abuse, (Smith, 1995). There is however, very little research that discusses the potential for re-traumatisation via exposure to others self-harm. In the same way as was described in other literature, the women explained how seeing their

peers self-harm took them back to the place, the thoughts, and the memories of when they engaged in self-harm. The women spoke of their difficulty managing their own distress while others around them self-harmed and explained how others' increased distress can lead to a deterioration in their own mental wellbeing.

"You know ermm it is difficult at times you know it is up and down but like you just go with it you know I try not to let it stress me out because that is my downfall if I get stressed then my mental health goes down and that is when I start hearing voices when I am stressed my voices come on a lot stronger then I get unwell" (Ava, Service User)

Many of the women explained how it is hard to avoid exposure to others' self-harm, as despite in many cases not directly seeing the incident (i.e. during the night, or when another women is nursed in seclusion), the women spoke of being party to the sounds, and smells, and the management of an incident. This raises questions as to how this situation could, and should be managed, in an attempt to avoid re-traumatisation of women in forensic care, and adds to the body of evidence that currently suggests some aspects of secure mental health care can to some extent re-traumatise already traumatised patients (Sweeney et al, 2015).

Interestingly, in the aforementioned theme 'the severity of self-harm', staff and women discussed how they have experienced what was termed 'the domino effect', or the 'ripple effect', whereby there appears to be a trend when women engage in self-harm. Both staff and women shared accounts of how they feel at times the women copy each other, which can result in many women self-harming at the same time. The women and staff reported that they believed the domino effect was a socially influenced trend, underpinned by either the need to divert care from others, or elicit care from staff, or a result of life-threatening methods of self-harm becoming rationalised, normalised socially acceptable (for full explanation see Chapter 7, The reasons for and Pathways to LTSH). The findings align with literature that has previously reported a 'contagion' effect, whereby individuals imitate another person's self-harm behaviour in the community (Ortiz & Khin Kihn, 2018; Berman & Walley, 2006) and within inpatient settings (Taiminen et al, 1996). Whilst this conclusion is likely to be partly responsible for the domino effect, considering the stories discussed within this category, it is plausible that the process of re-traumatisation could also play a role. If one women self-harms, another may be transported back to their "old me" and recall the memories of their own self-harming behaviours. As a result, one women's self-harm may in fact trigger another - a process that may be felt across a ward.

“Erm I well when you are on the ward and you hear a lot of self-harm especially when you hear people choking and ligaturing or like banging their head it is quite upsetting as it reminds me of who I used to be…” (Isla, Service User)

"Shit it’s so shit… this time last year I nearly died from it I like I choked myself … and it reminds me of that this environment reminds me of self-harm and it is not nice and it reminds you of when you used to do it" (Poppy)

When trying to explain the domino effect, one member of staff likened the process to someone saying they are hungry – a statement that is commonly responded to with the other person also stating they are hungry. She explained how in the same way people can trigger another person to realise they are hungry; the women can trigger each other’s self-harm. The suggestion is supported by findings from Baker et al (2013) who interviewed women from a high secure forensic mental health hospital, who explained witnessing other people’s self-harm reminds them that self-harm is effective and viable for them too. This may indicate a need for a wider management process in response to an incident of self-harm that extends to an entire ward, and not just the individual engaging in the behaviour.

"If one room goes unsettled the other room goes unsettled, some staff say they are copying each other, some patients say they are copying each other, but I say it could be as simple as when someone started doing something then the other, I mean I know plenty of people who if you say oh I’m hungry the other person says well actually I am hungry too and so it could be as simple as one is triggering the other... it could be as simple as you don’t need to copy it could be actually that once you have heard something it has made you think of it and then you act on your own thoughts" (Lorraine, RMN)

6.6 Theme 4: Powerlessness

Between the staff and women, there was a perception that often their ability to make things better, or their efforts to improve the situation was futile. The staff explained how despite their efforts to support the women in their care, it was common for women’s self-harming behaviours to regress, despite them having made seemingly positive progression. Many staff described how they would work with someone over a long period of time and feel progress had been made only for the women to engage in self-harm behaviour, which created a sense of helplessness amongst the staff. A similar perception was held amongst the women; however their stories conveyed a sense of frustration, frustration at their situation and frustration at others’ self-harming behaviours. They too described how they felt unable to

make the situation better. Two categories emerged within this theme: futile efforts, and frustrations.

6.6.1 Theme 4, Category 4a: Futile Efforts "we try and try"

During the interviews many of the staff expressed a feeling of helplessness, and powerlessness when working with women who self-harm. They described their dogged efforts to support, and collaboratively work towards a goal of minimising, or preventing self-harming behaviours, only for it to be met with regression. They used words such as 'hard', 'desperately sad' and 'bleak' to describe how they felt when the women they believed had made progress, engaged in self-harming behaviours, and how sometimes they felt there was little they could do to help them. Therefore, there was the perception that at times, their efforts were futile.

"People will talk about needing to let that very intense period of self-harm and distress kind of run its course… and sometimes when they are in that incredibly bleak place it is almost how the staff think about it too you don't feel like there is much else other than interventions that are going to keep people safe" (Francis, Clinical Psychologist)

From the interviews it was obvious that feeling their efforts were futile was shared amongst teams. One member of staff explained how this does at times make the team feel that there is very little that can be done to help, outside of restrictive practices, which created feelings of defeat. This aligns with findings from Berly et al (2018) and Marzano, Adler & Ciclitria (2012) who reported similar findings amongst staff in high secure and custodial settings. A particularly pertinent account came from one registered nurse, who explained how at times she feels as though she is "feeding her bullshit", when she described her efforts to care for one woman's life-threatening self-harm. She was admirably honest when she shared how, at times; she had looked at the quality of life available to the woman in her care, and considering her experiences thought she could not blame the woman for wanting to self-harm. This is a powerful statement, and reflected that although the staff who took part in this research are dedicated to helping the women in their care to recover, they battle between the need to uphold safety and the moral standpoint of facilitating the continued distress and trauma of the women in their service.

"This is going to sound awful … but I can't particularly blame her. She sits in the same 4 walls every day and there is only so many activities you can do with a lady who isn't even allowed toilet roll and we try and try and try... but I mean when she does come out of her room she is in the pinel belt and it is very rare she gets to make phone calls and we have to hold the phone for

her you know it is not much of a life is it. And all the time she is sat there thinking of what has happened to her in her past and all the negative things and I mean she is not going to be sitting there thinking of the joys of spring after everything she has been through. So I can't blame her and sometimes... you just feel like you are feeding her bullshit... its shit to be honest" (Lorraine, RMN)

Feelings of helplessness and powerlessness have previously been reported amongst professionals who work with those who self-harm (Marzano, Alder & Ciclitra, 2012; Holdsworth et al, 2001). Hayward & Luke (2005) argued that often these feelings stem from staff perception that they may in some way be responsible for an event occurring (i.e. they were unable to stop it), despite the fact that in reality they are largely powerless to prevent it.

"Erm when you find them …when it's your first time you find something, your automatic response is to want to go straight in but you can't... it's really hard and like I am just standing there watching them and having to wait for a team... everyone is human and like I mean ultimately you are standing there watching someone basically killing themselves and it's horrible" (Lilly, HCA)

These findings suggest helplessness and powerlessness are common feelings amongst professionals working with a range of populations, however as women in forensic services are known to engage in self-harm frequently and repetitively, these feelings may be particularly strong amongst staff across the forensic pathway. It may therefore be useful for forensic services to consider the effects of helplessness and powerlessness amongst staff caring for women who self-harm and focus on providing service-wide supervision to help manage these feelings. As mentioned in the aforementioned theme on the trauma of witnessing self-harm, supervision is important to help staff develop effective coping, and reducing burnout rates (Davies, 2015).

6.6.2 Theme 4, Category 4b: Frustrations

Whilst discussing their experiences, both the women and staff expressed frustration. Comparing the stories shared by the staff and women, it was apparent that whilst they both discussed feeling frustrated, the source of their frustration differed. Consequentially, due to the differences within their testimony, in this category the accounts of the women and staff will be told separately.

The women were more forthcoming in expressing why they felt frustrated, however for many of the staff, they appeared more cautious. It is likely that because they were reluctant to sound uncompassionate, or indeed paint a negative picture about themselves. It is therefore important to note that when the staff described times where they feel frustrated, it should not be understood as the staff feeling angry or being irritated by the women. Instead, their frustrations stemmed from their inability to stop women engaging in self-harming behaviours, and by their disappointment that they were unable to prevent another incident. In fact, arguably, feeling frustrated demonstrates staff's vested interest in assisting the women with their recovery, and highlights another aspect of the emotional impact that working with women who self-harm can have upon members of staff. Feeling frustrated when working with those who self-harm has previously been reported amongst mental healthcare professionals (Thompson et al, 2008; Wilstrand et al, 2007; O'Donovan & Gijbels, 2006), and those who work with prisoners (Marzano et al, 2013).

"Erm sometimes it can be really sad really desperately deeply sad and erm you kind of get to the point where you just don't know what to say to certain things as it can just be so shocking and yeah it's so its sadness and erm also it can be really frustrating when you have been working with someone for ages who has been doing really well and then all of a suddenly they go whooshing back down so that can be quite hard" (Cathy, Trainee Forensic Psychologist)

"I think at times it can be quite frustrating in the sense that you think you have got so far in terms of moving them on to and doing work with them, and then they go back and do something again... not frustrating as in angry but like you want the best for them and you want them to at least minimise their self-harm or not be so severe so it can be a little bit like 'aghhh' where you just want them to be okay" (Annabelle, HCA)

"It's the round the houses bit I mean I get why but sometimes I would love to just say to them look just say you don't want to do it you don't need to trash the ward and split your arm open just tell me you don't want to go and that way your arm will be intact and my ward will be fine… yeah that is difficult" (Faye, RMN)

Staff

In a recent study conducted by Beryl et al (2018), enlisting the testimony of staff working within a high secure women's service, it was suggested that a key source of frustration also stemmed from a conflict that occurs between working therapeutically, and a need for security. It was reported that staff felt that at times, there was a distinct focus on upholding security,

and whilst they understood security was a necessity, some believed it had a 'stifling effect, restricting imagination, holding staff back'. In other words, staff members felt that at times their ability to adapt their care to the needs of their patients was hindered, meaning prescriptive, policy led care is delivered, which may or may not be suitable for the needs of the women in their care. These findings indicate that a focus on security and prescriptive care may restrict the ability to provide individualised care, as advocated and emphasised by the National Institute of Health and Care Excellence (2013).

Women

"Ermm well I have been in lots of different places and erm mainly just on this ward I just find it so frustrating because it's just brat like its brat like behaviour it is just like a kid screaming in the middle of the supermarket because they want an ice lolly like literally that is all it is down too… that is how it goes down every single day (Poppy)

The women who took part in the research also cited feelings of frustration. Their frustration largely stemmed from the fact they were involuntarily detained within forensic services, meaning they had no choice except to witness other people's self-harm behaviours. This point again relates to the fundamental standard of care adopted by the CQC, as it appears to be at odds with standard 4, which states service users must not be given unsafe care or treatment or be put at risk of harm that could be avoided. Whilst witnessing others self-harming behaviours is unlikely to be considered unsafe care or treatment, or putting another person at risk of harm, the finding that witnessing self-harm causes distress and can trigger self-harm behaviours. This, for some, could be construed as putting service users at risk of harm, as very few people would argue witnessing self-harm forms part of a care or treatment plan or constitutes safe care, and yet the women who took part in the research report it being a regular, if not daily occurrence. Coupled with the reported harm that can happen as a result of witnessing self-harm (i.e. increased levels of distress or triggering their own self-harm), the findings suggest it is warranted for future research to explore the effects of witnessing self-harm, and understand how to limit the impact such an experience can have on women.

It is also likely that the women felt frustrated at the restrictions placed on them, as they often believed their self-harm was justified. Unfortunately, these frustrations are unlikely to be alleviated within the current forensic pathway, as allowing self-harm to take place goes against the operational obligation (see chapter 1, Overview of Forensic Services) that all mental health services must uphold. The need to uphold patient safety does not negate the reality that women in forensic services are housed within wards where self-harming behaviours are

frequent, meaning they are regularly exposed to such incidents. It is therefore understandable that these women may feel frustrated at their circumstance, as by all accounts, many are trying hard to work on minimising, or stopping self-harm. Considering the sub-groups and functions of life-threatening self-harm described later in Chapter 7, it is also likely that the frustrations expressed by the women may in part stem from a desire to elicit care from staff. If another woman self-harms, they are going to receive attention (both medical and emotional) from the nursing team, meaning less time can be spent with those who are not actively self-harming. Three of the women described how feeling ignored can result in feelings of injustice and frustration, based on the perception that their self-harm was "real", or they have greater needs than others. Feeling frustrated is however an important element, which forensic services ought to consider, as findings presented later in (chapter 7) identify, frustration as a predictive risk factor for life-threatening self-harm. It is therefore important that frustrations are acknowledged and managed appropriately, to ensure they do not turn into feelings of anger, which has also been shown to have a predictive relationship with life-threatening self-harm (see Chapter 7, Functions of and Pathways to Life-Threatening Self-Harm).

6.7 Critical Reflections

Having worked in forensic mental health services and prisons for the last 8 years, I know how difficult it is to witness people in extreme distress, and self-harm and suicidal behaviour. I can recall many a time where I have felt physically, mentally and emotionally drained having tried my best to help keep the people in my care safe and to try and alleviate even the smallest part of the suffering. Such a day would typically end with me going for a run to clear my head or a hot bath, a book and a glass of wine, or anything really that I had learned helped me to separate my own life from the lives of those I cared for and their distressing thoughts, feelings and behaviours.

When I reflect over the times, I have felt relief to be leaving the secure sides of hospitals I can't help but feel a slight sense of guilt. While I understand and accept my relief to leave the intense environment of a ward, I wonder how often staff like myself forget to consider that the people we have spent the day caring for also feel the need to flee the wards after a difficult day, and yet due to their mental health status, have no choice but to remain. In thinking this, I find myself questioning whether it is acceptable to allow those in the care of secure forensic mental health services to be exposed daily to behaviour, which in the words of the Psychiatrist who took part is 'harrowing'.

The powerful stories told to me by the women who took part in this research led me to a place of conflict whereby I was torn between my belief that the right mental health environments can promote and facilitate recovery, and the harsh reality of how flawed the current system around caring for forensic mental health patients can be. Reflecting on this, I wonder whether there is a better, more therapeutic way to keep people safe whilst caring for them and supporting their recovery. Whilst I do not have the answers, what I do know is that the way we manage and care for individuals who self-harm within secure services needs to be reconsidered. In doing so this might help to alleviate the suffering of those we seek to care for and provide a better work environment for the staff who dedicate their professional lives (sometimes to the detriment of their personal life) to try to improve the lives of the women they care for.

Chapter 7: Findings
The Functions of and Pathways to Life-Threatening Self-Harm

7. Overview

Chapter 7 presents findings from individual interviews that were analysed and used to address one of the key research aims – to understand the functions of and pathways to life-threatening self-harm. In doing so, seven sub-types and pathways to life-threatening self-harm emerged. The characteristics of each sub-type are presented below, along with an outline of the pathway to life-threatening self-harm. Each sub-type provides information regarding whether life-threatening self-harm is enacted with suicidal intent, and a short discussion is held for each in regard to the clinical considerations that arise as a result of the findings. Importantly, as the women and staff who took part in the research posit that in almost all instances, life-threatening self-harm occurs without suicidal intent, each sub-type will be compared with existing theoretical models to evidence how findings from the research extends current thinking. This finding is a major finding from the current research and is important as the existing literature relating to life-threatening self-harm posits that it is enacted with suicidal intent.

7.1 Introduction

There are many reasons why women receiving forensic mental health care enact life-threatening self-harm. Identifying who is at risk and understanding why women enact life-threatening self-harm is however complex, as life-threatening self-harm looks epidemiologically similar to suicide attempts and to other types of life-threatening self-harm. Despite this, there are a number of distinct differences between individuals who enact life-threatening self-harm that can be used to inform typologies or subgroups of those that harm themselves (Rivlin et al, 2013). In doing so, it is suggested that typologies can assist with the process of clinical assessment and formulation, by highlighting patterns and similarities between those who harm themselves (Rivlin et al, 2013). However, until now, typologies have only been developed amongst male prisoners who enact 'near-lethal suicide attempts' (Rivlin et al, 2013; Danto 1973; Hatty & Walker, 1986; Dooly, 1990; Lester & Danto, 1993). Such literature is helpful as it highlights how the reasons for complex self-harming behaviour are multifaceted and reinforces its individualised nature. In the case of the prison literature, such reasons include the prison situation, outside pressures, mental illness, and a desire to achieve a particular goal.

The current literature is however limited, as all the identified typologies have been informed through psychological autopsies, or via analysis of prison records. Both methods are known to be flawed as prison records are often completed to a poor standard, fail to include important information, and lack the invaluable insight of those able to recall their own experiences of life-threatening self-harm (Rivlin et al, 2013). Incorporating such insight allows research to go beyond being able to group people based on demographic differences and allows for the inclusion of important environmental and social factors that may influence life-threatening behaviour (Rivlin et al, 2013). Therefore, more recently in a bid to overcome the limitations of previous research and to incorporate the experiential knowledge of those who engage in near-lethal suicide attempts, research has employed individual interviews (Rivlin et al, 2013; Liebling, 1992; 1995). Consequentially, the most recent study (Rivlin et al, 2013) concluded there are five types of male suicidal prisoner, including:

- 'Prisoner unable to cope in prison', who enacts near-lethal suicide attempts as they feel overwhelmed by prison life and who is usually dealing with recent traumatic life events
- 'Psychotic prisoner', referring to those who are acutely psychotic during their near-lethal suicide attempt
- 'The instrumental motive' prisoner, who does not wish to die but self-harms in order to achieve a recognised goal
- 'The unexpected attempt', whereby a prisoner who is thought to be relatively adjusted to prison life experiences a range of life events, leading to an individual feeling overwhelmed or unable to cope with prison life
- 'Prisoner withdrawing from drugs', incorporating those who are relatively new to prison life and are withdrawing or detoxing from drugs

Whist the aforementioned literature is helpful in that it acknowledges people who enact life-threatening behaviour are not a single, homogenous group, such literature is limited in that it is unable to explain how such behaviour develops. Arguably, without understanding the different pathways to life-threatening self-harm, a sub-type becomes a largely meaningless category that allows people to be grouped primarily based on demographic factors but does little to explain the reasons for the behaviour being grouped (Gadd & Corr, 2017). Therefore, by developing an understanding of the functions, and the pathways in which people may move towards life-threatening self-harm, pathways for intervention, prevention and care can be specifically tailored towards the needs of the different groups (Atkins et al, 2017). Being able to distinguish groupings based on not only behaviour, but also on the reasons why behaviour

occurs, is important as it allows for the development of more effective treatment (Atkins et al, 2017). Such an approach has previously been adopted amongst the forensic population, (both for prisoners and mental health patients), in relation to better understanding different types of offending. Whilst both sexual and violent offending relates to harming another individual, (i.e. there are similarities between the behaviours), there are also distinct differences between the types of offences, which require different types of treatment (Ireland, Ireland & Birch, 2018). Because of these differences, treating both types of offending in the same way would prove ineffective (Farrington, Gaffney & Ttofi, 2017a; Farrington, Gaffney & Ttofi, 2017b).

Whilst clearly there is a need for better understanding life-threatening self-harm, our knowledge of the motivations for, and pathways to life-threatening self-harm amongst those receiving forensic care is lacking (see Chapter 2, Defining Self-harm and Suicide). To the author's knowledge, there is yet to be a study that seeks to clarify the reasons for and pathways to life-threatening self-harm amongst women receiving forensic mental health care. Therefore, in a novel approach, the research outlined in the thesis adopted a similar approach to that employed by Rivlin et al (2013), and conducted interviews with women forensic mental health patients and the staff who care for them in a bid to explore and explain the reasons for, and pathways to life-threatening self-harm.

7.2 Summary of Method

As detailed within Chapter 5, Methodology, individual interviews were conducted with women forensic mental health patients and staff from one forensic pathway. To summarise, Summative Content Analysis (SCA) was used to analyse the data from the interviews. The SCA took part over two phases (manifest and latent analysis). For the manifest analysis, each interview transcript was read through at least twice and the most commonly cited words identified. For the latent analysis, each interview was read through a further two times and codes that represented the key concepts and thoughts within the transcripts were identified (Hsieh, 2005). The transcripts were then re-read, and the original codes were condensed into subcategories. The quantitative data (word frequencies) and the qualitative findings were then considered alongside the data from chapter 6 and common themes were identified between both sets of data to identify similarities and differences between the reasons for and pathways to life-threatening self-harm. Seven fundamental reasons for and pathways to life-threatening were identified. Once drafted, the findings were taken back to the staff and women who took part in the research and were reviewed and refined through a process of

critical reflection. The critical reflection of the findings happened via a focus group with staff and individual feedback sessions with the women.

7.3 Findings

The table below details the findings from the manifest content analysis, whereby the word frequencies are presented for the most commonly cited words, phrases or sentences.

Table 11: Manifest Content Analysis Word Frequencies

Word Frequency	*Women*	*Staff*	*Total*
Flashbacks / intrusive thoughts	16	96	112
Significant Life event/ death/ bad news	63	24	87
Family /relationship issues	60	20	80
Help, attention, reassurance seeking / care eliciting	36	42	78
Distress	49	22	71
Anger/ frustration/ arousal	48	12	60
Unsettled ward	17	21	38
Lack of hope	33	3	36
Withdrawal/ disengagement	19	13	32
Impulsivity	25	5	29
Guilt and shame	22	7	29
Changes in behaviour	15	12	27
Early stages of treatment	21	0	21
History of contact with services	16	6	22
Poor communication skills	8	9	17
Self-hatred/ self-loathing / self-critical	12	5	17
Suicidal Intent	12	5	17
Diagnosis of personality disorder	12	4	16
Isolation	12	3	15
Lack of other coping strategies	11	3	14
Ambivalence	10	0	10
Poor attachment	9	2	11
Rejection	5	1	6

Hallucinations	3	3	6
Poor problem-solving skills	3	1	4
Rumination	3	0	3
Paranoia	2	1	3

In the following section a description of each subgroup will be presented, which outlines the distinguishing features of each sub-type and provides an explanation of the functions of, and pathway to, life-threatening self-harm. Each sub-type will then be discussed in terms of where the sub-type fits within the current literature and theoretical frameworks. Specifically, each sub-type will be related to the Four Functional Model (FFM) of non-suicidal self-injury (Nock, 2009, 2010; Nock & Prinstein, 2004), which is explained in depth in Chapter 3, (Why do people self-harm and how do people die by suicide: Theoretical Frameworks). The presented findings around life-threatening self-harm will be contextualised within the FFM, since the current study identified a shared understanding that typically, life-threatening self-harm occurs without suicidal intent.

"I have not met anyone here that has engaged in life-threatening self-harm because they want to end their life… that is my personal opinion but I know these people well... I don't see anyone here that wants to die and I have not met anyone here who is engaging in life-threatening self-harm because they want to die, cause if they did then they would… people do die, two people have died here… if you want to die you will die you will do it". (Freya, Service User)

"Erm intention, erm I think that sort of self-harm (life-threatening) the intention is to have an output, it is to erm sort of there can be lots of reasons why people do it but it is about having a way of expressing in the moment but it is not an attempt on your life" (Chloe, Service User)

"The more serious stuff and life threatening self-harm ermmm I think in the moment you might well think it is an attempt on my life and that is what I want to do but I don't necessarily think all the time that is what they really want to do or what I have wanted, I really don't think it is always the case ermm I certainly have made attempts on my life but it hasn't been to kill myself" (Olivia, Service User)

"Ermm well some people like just do that sort of self-harm for the release or something not everybody wants to die you know, they don't, it can just be for the release not to die, but it can

go wrong you know what I mean someone might only want to do it for the release but then it goes too far and obviously sadly they die, but can you see there is a difference" (Ava, Service User)

"Well I think if you are classifying this life-threatening self-harm and suicide then you need to know that they are completely difference things… it makes me angry when people say high risk of self-harm when actually it is suicidal ideation because it is so different. So self-harm when I do it is more about getting people to notice me, it's not about being suicidal" (RT64 015, Service User)

The FFM model was presented and discussed at length in Chapter 3, (Theoretical Frameworks). In summary, the FFM posits self-harm enacted without suicidal intent is motivated and maintained by four distinct functional reinforcement processes. These processes include: reducing adverse emotional or cognitive states (negative intrapersonal reinforcement); generating positive feelings or stimulation (positive intrapersonal reinforcement); escaping social situations or removing interpersonal demands (negative interpersonal-social reinforcement); and eliciting attention, facilitating access to resources, or promoting help-seeking behaviour (positive interpersonal-social reinforcement). Despite a great deal of evidence to support the FFM in adult and adolescent populations (Bentley et al, 2014; Klonsky et al, 2014; Zetterqvist et al, 2013; You et al, 2013; Muehlenkamp et al, 2012; Turner et al, 2012; Nock 2008; 9; Heilbron & Prinstein, 2008) to date there is very little that explores its utility in explaining self-harm within forensic mental health patients, or in relation to non-suicidal life-threatening self-harm (see Chapter 2, Defining Self-harm and Suicide). The findings from the thesis are therefore considered within the framework of the FFM in an exploratory way to determine whether the theory has relevance within a female forensic population.

Table 12: The Reinforcement Process Behind NSSI (Informed by Nock, 2009)

Function	Reinforcement Process
To alleviate negative internal emotional or cognitive states	Negative- Intrapersonal reinforcement
The generation of positive or desirable internal emotional or cognitive states	Positive-intrapersonal reinforcement

Escape from or cessation of social situations and interpersonal demands	Negative interpersonal-social reinforcement
To elicit care or obtain a positive response from others	Positive interpersonal-social reinforcement

Using the first-hand lived experience of both the women and staff who took part in individual interviews; seven different sub-types of life-threatening self-harm were identified.

- The Overwhelmed
- The Taught
- The Care Eliciting
- The Am I Worth Saving
- The Trauma Threat Responder
- The Progressive
- The Angry-Controlled-Aroused

Table 13: Summary of sub-types of life-threatening self-harm

	Name	Summary	Key Characteristics	Pathway to Life-Threatening Self-Harm
7.4	The Overwhelmed	*A woman who engages in life-threatening self-harm during a time of overwhelming distress, whose behaviour is normally triggered by a significant life event.*	• History of non-life-threatening self-harm • Likely to have difficulties managing distress • Likely to have difficulties communicating distress	Enacts life-threatening self-harm in response to a significant life event.
7.5	The Taught	*A woman who engages in life-threatening self-harm using methods she has been taught or has observed being used by other people.*	• Long term admissions and extensive care service history (including child services) • May or may not have a history of non-life-threatening self-harm prior to hospital admission • Women who have a preferred method of self-harm, but whose methods of self-harm have changed unexpectedly or over time.	Observes life-threatening self-harm which becomes rationalised, normalised and justified by a woman and her peers. Can also learn life-threatening methods through other women providing 'tips' on how to improve the lethality of their self-harm.
7.6	The Care Eliciting	A woman who engages in life-threatening self-harm to	• History of neglect and invalidation • Likely to include women with personality disorder	Life-threatening self-harm stems from life experiences

		elicit a care response from members of staff.		whereby they have not been cared for, and/or have had their distress invalidated. Leads to an inability to articulate their distress or convey their need for support, and a belief that their needs will not be acknowledged or met unless they use extreme methods to get noticed.
7.7	The Am I Worth Saving	Women who engage in life-threatening self-harm with the aim of creating a situation whereby they require saving so they can question whether a care giver is capable of saving their life, and to determine whether their life is worthy of saving.	• Histories of extreme neglect where basic needs have not been met • Report feeling worthlessness • Report low self-esteem • Life-threatening self-harm may always occur around one member of staff	Early life experiences of neglect and maltreatment result in perceptions of unworthiness and contribute to the development of insecure attachments to caregivers. Women enact life-threatening self-harm to test the ability of care givers to notice and respond to their distress.

7.8	The Trauma-Threat-Responder	Women enact life-threatening self-harm to try and cope with intrusive thoughts and flashbacks associated with their past traumatic experiences.	• History of extreme sexual, physical, and/or psychological abuse • Experiences flashbacks and intrusive thoughts related to traumatic experiences • Generally, will only engage in a life-threatening self-harm ("all or nothing") • May express suicidal intent • Report feelings of guilt or shame	Enacts life-threatening self-harm as non-life-threatening methods are not able to provide them rest or peace from their intrusive thoughts and flashbacks. Life-threatening self-harm is the only way they are able to cope.
7.9	The Progressive	Women enact life-threatening self-harm to cope with or release distressing emotions, or to 'feel something'.	• Long history of non-life-threatening self-harm • History of long admissions in services (both in childhood and adulthood) • May experience dissociative symptoms (including feeling numb) • Will change methods over time to those with higher lethality, or inflict more serious injuries	The life-threatening self-harm occurs as part of a progression along a continuum, whereby non-life-threatening self-harm is no longer able to meet their needs.
7.10	The Angry-Controlled-Aroused	Women enact life-threatening self-harm to demonstrate the internal frustration, anger, and over arousal they are experiencing.	• History of violent, or aggressive behaviour within services • Likely to assault staff during intervention	Life-threatening self-harm occurs in response to feeling powerless, angry and frustrated over their experiences. Life-threatening self-harm is enacted to manage over arousal.

7.4 The Overwhelmed

"Anything kind of stressful really, stressful events and I mean that doesn't have to be a huge thing like outside, because some patients will really feel something as a result of an event that might not be that big but yeah… it could be something like a shock so a death erm a death of a family member and just not being able to deal with and cope in that moment" (Francis, Clinical Psychologist)

7.4.1 Summary

A woman who engages in life-threatening self-harm during a time of overwhelming distress, whose behaviour is normally triggered by a significant life event.

- History of non-life-threatening self-harm
- Likely to have difficulties managing distress
- Likely to have difficulties communicating distress

7.4.2 Function

Typically, women from The Overwhelmed sub-type will have a history of non-life-threatening self-harm that is associated with emotional coping and managing low-level distress. In usual circumstances, their non-life-threatening self-harm occurs in a bid to stop or manage negative feelings. In the instance of life-threatening self-harm, a woman may feel overwhelmed with their current life experiences and she simply does not know how to articulate her distress in any other way. The message behind this type of life-threatening self-harm is to convey how much she is hurting and how she needs others to help her.

7.4.3 Suicidal Intent

Among the women and staff, it was generally accepted that for women within The Overwhelmed sub-type, their life-threatening self-harm was not enacted with suicidal intent. Instead, as reported in Chapter 6, Experiencing Life-Threatening Self-Harm, the women and staff said many women enact life-threatening self-harm in response to unbearable distress, and believed this type of life-threatening self-harm represented a "cry for help". In some instances, women in The Overwhelmed sub-type may say in the moment they wanted to die, due to this distress. However, later, they are likely to report they were indeed unable to cope with their distress at the situation, but, with hindsight, did not want to end their lives. Despite this, many reported that life-threatening self-harm amongst this sub-type was often impulsive, which may mean they are at greater risk of dying by suicide after a significant life event. This is

because literature has evidenced a relationship between impulsivity, trigger events and suicide amongst clinical samples who self-harm (Gvion & Apter, 2011; Madge et al, 2011; Klonsky & Mae, 2011).

"It is just a cry for help and you hear that saying a lot don't you but I do think it is about just erm you cant communicate how bad you feel or how distressed you are feeling about what is going on for you and you feel like erm it needs to be something really serious to show that and I don't think you even have the thought process before thought I think it just all happens quite quickly and impulsively" (Olivia, Service User)

7.4.4 Pathway to life-threatening self-harm

Women within The Overwhelmed sub-type are typically going through a period of increased distress and are finding their current experience to be overwhelming. Whilst it is likely that these women will have a long history of self-harm behaviours, in almost all instances, their self-harm is enacted with non-suicidal intentions, and is instead used to help them manage negative feelings. For women in The Overwhelmed sub-type, life-threatening self-harm can be impulsive and normally occurs in response to a significant life event, whereby they experience far greater levels of distress compared to normal. Typical life events are reported to include bereavements, important anniversaries, being bullied, notification of discharge, ward or hospital transfer, having a disagreement with a peer or member of staff, and receiving bad news. The Overwhelmed sub-type aligns with the current literature that states experiencing a negative life event can act as a trigger for self-harm in community samples (Haw & Hawton, 2008; Milnes et al, 2002; Heikkinen & Lonnqvist, 1994) and both male and female prisoners who engage in life-threatening self-harm (Marzano et al, 2016; Marzano et al, 2011a; Marzano et al, 2011b, Oakes-Rogers & Slade, 2015).

"Some people like if they have an upsetting phone call or something has happened so like bad news or something… that is massively what happens… it's like whenever I hear bad news or something has happened then I turn to it [life-threatening self-harm]" (Isla, Service User)

It is however important to note that not all events that have a significant impact will appear 'significant' to staff members, or indeed the women's peers. A significant life event was reported as also including events such as not being able to get through on the telephone to a loved one, feeling as though they have not succeeded in something, losing an important personal item, or having to miss an activity they enjoy. These findings again align with research that suggests there will be variation amongst populations as to what individuals

perceive to be a life event or problem, as what defines a 'negative live event' is not universal (Haw & Hawton, 2008).

"It's individual that move so it could be anniversaries, it could be a bad day on the ward, it could be they haven't accepted medication one day, it could be an argument with a peer or even a staff members, erm very small things sometimes will just erm… tip them over the edge so suddenly they don't feel like they are liked by someone erm it could be they couldn't get through on the telephone to someone or they haven't received a letter in a while" (Lorraine, RMN)

7.4.5 Comparison with existing theoretical models

The Overwhelmed sub-type aligns with the automatic negative intrapersonal dimension on the FFM (Nock, 2009, 2010; Nock & Prinstien, 2004). According to the FFM, individuals enact non-suicidal self-harm with an aim to escape intrapersonal adverse cognitive states and negative emotions. In the case of the women and staff in the current research, they report how women who engage in this type of life-threatening self-harm can feel overwhelmed by negative emotions and stress, associated with significant life events. In other words, they are trying to bring an end to these adverse states. According to Nock and Colleagues, engagement in self-harm becomes reinforced over time as it provides what they perceived to be an effective way of managing distress and provided help to reduce negative feelings. The findings from the current research therefore align with the widely accepted understanding that self-harm is utilised by some people as a distress and emotional management technique (NICE Guidelines 2013, Preventing Suicide in England, 2012).

7.4.6 Clinical Considerations

The findings in the current study provide confirmation that significant life events can act as a trigger for life-threatening self-harm, as some women find their increased levels of distress to be overwhelming (Marzano et al, 2016; Marzano et al, 2011a; Marzano et al, 2011b, Oakes-Rogers & Slade, 2015). The findings from the current research therefore build upon the current knowledge base and is the first to apply our understanding from the prison population and confirm it amongst women receiving forensic care. Consequentially, the research emphasises the need to work in an individualised manner, and to establish whether someone views an event as significant or distressing. The findings from the research also highlight the need for forensic mental health providers to play close attention to patients who have experienced a

life event, such as bereavement or an important anniversary, and to those who appear distressed following less conventional ‘significant life events’.

Table 14: Quotes to support The Overwhelmed Sub-type

Meaning unit	Condensed Meaning Unit	Code	Theme
"I think if they have never used life-threatening and they go and do it would be in response to a life event like a death… actually there was a patient who engaged in self-harm but low level and she experienced a death… it just spiralled her and she was out of control and regressed to the worst place she had ever been in her life... so yeah if someone had never engaged in life-threatening self-harm before then yeah a significant life event" (Annabelle, HCA)	"If they have never used life-threatening and they do it, it would be in response to a life event like a death… there was one patient who it spiralled her out of control and she regressed… so yeah a significant life event"	Loss/Bereavement	The Overwhelmed
"Yeah we have had it one of my girls she is a superficial scratcher … but at the loss of grandma, Grandma died and she ligated… that is what moved her I have seen it before in like a few of the women so I am sure that was what it was" (Faye, RMN)	"One of my girls is a superficial scratcher, but at the loss of Grandma she ligated… that is what moved her, I am sure it was"	Loss/Bereavement	
"She did tend to be superficial to be fair… but the news the bad news that was her initial thing to deal with the stressful events was to self-harm... it made her go further... it's just always the news that sends them over the edge" (Lilly, HCA)	"She tended to be superficial but the bad news, it made her go further"	Life Event	
"Just trying to think of my own experiences erm I definitely think that other things can occur that could make you go to the higher level of self-harm so for instance erm some negative news or something bad happened and in the moment that can just trigger you to want to do something more serious" (Evie, Service User)	"One of the things that could make you go to higher level of self-harm, so some bad news or something bad happening, it can just trigger you to want to do something more serious"	Bad News	

“There was another patient much before my time… she was a big superficial self-harmer, managed to get her settled she was just waiting for a bed for her in a locked rehab… then she did something really significant… it was the waiting for another service, it was that limbo phase… it’s a really unsettling phase which can trigger someone” (Marie, Assistant Psychologist)	“She was a big superficial self-harmer, managed to get her settled she was just waiting for a bed for her in a locked rehab… then she did something really significant… it was the waiting for another service, it was that limbo phase… it’s a really unsettling phase which can trigger someone”	Significant Life Event	
"I had one patient who generally speaking she wasn’t self-harming that much ermm but then she started to do like more lethal stuff so ligatures… there was lots of kind of interactions on the wards that were negative you know patients putting her under pressure erm bullying and she didn’t feel able to speak out and communicate that to staff... I think it got too much for her so a bit like a bottle of pop that will explode ... it triggered her off it was like a big deal for her and a big event for her" (Cathy, Trainee Forensic Psychologist)	“I had one patient who didn’t really self-harm that much, but then she ligated. There were lots of interactions of the ward that were negative and she was under pressure and being bullied and she couldn’t speak out or communicate, it just got too much for her like a bottle of pop that will explode… it triggered her off it was a big deal for her a big event”	Significant Life Event	

7.5 The Taught

"Exposure to an environment where people engage in lots of self-harm probably doesn't help, erm people who hurt themselves often share ways to do it, the same as people who are anorexic share tips on how to stay thin, same as people who play golf share tips on how to do the best swing" (Jamie, RMN)

7.5.1 Summary

A woman who engages in life-threatening self-harm using methods she has been taught or has observed being used by other people.

- Long term admissions and extensive care service history (including child services)
- May or may not have a history of non-life-threatening self-harm prior to hospital admission
- Women who have a preferred method of self-harm, but whose methods of self-harm have changed unexpectedly or over time.

7.5.2 Function

Typically, a woman in The Taught sub-type is likely to have a long history of contact with care services (both during childhood and adulthood), whereby she has been exposed to self-harm behaviours. Women who fall into The Taught sub-type observe self-harm behaviours over time and either learn how to self-harm, or observe new methods of self-harm, including those that can cause life-threatening injuries. Behind The Taught sub-type, women use life-threatening self-harm to manage their own emotional distress and fulfil their own intrapersonal needs.

"Yeah it is learnt behaviour self-harm, when I first hurt myself I was 13 years old and I was at my first children's home and I took 32 paracetamol and a bottle of vodka… but then I went to prison and ligated and that was learnt behaviour, you know cutting my arms was learnt behaviour because I only ever used to take overdoses but I couldn't in there so I watched and I learnt and I changed… It is all learnt" (Chloe, Service User)

7.5.3 Suicidal Intent

There was consensus amongst the women and staff that in the majority of instances, women who fall within The Taught sub-type enact life-threatening self-harm without suicidal intent. Instead, for women within this sub-type, their life-threatening self-harm is the result of

learning new methods of self-harm from other women and is used to manage emotional distress. Despite this, as reported within Category 2b, Chapter 6, Experiencing Life-Threatening Self-Harm, a concern shared amongst many of the staff was that women within The Taught sub-type might die of accidental suicide. This is because they felt, in some instances; those who enact life-threatening self-harm using methods they have learnt from their peers do not always understand their potential lethality. Some staff members reported that this resulted in the women believing the methods they were using were minor or posed low risk to life, even though, in reality, the new method they had learnt was potentially lethal. This was described by three women as 'taking it too far'.

7.5.4 Pathway to life-threatening self-harm

All of the women who took part in the current research described times when they had been told about, or shown how to use, a new method of self-harm. Three of them also openly recalled sharing 'tips' with other women on how to make a method of self-harm more lethal. This means for some women in forensic mental health services, their self-harm behaviours become life-threatening as they are taught, or they learn from others, that life-threatening methods provides a viable and effective way to manage their own emotional distress.

"Ah see erm banging my head because I have done it from a toddler I have grown up with it but that is one that lots of people actually learn so erm yeah basically they learn it I mean I had a friend who asked me how to bang their head I told her and she done it really bad really bad she had to have staples" (Poppy, Service User)

The impact of sharing and normalising methods of life-threatening self-harm within social groups is however relatively unexplored in both the female forensic mental health and female prison population. Despite being limited in quantity, amongst the literature that does exist, it is generally accepted that social learning plays a role in the development of self-harm behaviours (Lanes, 2009; Fonagay, 2004). Linehan (1993) identifies self-harm as a learnt problem-solving technique (particularly within secure environments), Rosen & Walsh (1989) posits behaviours are learnt via social imitating, and Nock & Prinstein (2005) suggest self-harm is a representation of social modelling. Furthermore, Baker et al (2013) reported how women from a high secure forensic mental health hospital adopt new methods of self-harm from their peers, in a bid to improve the effectiveness of their self-harm behaviours. The findings align with those in Chapter 6, Experiencing Life-Threatening Self-Harm, where the staff and women reported the impact of social learning on life-threatening self-harm.

"I can pretty much slash the same big cut each time… and like squeeze it down the toilet and stuff… I learnt that trick I actually learnt that trick here someone taught me that and I would never have thought of that I used to put it into tissue so that is something I learnt... I mean I didn't even think of that someone taught me that... and that allows me to up it" (Freya, Service User)

These findings align with literature from the general adolescent population whereby some individuals who self-harm immerse themselves within virtual communities where they are exposed to stories of new self-harm methods. Typically, these communities develop within online web forums and provide a platform for people to seek support from those with similar experiences (Harris & Roberts, 2013). It is however known that such website forums are not always positive (Harris & Roberts, 2013; Rodham et al, 2007), and many have been shunned publicly as they are also used to share alternative methods of self-harm (Lewis & Seko, 2015; Daine et al, 2013; Harris & Roberts, 2013; Lewis et al, 2012). Rodham et al (2007) suggested a key negative impact of online forums was the legitimisation, normalisation, and minimisation of shared harmful behaviours, which may serve to reinforce and maintain self-harm behaviours (Daine et al, 2013; Lewis & Seko, 2015; Lewis et al, 2012). In many instances, literature has reported this leads to the worsening of self-harm, both in terms of the frequency and lethality (Daine et al, 2013). Cultivation Theory (Gerbner et al, 1985) encapsulates the process of normalisation, which may help to explain how self-harm is normalised and learnt amongst those within The Taught sub-type. Cultivation Theory posits normalisation of behaviour is particularly pronounced when individuals relate to the story being told (i.e. they also have self-harm thoughts and behaviours), view self-harm positively (i.e. it is an effective coping strategy), and believe self-harm is justified (Whitlock et al, 2009; Lewis & Baker, 2011). The theory therefore aligns with the women and staff's accounts, as discussed in Chapter 6, Experiencing of Life-Threatening Self-Harm, whereby there was consensus that self-harm was a justified and effective coping strategy.

"I don't know if it is just a normal thing but like you know when a bunch of people get together and they start sharing ideas and they end up coming out with the same ideas even if no one has spoken about them beforehand I don't know if that is a sort of factor around it I mean they are around each other all day... so we had one lass who I think she put 3 pens into her arm in the space of 2 weeks and then we see other people starting to put items inside of their bodies and it's like maybe some copycat antics going on" (John, HCA)

It may also be useful to draw upon Script Theory (Abelson, 1976) to help explain the process behind women in The Taught sub-group learning that life-threatening self-harm offers a better way to manage their distress, compared to non-life-threatening methods. Script theory suggests individuals develop "responses to their environments which manifest as scripts that guide future behaviour" (Lewis & Baker, 2011). In other words, those who self-harm may adopt scripts which rationalise that self-harm occurs in response to affective (e.g. distress), and environmental (e.g. stressors) factors, and such scripts are reinforced by observation of other people's storylines (Whitlock et al, 2009). Script theory may therefore explain how women in forensic mental health services learn and adopt scripts that rationalise life-threatening self-harm, as forensic wards create an easy environment for sharing storylines and observing others self-harm behaviour. This is largely due to the close proximity in which the women live and the extended period of time the women will spend on a ward during an admission.

7.5.5 Comparison with existing theoretical models

The function of The Taught sub-type aligns with the intrapersonal-negative reinforcement domain of the FFM, as the women and staff conceptualise life-threatening self-harm as a coping strategy for some women, which is used to manage increased levels of distress (see Chapter 6, Experiencing Life-Threatening Self-Harm). For some women, life-threatening self-harm is therefore a viable option to help manage and control negative emotional or cognitive internal states.

The FFM may also prove helpful to explain the pathway to life-threatening self-harm for The Taught sub-type. As detailed within Chapter 3, Theoretical Framework, one hypothesis within the FFM posits people learn from other people that non-suicidal self-harm offers a viable way to overcome emotional or cognitive distress, and elicit a response from others (Nock, 2009). This, according to Nock (2009), is explained by the Social Learning Theory (Bandaura, 1976), which posits behaviour is observed and reinforced by the response of others. Considering the evidence presented within The Taught sub-type, it is clear that the women and staff are aware that some women in forensic mental health services learn new, life-threatening methods of self-harm from each other.

Combined, Social Learning Theory, Script Theory and Cultivation Theory may also be able to explain why at times trends are noticed in the methods used by women receiving forensic mental health care. As detailed within Chapter 6, Experiencing Self-Harm (category 2a and 3c), the women and staff referred to this the 'domino effect' or the 'ripple effect'. This refers

to the process whereby one woman enacts life-threatening self-harm using a method that is unusual or new to the ward, which is soon followed by a number of other women who enact the same behaviour in the same way. Applying the aforementioned theories, in the case of the domino effect, a group of like-minded women (all of whom relate to self-harm behaviours, view self-harm positivity and justify its use) openly witness other women enacting life-threatening self-harm using a new or unusual method. Openly witnessing other women's self-harm will facilitate the process of rationalisation, normalisation and imitation of the new life-threatening method amongst the ward community and reinforce its use. Consequentially, women in The Taught sub-type learn from each other new methods of life-threatening self-harm via exposure to others behaviour

"I think there is probably a distinction to be made between directly copying someone's behaviour and just being in an environment where there are lots of distressed and disturbed people so obviously we endeavour to keep the wards as therapeutic as possible but the reality is that lots of patients will see other patients self-harming or they might see them being restrained and really difficult things to see… but the nature of the ward is that you are pulling lots of disturbed and violent people into the same space and I think that should not be underestimated". (Michael, Speciality Doctor)

7.5.6 Clinical Considerations

The findings in the current research identify that life-threatening self-harm is influenced by social factors and confirms a pathway to life-threatening self-harm via learning new methods from other people. The study therefore builds on literature that explores the social impact of online self-harm forums on the frequency and severity of self-harm (Lewis & Seko, 2015; Daine et al, 2013; Harris & Roberts, 2013; Lewis et al, 2012), as it is the first to explore whether there is a social impact on life-threatening self-harm within forensic mental health services. The current research therefore provides important insight into how life-threatening self-harm can develop via exposure to others self-harm and offers an explanation for the observed 'domino' or 'ripple' effect.

Table 15: Quotes to support The Taught Sub-type

Meaning Unit	Condensed Meaning Unit	Code	Theme
"erm I think people see what is going on around them because a lot of people's behaviour is learnt from like what you see in hospitals, especially hospitals so what you see you learn like" (Isla, Service User)	"A lot of people's behaviour is learnt from like what you see in hospitals, especially hospitals so what you see you learn like"	Learning	The Taught
"You might see someone else head banging and then they think ah I have never seen or done that before and then they go and do it… you know we actually had a patient who wasn't a self-harmer AT ALL and you know she would see people here like scratching and cutting and staff responding to that … they are seeing other patients and learning how they kind of do things and you know they might just see it and like take that upon themselves " (John, HCA)	"You might see someone else head banging and then they think ah I have never seen or done that before and then they go and do it… they are seeing other patients and learning how they kind of do things and you know they might just see it and like take that upon themselves"	Imitation	
"So they might see new behaviours and learn these, especially when for example in hospitals everything is around you and you think everybody is just trying to learn how to do things the best way… it can make it worse and more dangerous yeah so it is about seeing what else can be brought to the table and then you can use that to get a new reaction or a different one and people sometimes like it" (Cathy, Trainee Forensic Psychologist).	"So they might see new behaviours and learn these, especially when for example in hospitals… it can make it worse and more dangerous… it is about seeing what else can be brought to the table and then you can use that to get a new reaction or a different one"	Imitation	
"So yeah learnt behaviour… your superficial's who are around women who do self-harm sort of far more severely, its learnt behaviour but like it's the question of do you really understand what you are doing? Sometimes we are not going to be able to help you or get it out… so yeah I think the superficial's when it is learnt behaviour, have an ignorance to quite what they are messing with because all the people who tie ligatures and that, your Vegas' nerves and that if you tie a ligature and crush them its lights out but yeah they just don't get it" (Faye, RMN)	"So yeah learnt behaviour… your superficial's who are around women who do self-harm sort of far more severely, its learnt behaviour"	Learning	

7.6 The Care Eliciting

"For them it is a good coping strategy and as negative as it is they have used it for such a long time that actually it does get them what they want if it is like a bit of TLC or ermm I just you know just feeling that care and attention it does get them that so it does have a function for them" (Annabelle, HCA).

7.6.1 Summary

A woman within this sub-type engages in life-threatening self-harm to elicit a care response from members of staff. This is not to be confused with attention seeking and is instead underpinned by a driving need to be cared for. This behaviour is likely to stem from life experiences whereby they have not been cared for, and/or have had their distress invalidated. This leads to an inability to articulate their distress or convey their need for support, and a belief that their needs will not be acknowledged or met unless they use extreme methods to get noticed.

- History of neglect and invalidation
- Likely to include women with personality disorder

7.6.2 Function

Women who fall within the 'care eliciting' sub-type engages in life-threatening self-harm with a desire to receive care from members of staff during times of distress. For these women, life-threatening self-harm is the most effective way to demonstrate their emotions and to ensure they receive care and support from others. The support and care they receive because of their life-threatening self-harm help to validate their distress and reminds them that people care for them. Therefore, through experience, they have learnt that life-threatening self-harm prompts a care response, which validates their distress and reinforces their behaviour.

"I mean if you have got something weird and wonderful wrong with you that requires lots of people to come and see you… and you have got medics coming and surgeons coming and a 4-man nursing team and then you have got other nurses from the main hospital and she is just sat there on the bed with her hand cuffs on and all these people ahhh you know that feeling of creating care when you have never been cared for to have all of that around you is so comforting" (Faye, RMN)

7.6.3 Suicidal Intent

The women and staff conceptualised life-threatening self-harm within the 'care eliciting' sub-type as occurring without suicidal intent. Instead, life-threatening self-harm allows the women to convey their distress to others and occurs with the aim of achieving a desired outcome – care and support from members of staff.

"*I think for lots of people life-threatening self-harm is about a release and it is something private its something that you keep to yourself and something that you do alone so I think the people who harm themselves and sit in front of people and 'attempt suicide' in front of someone, like well why would you do that because we all know it isn't going to happen because they are sat right in front of you… so they are just doing it for a reaction its not about dying it's for a reaction". (Freya, Service User)*

7.6.4 Pathway to life-threatening self-harm

Women who fall into the sub-type of 'care eliciting' are those who have histories of neglect, whereby they have had their emotions and/or experiences invalidated. For these women, they learn that life-threatening self-harm is a way to articulate their need for support, as many feel unable to ask more directly for help. It is likely that in the past, women within the Care Eliciting sub-type may have reached out to their caregivers in times of distress, however, either the care they needed was not provided, or their distress was not believed. Consequentially, women in the Care Eliciting sub-type increase the severity of their self-harm, as they have learnt through experience, that life-threatening self-harm prompts a care response. Such a care response validates their distress and reinforces their behaviour.

"A lot them they do it to get us, I don't mean in the sense of attention seeking please don't think I do mean it like that but they just want us to care for them, or just to engage with them so they do it knowing what will come next… it's the only way they know how to get people to care for them, I mean imagine never having been really looked after or being able to get people to help you, like I said so many of them have been in foster care so really they didn't have anyone so it's the only way they know how to" (Annabelle, HCA)

"So erm lots of low-level stuff can also build up to something significant… I have been in situations where I have done low level stuff and it is a way of communicating and that need hasn't been met so it kind of ups the ante, so you go more extreme and more extreme until you are trying to get that need met so erm at those times it hasn't been helpful if people sort of haven't taken any notice or just said it's okay… I think 9 times out of 10 it is really

difficult to meet that need yourself you know what I mean so that needs to come externally to meet that need and well significant stuff that gets that external stuff" (Olivia, Service User)

Women within The Care Eliciting sub-type may have learnt that life-threatening self-harm provides an effective way of diverting care from others and may enact life-threatening self-harm if they feel neglected (i.e. they care needs are not being met), or feel they are not receiving the same level of care as others around them. For some women in The Care Eliciting sub-type, their life-threatening self-harm may therefore appear to be enacted at a time where a peer is receiving increased levels of care. The women and staff explained that life-threatening self-harm amongst women in The Care Eliciting sub-type can be motivated by feelings of anger, jealousy or a sense of injustice that someone else is receiving support from staff, when they believe they have a greater need for care.

"So erm one of the functions I have spoken about is erm to get staff time… and to pull staff away from others. So, if they are jealous of their peers, or they don't particularly like someone then ermm or they have an issue with peers then you quite often find they will trigger something so that they don't have their time... you see on my ward all of our girls are segregated… and ermm we have a lot of do not mix so if one patient is up that means the other patients cannot be up at the same time… you can put one back in their room with them having the knowledge that a certain young lady or women is about to get up so they will do something to stop someone's time" (Lorraine, RMN).

"It's bad because it is learnt behaviour right… I understand why people get into the pinel belt because if you are in the pinel belt then you get like sweets and chocolates out the locker… and then you see people in the pinel belt getting chocolate out their locker and it's like look at how nicely they are being treated in there… they are just being rewarded for that type of behaviour with their sweets and chocolates" (Chloe, Service User)

Previous literature has suggested that women who enact self-harm with the aim of achieving a specific goal are likely to be stereotyped as 'attention seekers' or 'manipulative' as the main reason for their self-harm is to elicit something from another person (Gratz, 2003; Conterop & Lader, 1998; Favazza, 1992). Prison literature refers to these as instrumental goals and typically refers to goals that involve another person giving, or doing something for them (Rivlin et al, 2013; Gratz, 2003). Although it is true that the women who fall within The Care Eliciting sub-type seek something from other people and achieve this through an intended action, the motivation behind their self-harm differs to that reported within the prison literature.

Comparably, those who took part reported that women in The Care Eliciting sub-type do not seek external or material gains; as their behaviour is underpinned by a distinctly different need: to be cared for. Instead, the goals for women in forensic mental health services could be as simple as wanting someone to talk to, or to be offered encouraging words of support. They also described how some women seek physical contact from another person and feel the only way to achieve physical contact is to engage in life-threatening self-harm that will require physical restraint. Therefore, over time, women in The Care Eliciting sub-type learn that life-threatening methods of self-harm prompt the appropriate care response their seek.

"People know how to get the best reaction and the best way honestly… to get the best reaction it's to swallow something so obviously if something is lodged in your throat even for a minute they [the staff] get it out they are going to stay with you and they are not going to leave you alone.... I don't know if you can hear now but there is someone who is trying to make themselves sick. They are not actually making themselves sick, but they make that noise, so staff come because they think they are choking… look see, the staff are running down there now... honestly, she will progress now because they have … they looked at her so she knows she has got their attention… so this is when the anti gets up so the anti only gets up when there is a crowd " (Freya, Service User)

"It's kind of like I know if I head bang staff are going to come in and kind of take me into holds so I know I am going to be held, and I'm going to be cleaned and I'm going to be looked after and kind of all those things… I mean they have not really had that happen to them in appropriate ways so kind of … that is always the way they have been able to receive care… so like I guess they would have kind of developed attention and nurturing care using maladaptive ways *" (Marie, Assistant Psychologist).*

The women and staff also described how a similar yet somewhat different function for women within The Care Eliciting sub-type is seeking a medical response. Although these women still wish to seek a care response from others, they are less focussed on receiving emotional support and more so on receiving medical treatment. A need to seek medical treatment and care from others has been evidenced amongst other mental health disorders (including Munchausen's and Munchausen's by Proxy), whereby people intentionally produce symptoms of illness in order to receive care and attention from others (NHS England, 2018; Lawlor et al, 2014; Feldman, 2008). Literature has previously highlighted the important role that receiving care (albeit often very brief) plays within the development and continuation of self-harm in populations suspected to have such mental health disorders (Fliege et al, 2002).

"So erm I do it to get out of hospital… it's part of my illness you see… it's just the way I feel you know I enjoy it… I just enjoy the experience of being in there you know like being in a hospital setting you know like injections and being put under anaesthetic and probably an operation you know… it's about being looked after and being cared for I would say" (Ava, Service User)

"See you have the people who don't harm themselves actually harming themselves they just like erm they want medical attention so like they will swallow something and then like 5 minutes later say they are in pain and get pain killers and then healthcare centre has to come or they have to go out of grounds or they have to have it removed or ermm all of that and that is just for the er for the medical attention - just so people have to look after them" (Poppy, Service User)

Interestingly, the findings from the current study differ to previous research from Levenkron's (1999) and Linehan (1993) who discussed the notion of care eliciting being a 'secondary gain' of self-harm behaviour. Levenkron (1999) and Linehan (1993) suggest people do not self-harm with the intention of eliciting a care response from others, however, the care response provided reinforces the self-harm behaviour. This is however different from the accounts provided by the women and staff from the forensic pathway who posit self-harm is enacted with the specific aim of eliciting care and attention from other people. The findings from the current study therefore indicate that for women within The Care Eliciting sub-type, care eliciting is in fact the primary aim of life-threatening behaviour.

7.6.5 Comparison with existing theoretical models

The function of The Care Eliciting sub-type aligns with the FFM as the women and staff reported that, for some, life-threatening self-harm is enacted with an aim of eliciting care or a positive response from other people (Nock, 2009; 2010; Nock & Prinstein, 2004). According to the FFM, such behaviour falls within the interpersonal-social positive reinforcement domain and is reinforced by other people's response. This aligns with the women and staff accounts whereby they report some women enact life-threatening self-harm as they have previously learnt it is effective at eliciting a care response from members of staff. As previously mentioned, this also aligns with current prison literature that supports the idea that some women enact self-harm behaviours with an aim of seeking care from members of staff (Rivlin et al, 2013; Gratz, 2003).

Social Learning Theory (Bandura, 1977) may also offer a suitable explanation of the pathway to life-threatening self-harm amongst women in Care Eliciting sub-type. In short, Bandura (1977)

suggests people learn new behaviours through behavioural reinforcement. Women within The Care Eliciting sub-type learn from the response of their environment and members of staff that engaging in life-threatening self-harm will elicit a particular care response. The care response itself reinforces their behaviour as life-threatening self-harm offers the most effective way to elicit care from the largest group of people and ensure that care is given to them and not to other people.

7.6.6 Clinical considerations

The findings from the current research raise important practical questions in relation to how we respond to women who self-harm, and whether staff reactions play a role in the pathway to life-threatening self-harm. Although related to non-life-threatening self-harm, Linehan (1991) highlighted the reinforcing role staff responses have after an incident of self-harm. According to Linehan (1991), providing appropriate support to those who ask for help before they self-harm helps to reinforce adaptive coping strategies (i.e. articulating their distress and asking for help). Comparably, not providing a care response after an incident of self-harm for a set period of time acts as an adverse consequence for maladaptive behaviour (Brown, 2001). The idea that care responses can reinforce self-harm is recognised by Dialectical Behavioural Therapy (DBT) (Linehan et al, 1991). DBT has been evidenced internationally as one of the most effective treatment for individuals who self-harm (Feigenbaum et al, 2012; Muehlenhamp, 2006; Shearing & Linehan, 1992) and utilises behavioural and cognitive strategies to reduce vulnerability to self-harm behaviours and develop skills to increase distress tolerance (Linehan, 1993). Within DBT supportive phone calls are available during times of increased distress, however when self-harm occurs, phone calls become unavailable for 24-hours after self-harm (Brown, 2001). Whilst often seen as somewhat unsympathetic, the 24-hour rule has clear boundaries that all participants of DBT agree too and is designed to prevent care responses reinforcing self-harm behaviour (Linehan et al, 1991). Considering the evidence that supports the reinforcing role care responses can have on self-harm behaviours, in a bid to prevent the pathway to life-threatening self-harm within The Care Eliciting sub-type, it may be helpful for forensic mental health services to consider adopting a similar approach to that of DBT and set clear boundaries that non-life-threatening self-harm will not be responded too. Instead, women who as for help during times of distress ought to receive support from a member of staff to help validate their distress and positively reinforce their adaptive coping skills.

Table 16: Quotes to support The Care Eliciting Sub-Type

Meaning Unit	Condensed Meaning Unit	Code	Theme
"A lot of it unfortunately can be learnt behaviours, that that is the fastest way to get staff because if you are short staffed, if you do something then the staff will have to come ermm which is you know unfortunate but is the way of any life event so like if you have a ward in a general hospital and everybody is okay but then one person gets sick on that ward then they will get staff, so erm in mental health hospitals you have the people who are on the ward however if one of them self-harms then you will have staff going to them and that is the way it is" (Lorraine, RMN)	"A lot of it unfortunately can be learnt behaviours, that that is the fastest way to get staff because if you are short staffed… if one of them self-harms then you will have staff going to them and that is the way it is"	Diverting care	The Care Eliciting
"Some of them after much prodding and poking they will tell you that it was because they wanted to elicit care for you that there was something about you that maybe about you as an individual they really liked and they wanted to get that care from you". (Sadie, Clinical Team Leader).	"They will tell you that it was because they wanted to elicit care for you… something about you that maybe about you as an individual they really liked, and they wanted to get that care from you"	Eliciting care	
"Yeah coping and a way of communicating and erm voicing that inner emotion to staff or peers... so yeah I mean the care elicitors … really that is about getting some sort of care or just human attention" (Paula, Forensic Psychologist).	"The care elicitors … really that is about getting some sort of care or just human attention"	Eliciting care	
"All methods of coping will be unique to people and their own experiences and the meaning of them will be different from person to person, however some people need input and it hurts if they are not getting cared for and being treated as somebody who is worthy of care you know for some people they find they have to progress their self-harm to get the same level of care as people very quickly get used to scratches and burns or things like that". (Jamie, RMN)	"some people need input and it hurts if they are not getting cared for and being treated as somebody who is worthy of care… some people they find they have to progress their self-harm to get the same level of care as people very quickly get used to scratches and burns or things like that"	Progression based on reactions	

7.7 The 'Am I Worth Saving'

"I think some women engage in life-threatening self-harm with the aim of being saved, save me save me, erm and then it gives them that feeling of I am worth being saved and it gives them that opportunity to flirt around with the idea 'am I worth' 'it will they notice it' 'am I important enough to save' 'am I worth it'. So, they engage in life-threatening with no intention of dying but just that sole aim of save me and let me know I am worth it, let me know I am worth saving" (Faye, RMN)

7.7.1 Summary

Women, who fall into The Am I Worth Saving sub-type, engage in life-threatening self-harm with the aim of creating a situation whereby they require saving. For them, engaging in life-threatening self-harm provides an opportunity to question whether a care giver is capable of saving their life, and to determine whether their life is worthy of saving.

7.7.2 Function

Women who fall into the 'Am I Worth Saving' sub-type are typically those with extreme neglect histories, where their basic needs for safety have been denied, or ignored. Sadly, many of these women will have had experiences in their lives whereby the people who are supposed to protect them have not. As a result, these women are left with feelings of low self-worth, self-loathing and a perception they do not deserve, or are not worthy of protection, or saving. As a result, women in The Am I Worth Saving sub-type engage in life-threatening self-harm to determine whether they are indeed worth saving and whether those who are there to support them are able to keep them safe. Women who fall within this sub-type typically enact life-threatening self-harm in private areas of the ward (e.g. bedrooms) with the intended aim of concealing their behaviour. This is to facilitate the rescue plan, which involves staff being able to find them and save their lives.

- Histories of extreme neglect where basic needs haven't been met
- Low self-worth
- Poor self-esteem
- Life-threatening self-harm may always occur around one member of staff

7.7.3 Suicidal Intent

Among the women and staff, it was accepted that women who fall into the 'am I worth saving' sub-type enacted life-threatening self-harm without suicidal intent.

"It's like the life-threatening yeah, so swallowing something is life threatening yeah but when you have two staff sat outside the door you know that when you do it they are going to bang it back out when they can get to you, so you see they are doing it because they want, they need that reaction from the staff not because they wanna die" (RT64 013, Service User)

"I have lost two people both of those have been in places like this who died using ligatures when they didn't mean too… some people do it because they are going to get found so they think they will be found in time so its like me so I am on 15 minute obs and if I tie a ligature yeah I do it and I want to be found so I do it at a time I know they will find me… we know exactly what we are doing" (Chloe, Service User)

Despite this, women within The Am I Worth Saving sub-type were a serious cause of concern as it was reported that women in this sub-type often enact the most dangerous forms of self-harm, including occluding the airways. When discussing women who had died within forensic mental health services as a result of their self-harm behaviour, the staff and women believed their deaths were an accident and occurred as they thought staff would save them.

"Two people have died here and they were both accidents, I am guessing they relied on staff to find them and they didn't" (Freya, Service User).

"The ignorance of not understanding you know, some people don't understand I suppose the save me's, they are sort of a wing and a prayer aren't they that you are going to be there on that 5 minute check, and you are not going to have gone for a pee and told someone else to check on them and they have forgotten, or they have found someone else who self-harmed, it's a bit of a wing and a prayer" (Faye, RMN).

7.7.4 Pathway to life-threatening self-harm

For women who fall within the 'am I worth saving' sub-type, their life-threatening self-harm develops as a result of neglectful childhoods whereby their basic needs were unmet by their caregivers. Early life experiences of neglect and maltreatment can result in perceptions of unworthiness (Larose & Bernier, 2001) and contribute to the development of insecure attachments to caregivers (Ainsworth et al, 1978). Literature highlights a relationship between insecure attachment styles and negative self-image and demonstrates how people with insecure attachments often exaggerate their emotional responses to gain security from others (Kobak et al, 1993). Together, negative perceptions of the self, negative expectations of care from others and insecure attachments have been cited as risk factors for non-suicidal self-

injury (NSSI) whereby NSSI is used to obtain attention from caregivers (Yates, 2004; Gratz et al, 2002; Adshed, 1998).

"I think the act [occluding the airways] almost really sort of puts this question out there of your care givers and the question is sort of are you going to get here and are you going to save me. So there is something about working through a rescue and those behaviours… the occluding and it was that it was that needing to ask a question of the staff around erm am I worth saving are you going to get there on time will you try will you do it every time" (Francis, Clinical Psychologist)

As a result, women in the 'am I worth saving' sub-type enact life-threatening self-harm to test the ability of care givers to notice and respond to their distress. Bion (1962) described this process as the maternal containment function, whereby the caregiver helps another to develop the capacity to tolerate anxiety and distress. Therefore, on some level, staff members may fulfil a containment function for the women (Admead, 1998), whereby the women look to the staff to help relieve their anxiety in times of distress (Kraemer, 1992). Therefore, in practise, their life-threatening self-harm may be centred on particular members of staff, as they seek self-affirmation and support from those they have formed new attachments with. Sadly, based on their experiences of neglect, these attachments need to be tested. This aligns with literature that has previously demonstrated that for some, self-harm offers a viable way to stop caregiver's from leaving, as without them, people can feel their distress and anxiety will not be attended to (Admead, 1998).

"So one of our women she would frequently self-injure to a life-threatening degree but only when certain of us were on duty and that transpired because she saw us as being experienced clinicians that would save her and I was one of them and if I walked on duty and saw this particular member of staff, you could almost guarantee that we would be resuscitating her at some point… and we actually asked her and that is what she said to us that she knew we could save her" (Rose, Clinical Nurse Practitioner).

"Like some people like it is always coincidental that when certain people are working that they like that they just so happen to find them in a state its like its stages" (Freya, Service User)

There was the perception that women who enact life-threatening self-harm with the aim of being saved present a particularly dangerous group, who despite not wanting to die, are at increased risk of dying from their self-harm behaviours. The women and staff report this is because their need for containment and validation is so strong that they are prepared to risk

their own lives through enacting life-threatening self-harm in secret, in the hope that a member of staff will find them and save them. Sadly, the women and staff reported it was not always possible due to the notable pressures faced by staff on forensic wards (including staff shortages), meaning there have been times where staff have not found women in time to save their lives.

"You know one lady she never expressed a wish to die… the problem is though we cant always manage it and we could be going to the toilet or you know even when we are there managing it we cannot always be successful" (Rose, Clinical Nurse Practitioner).

7.7.5 Comparison with existing theoretical models

Unlike the aforementioned typologies, the 'am I worth saving' sub-type appears to align with two domains within the FFM. This is because women in this group enact life-threatening self-harm to alleviate intrapersonal feelings of worthlessness, but to do so, seek social validation and a positive response from members of staff. This means the 'am I worth saving' sub-type aligns with both the intrapersonal-negative reinforcement and the interpersonal-social positive reinforcement domains. The medical and managerial response afforded to women within this sub-type validates they are worth saving, which in turn reinforces that life-threatening self-harm offers a viable way to manage feelings of worthlessness and test the ability of caregivers to keep them safe.

7.7.6 Clinical considerations

The findings in the current study provides confirmation that like NSSI, life-threatening self-harm can serve as a function to obtain maternal containment from members of staff in times of distress and feelings of worthlessness (Kraemer, 1992; Bion, 1962). This study extends the current literature which confirms a relationship between neglect, insecure attachments, worthlessness and self-harm (Yates, 2004; Gratz et al, 2002; Adshed, 1998), and evidences a similar relationship amongst women who enact life-threatening self-harm. These findings therefore highlight an important area for clinical consideration in terms of a need to educate women on communication and help seeking skills, and work on attachments and self-worth.

Table 17: Quotes to support The Am I Worth Saving Sub-type

Meaning Unit	Condensed Meaning Unit	Code	Theme
"I mean certainly in some cases it appears that there is a very clear function about you know getting a team of typically nursing staff to give them 1:1 attention and have their stress validated in a very particular way that means a lot of people come to their aid" (Marie, Assistant Psychologist)	"there is a very clear function about you know getting a team of typically nursing staff to give them 1:1 attention and have their stress validated in a very particular way that means a lot of people come to their aid"	Wanting to be saved	The Am I Worth Saving
"Some patients will look to see you manage something really well because then they know this is a safe environment ermm some patients will look to see lots of people arrive, the doctor arrive, because that makes them think oh yeah they really do care" (Jamie, RMN)	"Some patients will look to see you manage something really well because then they know this is a safe environment… they see lots of people arrive, the doctor arrive, because that makes them think oh yeah they really do care"	Testing containment	
"erm well I suppose obviously the reasons are different for different people… but I think for the majority of our women… ermmm… especially at this time... I think the main function is actually to be saved... we have procedures in place so they are saved and then often afterwards they will say thank you and they will express that they wont ever do it again but then they do go on to do it again because they want to experience that feeling of being saved" (Annabelle, HCA)	"I think the main function is actually to be saved... we have procedures in place so they are saved and then often afterwards they will say thank you… but then they do go on to do it again because they want to experience that feeling of being saved"	Wanting to be saved	
"However most of the time they will be looking also for an opportunity when they know they will be helped so someone is coming or they will be checked erm its not like any of our patients really hide away, quite often it is quite explosive snatching something, grabbing something, pushing someone out of the way to get something so you know there are elements there of them testing us to see how we are reacting to see if	"Most of the time they will be looking also for an opportunity when they know they will be helped so someone is coming or they will be checked… there are elements there of them testing us to see how we are reacting to see if we can keep them save and that is common amongst these women"	Testing containment	

we can keep them save and that is common amongst these women" (Lilly, HCA)			

7.8 The Trauma-Threat-Responder

"For some people they also talk about their being some sort of addictive quality to the moment of almost passing out, where you are not sort of conscious anymore, ermm and actually if you have a head full of horrors, you know the real trauma symptoms, or self-loathing those real feelings that you don't have any way of getting rid of, that moment of being able to cut off must be so valuable" (Francis, Clinical Psychologist).

7.8.1 Summary

A woman in The Trauma-Threat-Responder sub-type is one whom has suffered extreme, enduring traumatic experiences. Because of her traumatic experiences, she experiences trauma related flashbacks and intrusive thoughts, which cause her to engage in life-threatening self-harm. Women in this sub-type may have intense feelings of guilt and shame and enact life-threatening self-harm to try to stop the flashbacks. Women in this sub-type may enact self-harm with some suicidal intent, however others seek a peaceful moment whereby they are not traumatised by their past.

- History of extreme sexual, physical, and/or psychological abuse
- Experiences flashbacks and intrusive thoughts related to traumatic experiences
- Generally, will only engage in a life-threatening self-harm ("all or nothing")
- May express suicidal intent
- Report feelings of guilt or shame

7.8.2 Function

For women in the trauma-threat-responder sub-type, the function of their life-threatening self-harm is to try and cope with intrusive thoughts and flashbacks associated with their past traumatic experiences. Women within this sub-type will enact life-threatening self-harm frequently and are unlikely to enact non-life-threatening self-harm.

7.8.3 Suicidal Intent

Unlike all other typologies, the women and staff believed that some women within the trauma-threat-responder sub-type could be attempting suicide when they engage in life-threatening self-harm. They explained how, for some women, they were unable to manage the lasting psychological and often physical consequences of being abused, and they struggled so intensely with their flashbacks and intrusive thoughts that they feel simply unable or

unwilling to cope. Therefore, some may feel the only resolution to their situation is to try to end their own lives. These suggestions are supported by literature that links traumatic flashbacks to suicide attempts in women (Jina & Thomas, 2013; Maltsberger et al, 2011; Creamer et al, 2001; Wiederman et al, 1998; Davidson et al, 1996; Kessler et al, 1995; Wanger et al, 1994). It is however important to note that not all women who fall into The Trauma-Threat-Responder sub-type are suicidal, as others may wish to stop their traumatic flashbacks temporarily, or cope with distressing memories.

"*Some people say it is they say it is to die and I mean some people might self-harm that bad for that reason, but I normally I do risky things erm how can I word it ermmmm the more serious the self-harm the more serious it is the more it helps me, as it takes away the underlying issue of what has really happened to me so you are just focussing on that physical form of pain… so sometimes it is (about dying) but most of the time it is just a cry for help" (Isla, Service User).*

"I think someone who has suffered trauma ermm… you know when I have suffered the trauma I have with all that is going on up there [taps head], I self-harm to get comfort from all that [taps head] so not to die but I feel pain to feel comfort" (Ava, Service User)

7.8.4 Pathway to life-threatening self-harm

Sadly, women who fall into The Trauma-Threat-Responder sub-type have a history of extreme, complex, and long-term traumatic experiences. For the majority this will include physical, sexual or psychological abuse. Whilst typically this sub-type will include women who have been abused, in some instance's women may also fall into this group if they have experienced an alterative type of traumatic event, which as a consequence they experience flashbacks and intrusive thoughts. Literature suggests self-harm behaviours are also related to being fostered or adopted and growing up in poverty (Longden et al, 2016). As most women in secure forensic services have a history of trauma (Longden et al, 2016), it would be easy for all women to fall into this sub-type; however, what separates women in this group to others, is the presence of frequent flashbacks and intrusive thoughts. For these women, remembering or reliving experiences from their past can trigger feelings of fear, worthlessness, guilt or shame, which makes them want to engage in life-threatening self-harm. The Trauma-Threat-Responder sub-type aligns with literature from Marzano et al (2011), whereby female prisoners cited flashbacks and voices related to their trauma as a key reason for their life-threatening self-harm.

"Some of them just simply cannot bare you know what happened to them in the past even if it was 30 years ago you know they are still reliving it all and working through and just going over and over this horrific childhood" (Faye, RMN)

One member of staff pertinently described the women in The Trauma-Threat-Responder sub-type as those who have a "head full of horrors" and explained how they believed engaging in life-threatening self-harm provided a moment where they do not have to be reminded of traumatic experiences from their past. Fulfilling this function via life-threatening self-harm was described as 'chasing the peace' by two of the women who took part. They explained how enacting life-threatening self-harm was the only way they had found to "give themselves a break" from their intrusive thoughts and flashbacks. This aligns with findings from Rivlin and Colleagues (2012), whereby a small number of women prisoners cited they used life-threatening self-harm as a means of temporary escape.

"I believe you reach a point where you are doing life-threatening self-harm where you hit a place of ermm nothingness so things don't bother you anymore you haven't got a worry anymore and you are not connected with anything anymore and somehow that feels really peaceful and it feels really nice and ermm I have quite often chased that feeling so that is another reason why I do life-threatening self-harm because I haven't actually found that feeling doing anything else so it's not an attempt on my life" (Olivia, Service User)

"When I became depressed I was just doing it [life-threatening self-harm] and then I died for a bit and I got two minutes peace. My head went blank for two minutes and now I just crave it I crave the actual peace… so sometimes I want to die but almost most of the time I just want that two minutes of peace" (Poppy, Service User)

"So there was one women and she had seen someone else and so she thought she would try it particularly she used to open veins a lot erm and you know she said that she found… she really liked it if she lost a lot of blood she really liked the feeling of peace and that tranquillity so she was all day long life-threatening but she never thought that was her intention to end her life, her intention was that feeling of peace (Rose, Clinical Nurse Practitioner)".

The women and staff explained how experiencing flashbacks and intrusive thoughts also extend to those women who find themselves traumatised by their own offending history, or things they may have done to other people. Despite this specific traumatic event being the result of their own actions, many women struggle to come to terms with their past behaviour, and experience similar effects to those who were the victim and not the perpetrator of abuse.

"You know with women who are mentally unwell and then they have that realisation of what has happened to them and what they have done and it's like… it's a really big thing for them and a big burden to carry... the reality of oh shit I did that or I did that to someone the reality is huge" (Lilly, HCA)

"I have flashbacks about my past and sometimes I smell burning… I have a lot of guilt about what I have put my family through… they [flashbacks] really make me do it" (Chloe, Service User)

Whilst previously literature has confirmed the relationship between traumatic experiences and self-harm, more recently literature posits self-harm is associated with specific symptoms of trauma, rather than the traumatic experience itself (Smith et al, 2014; Klonsky & Moyer, 2008). The findings from the current research align with other literature, as previous studies have shown specifically frequent intrusive thoughts and/or flashbacks of the traumatic event mediate the relationship between traumatic abuse and non-suicidal self-injury (Smith et al, 2014; Weierich & Nock, 2008; Asmundson et al, 2004). This is particularly true for sexual abuse and literature has demonstrated experiencing symptoms or trauma (flashbacks and intrusive thoughts) is able to fully mediate the relationship between sexual abuse and the frequency of non-suicidal self-harm (Weierich & Nock, 2008).

Collectively, the findings from the current research and that of Smith et al, (2014), Weierich & Nock, (2008) and Asmundson et al (2004) may indicate positive symptoms (i.e. flashbacks and intrusive thoughts) play an important role in the pathway to life-threatening self-harm, whilst negative symptoms (e.g. dissociation) do not. This is because the women and staff highlighted they believed negative symptoms played an important role in NSSI, however overall they did not cite it as playing an important role in life-threatening self-harm.

7.8.5 Comparison with existing theoretical models

As some women within The Trauma-Threat-Responder sub-type are thought to enact life-threatening self-harm with suicidal intent, this is the first sub-type that does not align with the FFM. This is because the FFM posits NSSI will occur without suicidal intent. However, the findings relating to the traumatised sub-type may be better explained by The Power Threat Meaning Framework (PTMF) (Johnston & Boyle, 2018), which has recently been advocated by The British Psychological Society (2018). According to the BPS (2018), the PTMF conceptualises emotional distress as a result of four interrelated aspects; the negative operation of power (e.g. being sexually abused), the type of treat negative operation of power poses (e.g.

distressing emotional responses, flashbacks and intrusive thoughts), the perception of what negative power operation means to an individual (e.g. I am in danger), and the learned threat responses that individuals draw upon to ensure emotional, physical and social survival (e.g. self-blame, guilt and shame and self-harm). Whilst the PTMF remains in its infancy, it offers an ability to explain individual behaviour (i.e. threat responses) without diagnosing them with symptoms of psychiatric disorder (Johnston & Boyle, 2018). Considering the accounts of the women and staff who took part in the current research, it would appear that their understanding of the pathway to life-threatening self-harm amongst women within the traumatised sub-type aligns well with the explanation provided within the PTMF. The PTMF will be referred to again later in the thesis (see chapter 8), when impact of restricting access to means is discussed.

Table 18: Quotes to support the Trauma-Threat-Responder Sub-type

Meaning Unit	Condensed Meaning Unit	Code	Theme
"I think it is a coping strategy I think it is something that probably triggers with trauma, I think trauma and self-harm go together and my self-harm got so much worse through my teenage years and it was due to the trauma I was experiencing… its why I do it so bad now" (Ava, Service User)	"I think it is a coping strategy I think it is something that probably triggers with trauma, you know when I have suffered the trauma I have with all that is going on up there [taps head], I self-harm to get comfort from all that [taps head]… it was due to the trauma I was experiencing… its why I do it so bad now"	Flashbacks and thoughts	The Trauma-Threat-Responder
" The ones who have complex trauma for them that is never going to go away so the ones who are going to engage in life-threatening more often will be the ones with trauma so the flashbacks that's why they do it it's because the trauma never goes away… " (Annabelle, HCA)	" The ones who are going to engage in life-threatening more often will be the ones with trauma so the flashbacks that's why they do it it's because the trauma never goes away… "	Flashbacks and thoughts	
"Erm they have quite often suffered trauma in their lives so being the victim of abuse or in fact being the abuser... it's just their output really. I would say erm it is definitely the abused for the ones who really go for it" (Sadie, Clinical Team Leader).	" It's just their output really. I would say erm it is definitely the abused for the ones who really go for it"	Trauma	

7.9 The Progressive

"Sometimes it's not enough like when I first discovered self-harm, as I got older I did it worse and worse but that is because it wasn't enough of a release anymore for me so I realised I needed to up the ante, I needed it to erm for it to be deeper and bleed for longer" (Freyer, Service User)

7.9.1 Summary

A woman who has over a period of time started using life-threatening self-harm in order to cope with or release distressing emotions, or to 'feel something'. The life-threatening self-harm occurs as part of a progression along a continuum, whereby non-life-threatening self-harm is no longer able to meet their needs. For some women in this sub-type, life-threatening self-harm can be accidental and is not always the intended outcome of their self-harm.

- Long history of non-life-threatening self-harm
- History of long admissions in services (both in childhood and adulthood)
- May experience dissociative symptoms (including feeling numb)
- Will change methods over time to those with higher lethality, or inflict more serious injuries

7.9.2 Function

Women who fall into The Progressive sub-type of life-threatening self-harm are likely to be those with an extensive history of non-life-threatening self-harm and long-term mental health inpatient admissions. Typically, they enact life-threatening self-harm for two reasons - either as a means of releasing, or coping with distressing emotions, or to allow them to feel something physical. In the first instance, the women and staff explained how life-threatening self-harm was an effective way to shift negative emotional pain they feel unable, or poorly equipped to deal with into a physical pain, which they find more manageable. In the alternative instance, the staff and women reported women in this sub-type enact life-threatening self-harm in a bid to evoke an emotional response by inducing physical pain. This they explained helps to counteract feelings of numbness.

"so erm yeah for lots of them it is getting that physical pain so the feeling of physical pain instead of the emotional pain" (Rose, Clinical Nurse Practitioner)

"Some people feel numb a lot of personality disorders they make you feel numb and they want to feel something so when they do it [life-threatening self-harm] they feel something so erm I think it is not enough so they just keep going" (Chloe, Service User)

Whilst women in The Progressive sub-type enact life-threatening to manage negative feelings (as do those in The Overwhelmed and The Taught typologies), what distinguishes women in this group is how their life-threatening self-harm has developed. According to the women and staff, life-threatening self-harm is not a representation of the intensity of the emotions they are feeling, rather it represents a build up of resilience and tolerance to lower-lethality forms of non-suicidal self-injury.

7.9.3 Suicidal Intent

In the majority of instance, the women and staff who took part in the current research did not contextualise life-threatening self-harm amongst The Progressive sub-type as suicidal behaviour. In many instances, life-threatening self-harm was not thought to be the desired outcome of self-harm behaviour, and many thought it could be the accidental consequence of non-suicidal self-harm when women employ new, more lethal methods. Despite this, it is important to acknowledge that the women and staff did recognise that women can die as a result of their repetitive, worsening life-threatening self-harm. This aligns with well-evidenced theory (see chapter 3: Theoretical Frameworks) that posits suicide is possible when an individual overcomes the fear associated with harming the self and acquires the capacity to enact behaviour serious enough to bring about death (Joiner, 2005). This according to Joiner (2005) occurs via repetitive non-suicidal self-harm. Such literature therefore may suggest that women within The Progressive sub-type may be at increased risk of suicide as they may have developed the capacity to enact life-threatening self-harm.

"Most people just do it like for the release because not everyone wants to die but erm I think it just goes too far sometimes and it is worrying… it's like say someone cuts themselves then they might go on and blood-let so that is scary you know that is not nice at all but they do similar things but depending on their frame of mind it can change and get worse over time" (Evie, Service User)

7.9.4 Pathway to life-threatening self-harm

For women in The Progressive sub-type, the staff and women described life-threatening self-harm as habitual and likened it to developing a substance addiction. Whilst women in this sub-type do not initially intend to engage in life-threatening self-harm, the journey to life-

threatening self-harm occurs over time when the methods they previously used to self-harm no longer fulfil their needs (i.e. it becomes less painful, or it no longer helps to manage their distress). Therefore, like someone dependent on substances, women in The Progressive sub-type engage in more lethal forms of self-harm in a bid to manage emotional distress or elicit desired feelings. Unfortunately, according to the women and staff, this results in life-threatening self-harm. The findings therefore provide support for the idea of self-harm behaviours to exist within a continuum (Ward, 2012; Kapur, 2013) and evidences how self-harm behaviours can change over time and manifest from NSSI into more lethal behaviour.

"It is natural things for some people as they have just done it for so long that they can't get out of the habit. Basically it just becomes an addiction and people have addictive personalities so like people get addicted to drugs, people get addicted to self-harm" (Poppy, Service User)

"I mean if you take paracetamol for a headache constantly eventually it is going to stop working so if you are self-harm for a release of sort of emotions and what not then after a while what starts of as scratches then goes to big cuts because of the amount of blood or that sense of pain isn't enough so I presume it's like a developmental type thing" (Faye, RMN).

7.9.5 Comparison with existing theoretical models

Like the over-whelmed, women who fall within The Progressive sub-type enact life-threatening self-harm to stop or elicit emotions align with the FFM's intrapersonal dimension. Intrapersonal functions include changing one's internal state, including their thoughts, emotions and sensations, (Turner et al, 2012). In the case of women from The Progressive sub-type who enact life-threatening self-harm with an aim of *stopping* negative intrapersonal emotional states, they align with the *automatic negative function*. Engaging in self-harm to avoid unwanted emotional states is well documented (Chapman et al, 2006; Brown et al, 2000) and literature has suggested inducing physical pain can help to distract or divert ones attention from their painful emotional experience (Gratz, 2006; Whitlock et al, 2006; Paivio & McCulloch, 2004; Klonsky et al, 2003; Brown et al, 2000).

Comparably, women who enact life-threatening self-harm to evoke physical pain align better with the positive intrapersonal dimension of the FFM as they wish to *elicit* a positive, or desired emotional state. This aligns with findings from Smith et al (2014); Weierich & Nock

(2008) and Klonsky et al (2007) who report many adults enact non-suicidal self-harm to counteract dissociative symptoms (e.g. feeling nothing), and provides evidence that their previous research also extends to reasons for life-threatening self-harm.

Whilst it is important to reinforce the women and staff did not believe life-threatening self-harm for The Progressive sub-type is enacted with suicidal intent, the progression from non-life-threatening to life-threatening self-harm also aligns with Joiner's (2005) theory of acquired capability. The Interpersonal Psychological Model of Suicide (IPM) (Joiner, 2005; Van Orden et al, 2010) posits that individuals must acquire the capacity to enact behaviour that is dangerous enough to bring about death, through repeated exposure to painful or fearful experiences (see Chapter 3, Theoretical Frameworks). Via repetitive non-suicidal self-injury, women in The Progressive sub-type acquire the capability to enact more dangerous forms of self-harm and lessen the effectiveness of their old non-life-threatening methods. As the women and staff explained, this means women within this sub-type progressively enact more life-threatening self-harm to meet their intrapersonal needs as they can no longer be met with non-life-threatening methods.

7.9.6 Clinical considerations

The findings from the current research provide confirmation that like NSSI, life-threatening self-harm offers women a way to either stop or elicit emotions. This is confirmatory for previously literature that evidenced similar reasons for NSSI (Smith et al, 2014; Weirich & Nock, 2008; Klonsky et al, 2007; Gratz, 2006; Whitlock et al, 2006; Paivio & McCulloch, 2004; Klonsky et al, 2003; Brown et al, 2000; and extends our current knowledge to reasons for life-threatening self-harm. Furthermore, the findings from the current research highlight how women's self-harm behaviour can change from NSSI, supporting the notion that self-harm and suicidal behaviours exist upon a behaviour continuum. Therefore, the findings provide important clinical considerations for women in forensic mental health services and highlight those who change methods over time as high risk for enacting life-threatening self-harm and potentially suicide. This is because current theoretical frameworks posit individuals who frequently enact NSSI can develop the capacity to enact more lethal behaviour in the future (Joiner, 2005).

Table 19: Quotes to support The Progressive Sub-type

Meaning Unit	Condensed Meaning Unit	Code	Theme
"I don't know some people do it just for the release so like its erm sometimes people do go too far people need that release to let go of whatever it is but I just think I don't know I think…. Like people need a release and I am not condoning it but if it is superficial I can understand but it is bad when it gets a bit too far and goes too far (Evie, Service User)	"Some people do it just for the release so like its erm sometimes people do go too far… it gets a bit too far and goes too far"	Progressively gets worse	The Progressive
"Well I have got a scar on my head where ermm it is from banging my head off corners and lots of people tell me it is very life-threatening and that one more knock to the head could kill you and stuff but the more people tell me that the more I will carry on doing it any how because I know that ermm it is something that I get a release from and the more dangerous it is the more it satisfies me" (Isla, Service User)	"Well I have got a scar on my head where ermm it is from banging my head off corners … I know that its life-threatening but ermm it is something that I get a release from and the more dangerous it is the more it satisfies me"	Lessening effectiveness	

7.10 The Angry-Controlled-Aroused

"I think people self-harm because erm when they are distressed it's their way of coping instead of getting angry towards other people. I know with me instead of getting angry towards other people I take it out on myself and I feel frightened about what I would do to other people, so I hurt myself to get that anger out and to release that frustration" (Isla, Service User).

7.10.1 Summary

A woman who falls within Angry-Controlled-Aroused sub-type is typically an individual known to be angry, aggressive, argumentative and/or disruptive on the wards. Prior to engaging in life-threatening self-harm, women in this sub-type may present as increasingly aroused and are likely to display extreme anger. Life-threatening self-harm for women in this group is an externalised representation of the internal frustration, anger, and over arousal they are experiencing.

- History of violent, or aggressive behaviour within services
- Likely to assault staff during intervention

7.10.2 Function

Women within The Angry-Controlled-Aroused sub-type enact life-threatening self-harm in response to explosive feelings of anger that causes heightened arousal and will typically occur after a period of argumentative behaviour. Life-threatening self-harm in this instance is enacted in a bid to overcome intense states of over arousal, and to demonstrate to other people their anger and frustration.

7.10.3 Suicidal Intent

For women in The Angry-Controlled-Aroused sub-type, life-threatening self-harm is understood to occur without suicidal intent. Instead, life-threatening self-harm for The Angry-Controlled-Aroused subgroup is enacted in a bid to resolve negative feelings of anger and arousal and to avoid harming other people.

"It's the adrenaline it's just the adrenaline, the rush of it all that is it for me it's not about ending my life it is about the adrenaline, that is what make me do it more… so for me I get too hyper active because I know I am planning something… so when I am planning I become too elated". (Isla, Service User)

7.10.4 Pathway to life-threatening self-harm

For women within the angry/aroused sub-type, life-threatening self-harm acts as a response to experiences whereby they have experienced negative operated control (Johnston & Boyle, 2018). As previously mentioned within the trauma threat responder sub-type, women who experience events whereby others negatively exert control on them may develop feelings of anger and frustration. This leads to a deep-rooted sense of injustice and feeling as though they are powerless to change their situation. Consequentially, women who fall within this sub-type are likely to be known as angry, aggressive and/or violent individuals, and will include those who assault staff, particularly during an intervention to prevent or limit the consequences of self-harm. These findings align with those from Langevin et al, (1982) and Rosenblatt and Greenlands, (1974) who suggested the rate of co-occurrence between self-harm and violence amongst psychiatric inpatients and female offenders was as high as 40%. Furthermore, Young et al (2006) emphasised the risk of violence in those who self-harm, highlighting how male offenders receiving care within a psychiatric hospital were eight times more likely to harm treatment staff, compared to those who did not self-harm. Lanes (2009; 2011) later confirmed this link amongst male prisoners, suggesting the pathway to self-harm and violence may interact for some (Slade, 2018).

"For some their self-harm seems to come with anger… so they get irritated and angry that say they haven't been able to do something so they fly off, so what is punching a wall going to do? It is going to hurt your hand, it's going to really hurt your hand… so at first it really hurts but that initial power of bang and then the feeling of release so yeah they have similar profiles to these women massively similar profiles" (Faye, RMN).

One possible explanation for the increased prevalence within both the prison and psychiatric inpatient population can be drawn from research that evidences the childhood abuse (both physical and sexual) as a prominent risk factor for both violent and self-harm behaviours (Beaver, 2008; Herrera & McCloskey, 2003; Low et al, 2000; Raine et al, 2011). Situating these findings within the Power Threat Meaning Framework (Johnston & Boyle, 2018), life-threatening self-harm may act as a threat response to those who have felt intense anger in response to feeling powerless and controlled during experiences of abuse. Adding to this, the women and staff reported many women who fall within The Angry-Controlled-Aroused sub-type feel an intense sense of injustice about their situation (i.e. being detained), as they are powerless to leave secure hospital, make decisions about who they are nursed by, or whom

they live with. As a result, life-threatening self-harm was described by many as the only form of control the women had over their bodies, and their lives.

"Erm a build-up of anger I think can be another one again that might be a long standing risk factor, I have so much anger about the injustice about what has happened to me and yet I can't possibly let it out... so I just suppress it but then actually where has it got to go - nowhere so it just comes back to me in an act of self-harm so yeah I think intense anger can also be one" (Francis, Clinical Psychologist)

"For many control is a really big thing and … if she feels like it's a controlled experience and she doesn't feel like she needs it, it can relate massively back to her trauma and trigger that dangerous self-harm " (Paula, Forensic Psychologist)

"I guess erm I think it is that control I think control is a big thing for some people because the idea of having that control over whether you live or die and I think that is quite a powerful thing for people who feel disempowered" (Cathy, Trainee Forensic Psychologist)

In response to feeling powerless, controlled, intensely angry and frustrated at their situation, the women and staff reported these feelings could trigger a physiological response of over arousal, which many are unable to control. This aligns with literature that evidences a relationship between emotional agitation, anger and over-arousal (Ramirez & Andreu, 2006). As a result, over arousal can trigger violent behaviour towards other people and/or incidents involving damage to property, which in the interest of safety would trigger staff intervention. The women and staff reported that for some, this further escalated their behaviour as it reinforced the threat response triggered by other people operating power. Consequentially, the women explained they enact life-threatening self-harm is an internalised effort to vent their anger, (whilst trying to avoid the associated punishments that come with being violent to others), and to try and regulate their state of over-arousal.

"I think violence and aggression and self-harm run parallel… you are being violent to yourself and the girl who rams pens in her arms like she was so angry she went through the muscle but didn't want to hit someone else as she knows every time she hits someone she prolongs her stay here and it costs her money as she gets fined so instead she does it to herself so they are well similar" (Lilly, HCA).

The women and staff explained that over arousal enabled them to engage in extreme forms of life-threatening self-harm as the adrenaline (high arousal) facilitated their bodies to withstand serious injuries. This is similar to literature that reports the impact of adrenaline on serious sporting injuries whereby adrenaline helps to mask pain and allows people to continue (Spencer, 2012; Fenton & Pitter, 2010). The findings presented within The Angry-Controlled-Aroused sub-type also aligns with literature that demonstrated the intensity of aggressive behaviour increases as does levels of anger and over arousal (Baron, 1971), and that which evidences a relationship between anger and agitation (a manifestation of over arousal) (Rogers et al, 2015). Most notably however, the findings from the current study relate to that conducted by Harmon-Jones, Summerelle & Bastien (2018) who identified a preference for painful activities amongst individuals who report high levels of anger. This Harmon-Jones et al (2018) provides a useful explanation why some people enact self-harm.

7.10.5 Clinical Considerations

The findings from the anger-controlled-aroused sub-type align with literature that confirms violence and self-harm can co-occur, and identifies a proportion of people who have both a history of violent and self-harm behaviours (Buri et al, 2009; Hunt et al, 2006; Flannery et al, 2001). These findings have been mirrored across many populations, including psychiatric inpatients (Fennig et al, 2005; Asnis et al, 1994), clinical (Hasin et al, 1988), forensic (Stalenheim, 2001; Maden et al, 2000), and prisoners (Slade, 2018). Whilst more recently literature has begun to examine the relationship between self-harm and violent behaviour, our understanding of duel-harmers, (individuals who display both harm to the self, and harm to others, Slade, 2018) is lacking. To date our understanding of those who enact both violent behaviour and self-harm is also scant amongst the forensic mental health population, and there has been no research that explores the relationship between co-occurring violence and self-harm amongst those who enact life-threatening self-harm. This therefore offers a novel sub-type for women who enact life-threatening self-harm, and serves to extend the current literature base, as it provides preliminary insight into an anger-aroused pathway to life-threatening self-harm. It also provides a novel snapshot of duel-harmers within forensic services, as it is the first literature to emerge relating specifically to females receiving forensic care, and the first to explore and identify the existence of duel-harmers in those who engage in life-threatening self-harm.

The findings highlight important information for clinical consideration as sadly, many women who are violent and self-harm may be those to whom staff are less compassionate towards, or

less tolerant of their behaviour. This being said, it is likely that those who experience women in this sub-type as draining or difficult to manage have been on the receiving end of violent behaviour from women in this sub-type. It is however important that forensic mental health services consider how they train their staff and educate them on the evidence that suggests for some, violence and self-harm can co-occur thus meaning they too could benefit greatly from a compassionate, consistent care-planned approach. This could be achieved through having joint care plans for individuals who display both behaviours, in a bid to better understand the reasons underpinning the behaviours and recognise warning signs and triggers. It is also important that services consider the role of control within life-threatening self-harm, and work collaboratively with the women in their care to try to foster a sense of empowerment over their lives and the decisions relating to their care, in a bid to limit the effects of disempowerment. To help confirm the presence of duel harmers within forensic services, it would also be beneficial for future research to conduct a similar study to that of Slade (2018), to act as an explorative study of this sub-type of life-threatening self-harm within the female forensic pathway.

Table 20: Quotes to support The Angry-Aroused-Controlled Sub-type

Meaning Unit	Condensed Meaning Unit	Code	Theme
"Sometimes it would be done in order to gauge a reaction from the staff so they would have to enter into seclusion to help her and then she would revert that anger onto them, so it has gone high enough to get us to go in so that it can help her to take that frustration out on us, so that has lead this one lady up to a higher pathway so she is at higher security now as we were just not able to manage her in the confines of a WEMS hospital" (Sadie, Clinical Team Leader).	"Sometimes it would be done in order to gauge a reaction from the staff… they would have to enter into seclusion to help her and then she would revert that anger onto them, to take that frustration out on us"	Coping with anger	The Angry-Aroused-Controlled
"Yeah I mean the ones that are particularly violent, lot of these acts are violent and after the event they tell us they felt violent or angry" (Michael, Speciality Doctor).	"Yeah I mean the ones that are particularly violent, lot of these acts are violent and after the event they tell us they felt violent or angry"	Coping with Anger	

7.11 Conclusion

Chapter 7, 'the functions of, and pathways to, life-threatening self-harm' aimed to describe the reasons why women in forensic mental health services enact life-threatening self-harm. Chapter 7 addresses a central aim of this thesis, which was to better understand the functions of life-threatening self-harm. Addressing such an aim was important as currently literature assumes that self-harm which poses high risk to life is enacted with suicidal intent (Marzano & Colleagues, 2009; 2011a; 2011b; 2012; 2013; Levi et al, 2008; Douglas et al, 2004). However, to date, there is yet to be a study that explores whether the functions of the behaviour reported amongst the prison and general population are generalisable to the female forensic mental health population. Therefore, without adequately understanding whether the same functions exist between populations, arguably it is unclear whether any prevention or intervention for life-threatening self-harm are able to meet the needs of female forensic mental health patients.

A major finding from the current research is that the women and staff believe that in the majority of instance, life-threatening self-harm amongst women receiving forensic mental health care occurs without suicidal intent. This is a novel finding as currently, literature that explores self-harm that poses high risk to life generally accepts that life-threatening self-harm is enacted with suicidal intent (see Chapter 2: Defining self-harm and suicide). It is however important to note that the women and staff did report that some women will enact life-threatening self-harm in a bid to end their own lives. This is most likely to apply to women from The Trauma-Threat-Responder subgroup who experience flashbacks and intrusive thoughts related to their, often extensive, trauma histories. The women and staff also acknowledged that women from The Progressive subgroup might find themselves at increased risk of dying by suicide on account of their capacity to enact behaviour serious enough to bring about death through frequent, increasingly serious non-suicidal self-harm. Despite this, the women and staff believed that, more often than not, suicide within forensic mental health services was typically accidental. Instead, seven alternative functions of, and pathways to life-threatening self-harm were suggested. The findings from the current research are therefore impactful for theoretical and practical understanding.

Firstly, the findings from the current research are able to inform and develop the current theoretical position relating to the functions of self-harm. The sub-types outlined within the current research have some alignment with the Four Functional Model of Non-Suicidal Self-

Injury (FFM), (Nock, 2009). As outlined in Chapter 3, the fundamental assumption of the FFM is that people enact non-suicidal self-injury as a result of early life experiences and stressors (see chapter 2, risk factors for self-harm), which has limited their ability to cope with stressful situations in an adaptive way. Therefore, for many, non-suicidal self-injury offers a viable way to manage negative emotional and/or cognitive experiences (Nock, 2009). The FFM suggests non-suicidal self-injury is motivated and maintained by one of four reinforcement processes: intrapersonal-negative reinforcement, intrapersonal-positive reinforcement, interpersonal-social-negative reinforcement, or interpersonal-social-positive reinforcement (Nock, 2009). In other words, people enact non-suicidal self-injury to alleviate negative emotional or cognitive states; to generate positive emotional or cognitive states; to escape from social situations and interpersonal demands; or to elicit a positive care response from others.

The FFM has been tested amongst the adolescent and adult population (Bentley et al, 2014; Klonsky et al, 2014; Muehlenkamp et al, 2012; Turner et al, 2012; Nock 2008), and is widely considered an acceptable theory of self-harm. However, the findings from the current research contribute to academic understanding of the FFM, as to date, the FFM has remained relatively untested amongst the forensic mental health population (Chapman et al, 2013). Although the current study did not directly test the FFM, it acts as validation for the different reinforcing factors, and highlights how they are applicable to the functions of life-threatening self-harm amongst the female forensic mental health population. In particular, the findings highlight the important role that interpersonal-social positive reinforcement (i.e. obtaining a response from others), and automatic negative intrapersonal reinforcement (i.e. escaping internal cognitive states and negative emotions) plays in the functions of life-threatening self-harm. This aligns with findings from research that has tested the FFM amongst the prison population, which evidenced the applicability of all aspects of the FFM, and highlighted a particularly important role of eliciting a response from others (Dixon-Gordon et al, 2012; Siebery, 2012; Klonsky, 2007). It is likely that as Fallon (2003) suggested, the findings may be explained by the high prevalence of personality disorder found amongst the forensic mental health population, which are characterized by a need for validating responses from others.

However, when considering theoretical models of suicide, it is clear that the findings from the current research do not align as succinctly. Fundamentally, the findings from the current research differ to widely accepted theories of suicide because the women and staff who took part thought that for the majority of women, life-threatening self-harm was motivated by something different to suicidal intent. Instead, life-threatening self-harm is thought to be motivated and maintained by the seven functions as outlined in chapter 7 and summarised

above. However, like many theories of suicide, the findings align with the idea that people who enact life-threatening behaviour will have experienced a number of life events and stressors that predispose them to life-threatening self-harm (Mae et al, 2016; Cukrowicz et al, 2013; Szanto et al, 2012; You et al, 2011; Van Orden et al, 2010; 2008; Hill, 2009; Joiner, 2005). In the case of the women from this study, such events typically include experiencing sexual, physical or psychological abuse, neglectful childhoods, and having been looked after children. Similarly, as outlined in the Integrated Motivational-Volitional Model of Suicide (IMV), the findings posit that women who enact life-threatening self-harm experience deficits in communication skills and coping strategies (i.e. threat to self moderators), which contribute to a sense that the only way to manage their distress is to enact life-threatening self-harm. There is also congruence with the idea that a lack of social support and exposure to attitudes that justify self-harm may also play a role in the development of life-threatening self-harm (i.e. motivation moderators). Finally, the findings from the current research align with the notion that social learning, impulsivity and access to means (i.e. volitional moderators) contribute to life-threatening self-harm.

There are however distinct differences in the development of life-threatening self-harm, which do not align with accepted theories of suicide. Most notably, this relates to the idea that suicidal ideation develops prior to the occurrence of behaviour that is dangerous enough to bring about death. In the instance of life-threatening self-harm, the women and staff who took part in the current research posit that for the vast majority, women do not experience suicidal ideation prior to life-threatening self-harm, nor do they enact such behaviour with the intention of dying by suicide. This, therefore, highlights a fundamental gap in theoretical understanding, as there is yet to be a model that adequately explains why people enact life-threatening self-harm without suicidal intent. Whilst there are undoubtedly similarities between the development of life-threatening self-harm and suicidal behaviour, and indeed life-threatening self-harm and non-suicidal self-injury, (see chapter 3, theoretical frameworks), further research is required to develop a new model that incorporates the development of life-threatening self-harm. The findings of the current research therefore offer an opportunity for future research to validate the experiences of the women and staff and use them to inform a new theoretical model for life-threatening self-harm.

Consequentially, as the findings from the current study have shown that there are distinct differences between the functions of, and pathways to life-threatening self-harm and suicide, the findings strongly support that there is a need to revisit the current application of knowledge regarding the testimonies of those who survive near-lethal self-harm to suicide

prevention strategies. This is because survivors of near-lethal self-harm are viewed as valid proxies to develop our understanding of why people die by suicide (Rivlin et al, 2012; Marzano et al, 2009; Fortune et al, 2007; Mosciki, 1995). Whilst such an approach may be suitable for some, the findings from this research indicate that not all individuals who enact behaviour dangerous enough to bring about death have suicidal intentions. This aligns with other literature that issues caution to using survivors of near-lethal self-harm as proxies for suicide, and questions whether they are able to provide accurate insight into the intentions of those who die by suicide, (Ciuhodaru et al, 2013; Andriessen, 2006). The findings therefore raise important questions in terms of understanding and preventing suicide, as recent suicide prevention strategies have been informed by literature that enlists survivors of near-lethal self-harm (Preventing Suicide in England, 2012).

The findings also highlight important practical considerations when using survivors of near-lethal self-harm as proxies for suicide prevention. In doing so, preventative strategies and treatment pathways for those who enact near-lethal self-harm are currently designed to target suicidal behaviour. Whilst using such literature to inform treatment and prevention strategies may be appropriate for some individuals, (i.e. those who are suicidal), the findings from the research indicate the current strategy is may be less suitable for women from the forensic mental health population, as they may not capture the needs of women enacting life-threatening self-harm without suicidal intent. Instead, the findings suggest it would be more suitable to acknowledge the different functions of life-threatening self-harm amongst the forensic mental health population and use them to further inform treatment and prevention that targets self-harm.

Consequentially, the findings from the research align with the notion that self-harm enacted without suicidal intent ought to be separated from suicidal behaviour (American Psychiatric Association, 2013; Klonsky & Muehlenkamp, 2007; Nock et al, 2006; Whitlock et al, 2006). Unlike before however, the findings contribute to literature and bolster our understanding, as they offer a new perspective from women in forensic mental health care. The findings do however raise questions as to the effectiveness of the current categorisation approach adopted by the DSM-5 (2013), whereby non-suicidal self-injury and suicidal behaviour are separated on the basis of suicidal intent and the frequency, severity and lethality of behaviour (see chapter 2, section 2.2). Clearly, on account of the findings, life-threatening self-harm falls outside of either category (i.e. it appears similar to suicidal behaviour, however is not typically enacted with the desire to end life), reinforcing the idea that self-harm and suicidal behaviours do not fit within homogenous groups (Ward, 2012). Consequentially, the findings offer

support for self-harm and suicide to be viewed upon a continuum of behaviours (Kapur et al, 2013; Butler & Malone, 2013; Klonsky, 2013; Muehelenkamp & Gutierrez, 2007; O'Carroll et al, 1996; Stanley et al, 1992), as such an approach is able to recognise both the similarities and the distinct differences between the behaviours.

The findings from the current research may also prove useful on a practical level, as they suggest it is possible to identify women who enact life-threatening self-harm, based on the function of their behaviour. The findings are therefore unique, as currently, literature has previously only suggested ways to identify male prisoners who enact near-lethal self-harm (Rivlin et al, 2013), meaning the research was the first of to develop sub-groups for women receiving forensic mental health care. This may help with the assessment and identification of those at risk, assist with informing more comprehensive formulations of why individuals enact life-threatening self-harm, and ensure the most appropriate treatment is provided. Importantly, although there are a number of similarities between the sub-types identified within the current research and those of Rivlin et al (2013), in general, the functions of life-threatening self-harm for women in forensic services appear fundamentally different to male prisoners. This adds to current literature and expands on knowledge that posits there are gender differences between the self-harm behaviours of males and females.

Unlike the sub-groups offered by Rivlin et al (2013), which provided the characteristics of different male sub-types, the creation of sub-types from this research have explanatory value, as they are able to explain how life-threatening self-harm develops amongst different groups of women who enact life-threatening self-harm. This is because although Rivlin et al (2013) provided valuable insight into the current factors of male prisoner's lives, which may contribute to the enactment of near-lethal self-harm, there are a number of common characteristics overlapping between the different types of male prisoners. This limits the potential utility of a categorisation system as individuals can easily be mistaken for the wrong sub-type, meaning the ability to identify those at risk is hindered. In contrast, the sub-types presented within this thesis are able to distinguish women in each sub-type because of different characteristics (including past and current life experiences), the functions of their behaviour, and the way in which life-threatening self-harm develops. Arguably, the findings may therefore be more useful in developing understanding and identifying the reasons why certain women are at increased risk of engaging in life-threatening self-harm. This is important, as without understanding the different pathways to life-threatening self-harm it is

challenging to prevent or treat such a complex behaviour. Therefore, by being able to distinguish women who enact life-threatening self-harm based on not only their shared characteristics, but also on the reasons why the behaviour occurs, we are able to develop more effective treatment to help prevent life-threatening harm.

7.12 Critical Reflections

Throughout the process of the research project, an overwhelming message that came from the women and staff was the need to develop an individual understanding of why each woman enacted life-threatening self-harm (LTSH). They described building therapeutic, trusting relationships as a key element of building a coherent formulation of a woman's LTSH, and firmly believed it would not be possible to understand woman's behaviour without it. Reflecting on the importance they placed upon viewing each woman as an individual, I spent time considering the best way to present the findings and questioned whether it was right to offer the functions and pathways to life-threatening self-harm as sub-type. In particular, I paid attention to the stories I heard, which highlighted the issue with current assessment tools, and the fact that some women perceived current assessment processes as a 'tick-box exercise'. This resonated with literature that posits some service users reject the medical model of diagnoses and feel labelling can be laden with stigma and can negatively impact their wellbeing and lives. I was able to identify with the women's stories, partly because clinically I advocate that individuals who self-harm are not one homogenous group, and because I have been critical of the dichotomous approach to separating self-harm and suicidal behaviour (APA, 2013), as I feel it can result in 'black or white' thinking. I therefore wondered whether presenting the findings from this research in sub-types would encourage clinicians to view the behaviour of the women in their care as a label or diagnosis and how this might feel for the women being assessed. Importantly, this contrasts with what the findings aim to do, which is to encourage clinicians to consider more carefully the functions of LTSH, and not to assume that all LTSH is driven by suicidal intent.

My concerns were however alleviated when sharing the findings of the research with the women and staff. The feedback from the individual sessions and focus groups was positive and the women and staff told me that the findings accurately represented the knowledge they had shared during their interviews. In particular, the sub-types presented within chapter 7 were warmly received and no one raised concerns about the using sub-types to describe the functions of and pathways to life-threatening self-harm. I wondered whether one reason why

the women were happy with the sub-types presented in chapter 7 was that the sub-types represented their words, stories and understanding, and were not labels placed upon them by other people. I reflected over how this must have felt different for the women who took part in this study, whereby many will have experienced mental health care and external agencies telling them what they were experiencing (and in many cases why), and not always asking to hear their understanding. Therefore, it felt as though offering sub-types using words the women themselves had described had empowered the women to name their own experiences and had given them an opportunity to share with clinicians and academics what they understand to be the functions of and pathways to life-threatening self-harm, and offer the terms they feel most accurately represent their behaviour.

I also wondered whether it is important to recognise that whilst the issues of diagnosis and labelling are contentious, for some, receiving a diagnosis or being able to name the difficulties they are experiencing can be helpful. This led me to reflect over my clinical practice and to remember individuals I have worked with who have found great comfort in receiving a diagnosis, (for example those with post-traumatic stress disorder), and those who have found naming their symptoms and learning the function of their behaviour life-changing (for example helping individuals who are emotionally disregulated to learn to label and name their emotions). This highlighted a need to remember that each individual will have a different perception of what is helpful or unhelpful. I wonder therefore whether it is instead helpful to offer terms, labels or diagnoses to the people we work with and to discuss how they feel about them and understand whether they feel the terms we use appropriately describe their experience. If not, perhaps it is more helpful to explain why we use diagnostic terms and discuss how naming symptoms or behavioural functions can help us to inform their treatment, but then like the current research did, focus on empowering service users to come up with their own descriptions or labels in a way they feel accurately describes their experience.

Chapter 8: Findings
Does restricting access to means affect life-threatening self-harm?

8. Overview

Chapter 8 presents the findings from semi-structured interviews that were analysed and used to inform and improve our understanding of the impact of restricting access to means on life-threatening self-harm amongst women receiving forensic mental health care. It is important to note that this thesis did not directly test whether restricting access to means predicts or contributes to life-threatening self-harm. Instead, the experiential knowledge of the women and staff who took part was combined and used to present their understanding and lived experience of how restricting access to means impacts the self-harm behaviours of women receiving forensic mental health care.

8.1 Introduction

Restricting access to means, or means restriction is a suicide prevention policy adopted in the community, prisons and forensic mental health hospitals (Preventing Suicide in England, 2012). As outlined in Chapter 2, section 2.7 (method selection, substitution and restricting access to means) means restrictions involves making access to means of self-harm and suicide more difficult, substituting high-risk means with ones that pose lower risk to life and limiting the volume or quantity of means available (Yip et al, 2012). It is believed that through restricting access to means, suicide can be prevented as it may help to delay the process of thinking about harming oneself and acting on suicidal thoughts (Florentine & Crane, 2010; Hawton, 2002). In particular, means restriction is thought to be most beneficial when access to lethal means are restricted as literature suggests it changes the context of a potentially fatal incident and forces the use of a less lethal method (Yip, 2010; Hawton, 2007; 2005). As outlined in Chapter 2, section 2.7.3, this process is known as 'method substitution'. Despite literature that posits lower lethality methods are used in response to means restrictions (Lester, 1990; Rich et al, 1990; Lester & Abe, 1989), in some instances literature has noted method substitutions to similar or higher lethality methods, for example hanging or jumping from heights when firearm access is restricted (Cantor & Baum, 1998; Rich et al, 1990). Florentine & Crane (2010) therefore argue, whilst restricting access to means may hinder a specific attempt, in the presence of alternative lethal methods, it does little to prevent suicidal behaviour in the longer term.

There is a body of literature which advocates that means restrictions has been successfully used within community populations, including reducing the number of suicides involving paracetamol overdoses, poisoning using pesticides and household gasses and suicides involving firearms (Mohamed et al, 2009; Ozanne-Smith et al, 2004; Haw et al, 2004; Bridges et al, 2004; Gunnell & Eddleston, 2003; Kreitman, 1976). The impact of means restrictions within forensic mental health services is however unknown, as currently there is little research that explores the effects of restricting means (James et al, 2012). It is therefore important for research to address the gap in the literature, as despite little evidence to support the use of restricted access to means, within forensic mental health hospitals access to a wide range of methods that pose both a high and low risk to life are restricted (Tromans et al, 2019; Sarkur, 2011). Furthermore, unlike within community populations, in many cases, forensic mental health service users are completely prohibited from possessing certain items, meaning many means of harm are actually *removed,* not only restricted. Consequentially, research that supports the use of means restrictions from community samples is directly imported directly into forensic mental health environments without testing whether they produce the same positive outcomes and whether they elicit method substitution.

8.2 Method

To try to understand whether restricting access to means plays a role in the pathways to life-threatening self-harm, semi-structured interviews were conducted with women service users and members of staff from three secure forensic mental health hospitals (for a full account see Chapter 5, methodology). Transcripts were analysed using Content Analysis. Each interview transcript was read through at least twice and codes that represented the key concepts and thoughts within the transcripts were identified (Hsieh, 2005). The transcripts were then re-read and the original codes were condensed into subcategories.

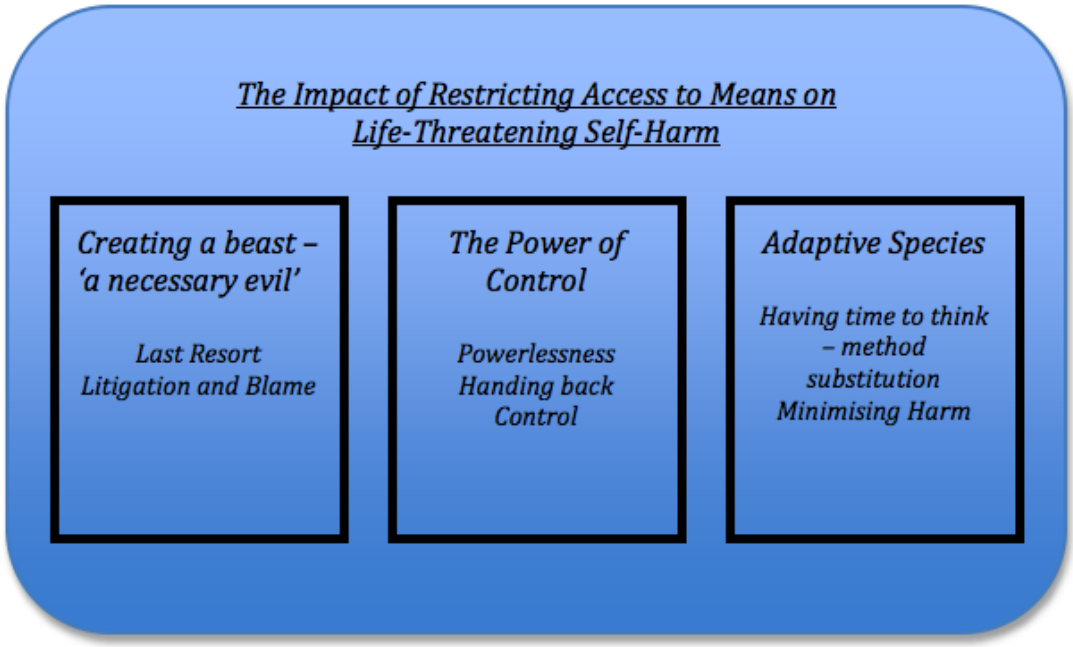
8.3 Findings

When exploring the impact of restricting access to means three main themes emerged. These include 'creating a beast – a necessary evil', 'the power of control' and 'adaptive species – method substitution'.

"Honestly I think people who want to self-harm will self-harm whether you give them the means or take away absolutely everything away, I have seen people almost die in rooms where they have nothing and they are naked… sometimes though removing that method although it provokes anxiety, and we can deal with that can be really helpful and there are quite a few

patients I can think of like that who have only ever had one method and once that method is taken away after a while they feel much better and don't feel the need to self-harm, but yeah some patients will find a way to self-harm no matter what you do or what restrictions you put in place because they have too". (Jamie, RMN)

Figure 12: Visual Representation of Themes



8.4 Theme 1: Creating a beast – "a necessary evil"

"I mean sometimes there is no other way to manage the patient apart from using a restrictive environment… but yeah I do think that sometimes it can just be so counter productive and it can actually make the person worse and it can sometimes create a beast" (Marie, Assistant Psychologist).

Between the women and staff there was a shared understanding that restricting access to means was a necessary, yet unfavourable managerial response to self-harm. For staff, much of the discomfort around implementing restrictive practices stemmed from the belief that alternative; more therapeutic responses were more effective than means restrictions. Despite this, many felt obliged to restrict access to means by the establishments they worked for, predominately because of the potential consequences of life-threatening self-harm. Whilst most of the women noted that they understood that, in some instances, means restrictions was the *only* way to keep people safe, all but one woman described means restrictions as a

controlling, traumatic experience, which they believed heightened levels of distress and risk of enacting life-threatening self-harm. Interestingly, many of the staff also identified restricting access to means as being potentially traumatic for the women. Most importantly, the women and staff explained that this was because means restrictions in forensic mental health hospital frequently involves the removal of personal possessions, meaning the emotional and psychological impact is far greater than it is for the removal of standard items or things that do not belong to them.

8.4.1 Category 1a: Last Resort

Many of the staff referred to restricting access to means as a 'last resort' behavioural management approach when they had exhausted all other options to keep women safe. Although in general the perception was that restricting means was at times necessary to help keep the women in their care safe, many did not believe it was particularly effective. Instead, the staff saw means restrictions as a procedural approach that was included within their hospital self-harm policy, and was part of the management plan that helped to fulfil their Duty of Care, Operational Obligation and Article 2 of The Human Rights Act (See chapter 1, overview of forensic mental health pathways). This aligns with previous literature which reports interventions used in the absence of alternative options are often perceived as necessary, despite the belief that they are known to be ineffective and non-therapeutic (Hopton, 1995).

"I don't think restricting is completely the answer and visa versa. Honestly in an effort to try and control that situation you create a different monster if that makes sense" (Sadie, Clinical Team Leader)

In fact, many staff stated that they felt they used means restrictions in the absence of any other constructive management plan, not because it was effective at reducing risk or supporting women in distress. This particularly applied when staff recalled working with women who had been at increased risk for long periods of time, or those who had proven particularly difficult to keep safe. Others shared similar stories of how they felt means restrictions were used when people were unsure what to do to help a woman, particularly when someone's risk increases suddenly and restricting access to means was used reactively. Their stories chime with findings from James et al (2012) who also reported that may self-harm prevention strategies are employed within secure inpatient services without any real understanding of why they are used, or how they impact self-harm and suicidal behaviour.

“We just have to do the best job we as a team can do and make sure it doesn’t go too far and that’s the big fear for everybody I think and sometimes it is an unspoken fear and sometimes it is a very overt and out there and people think of the worst possible scenario" (Francis, Clinical Psychologist)

"Ermm I mean in terms of occluding airways that is one that scares me and scares a lot of the staff it just gets it requires such an instant reaction from the staff trying to deal with that and it can cause panic as it can just go so very wrong" (John, HCA)

The women who took part in the current study also shared that they believed that restricting access to means was not an overly effective management response. Like the staff, whilst many of the women reported understanding that restrictions were necessary at times to keep people safe, they also believed that restricting access to means could make self-harm worse. They explained this was because when their risk increased, it is common for access to their own personal possessions to be restricted, which increases their levels of distress. These findings are concerning as increased distress is one of the most commonly cited reasons for self-harm behaviours (Nock, 2009; NHS England, 2013; NICE, 2013). For many, increased levels of distress can be experienced alongside a sense of helplessness, which many women reported finding overwhelming. Considering this finding with those detailed within Chapter 7 (section 7.4), it is possible that the experience of restricting access to means can act as an overwhelming significant life event. As detailed in chapter 7 (section 7.4), such findings are concerning as in the absence of effective coping strategies, overwhelming distress in response to a significant life event can trigger an incident of life-threatening self-harm.

“Ermm like it can be devastating... staff just saying right we are stripping your room you have nothing in your room you know what I mean and that is just destroying" (Evie, Service Users)

The women also described how restricting access to means can be counterproductive because, in some cases, the items that are removed are those which they have found helpful for self-soothing, or to distract them from their difficult thoughts and feelings or their urges to self-harm. One woman gave an example of having the photographs of her family removed (which she used to help remind her of reasons to live), even though she had never self-harmed using them before. Similarly, another spoke of having her pens locked away, despite it being in her care plan that drawing helped to distract her from her intrusive thoughts and emotional distress. As a result, the women reported that during times when their access to means is restricted, little is left behind that could serve as a protective factor and help them desist from self-harm. Consequentially, the staff and women highlighted how restricting access to means

does not necessarily act as a therapeutic intervention, as taking people's possessions away does not help to manage or alleviate urges to self-harm or offer alternative ways to cope. This is important, as many women in forensic mental health services are known to use self-harm as a coping mechanism (Nock, 2009). Therefore, in the absence of protective factors or alternative coping strategies, when their access to means of lower lethality is restricted, many feel overwhelmed and unable to cope with their distress. These findings chime with literature that posits other last resort behavioural management responses, (including physical intervention and rapid tranquillization); can be detrimental to the well-being of service users (Nelstrop et al, 2006; Fish & Calshaw, 2005).

"Erm I don't always think a stripped room really works because it can make people worse so like take the risk items but leave the stuff they are alright with because then at least they have something in their room with the, something they can use to help them yeah" (Ava, Service User)

Therefore, the stories shared by the women and staff indicates that the negative emotional impact of means restrictions within forensic mental health hospitals is specifically related to the removing or restricting access to personal possessions, and not everyday items. This is because means restrictions within forensic mental health hospitals involves items that are personal, individual, and often of high sentimental value, which can be particularly impactful as many of the women have few personal possessions. This is different to means restrictions within the community, whereby people are unlikely to have the same emotional connection to restricted items such as paracetamol or high-rise buildings (Mohamed et al, 2009; Ozanne-Smith et al, 2004; Haw et al, 2004; Bridges et al, 2004; Gunnell & Eddleston, 2003; Kreitman, 1976). This is important as the findings from the current study have not been reported before within the general population literature, suggesting future research is required to explore specifically the impact of restricting access to means on self-harm and suicidal behaviours in forensic mental health hospitals as it indicates the impact may be different.

8.4.2 Category 1b: Litigation and blame

Underpinning much of the anxiety associated with restricting access to means was the fear that a woman would inflict serious injuries or die. For staff, much of this fear was driven by the belief that they would be required to defend their decision-making in the event of a serious incident or death, as they would be held responsible for the lives of the women in their care. Consequentially, the staff shared how they often had to go against their clinical judgement regarding a more therapeutic approach and employ means restrictions in a bid to

protect their jobs and their professional registrations. This aligns with literature from Beryl et al (2018) who also reported members of staff from female forensic mental health services feeling torn between their obligation to uphold safety and security, and their desire to work therapeutically with the women in their care.

"Hmm well they are necessary at times although I think sometimes it is done in the absence of having great ideas about what to do with people and people do think about you know what is defensible and what is defensible to leave somebody with, it is that sort of defensive practice without a great deal of thought about what is going to be effective sort of in the short term which doesn't necessarily deliver for the long term" (Francis, Clinical Psychologist)

The expression of concerns regarding blame and litigation around working with women who self-harm is well documented across many aspects of healthcare, as it is believed there is an underlying 'culture of blame' (Wand et al, 2015; Lau, 2009). According to Khatri et al (2009), a blame culture evolves from 'bureaucratic management styles' whereby assigning accountability to individuals is of paramount importance. The idea of accountability, transparency, and honestly is particularly pertinent within mental health care, where Khatri et al (2009) argue the notion of 'blame' is compounded by media attention, failures, political forces, and public agencies. Whilst much effort was made to remove a culture of blame from the NHS, Wand et al (2015) report many people are still fearful of being scrutinized for inaccurate assessment and management of risk following an adverse incident within mental health settings. This leads to a balancing act between delivering of high levels of care whilst also ensuring legal and professional obligations are met (Slemon et al, 2017). As a result of such pressure, according to Morgan (2007), and in line with findings from the current study, mental health care settings often respond to adverse events in a control-based way, leading to high levels of risk-adversity in clinical decision-making. Literature however shows such an approach may in fact be detrimental to both patients and staff (Wand, 2017; Morgan 2007). Ultimately, according to Wand (2017), this leads to an "unhealthy dynamic whereby mental health clinicians are viewed distrustfully by their organisation and people accessing mental health services, which prohibits the development of a capacity building culture where positive risk-taking, personal autonomy and self-management of mental health are nurtured and encouraged".

"If you don't try positive risk occasionally how are you going to give these women the chance to get off the bottom of the barrel … but ermm I don't have the guts I certainly wouldn't have the guts as their RC to give them everything because they are so dangerous to themselves… ermm

they would be pretty fast to say something in coroners if we let them have stuff". (Jamie, RMN).

Literature suggests that to effectively promote the idea of recovery, professionals must manage their own personal anxiety about risk taking, blame and litigation, and respect the expertise by experience of those they care for (Schrank & Slade, 2007). According to Sowers (2005, p.770), promoting service users to take ownership of their recovery and respond less pessimistically to risk taking can help to promote a sense of autonomy. Whilst it is noted that an in-depth understanding of an individual's risks is paramount to help keep service users safe (McMurran et al, 2009), arguably, installing hope for recovery through autonomy and positive risk taking helps to move away from risk management towards the priorities of the individual and their lives (Slade, 2009).

Despite this, according to literature, the process of recovery and positive risk is overshadowed by legal fears or litigation and a need for forensic mental health services to maintain a place of containment (Craik et al, 2010). This is important and relates to findings from the current research, whereby many of the staff and women report that restricting access to means can make women reliant on mental health care to make decisions for them, which impacts negatively on their journey to recovery and discharge from secure services. This conflicts with the ultimate goal of a forensic mental health services, which is to reduce the risk an individual plays to themselves and members of the public, through treating the symptoms of mental illness and helping to prepare individuals for discharge back to the community (NHS England, 2013).

"Erm well I think erm people who come to secure services loose all ability to function outside there is no community leave there is restrictions on what you can do like you have got to be told when you can go out how often you can do stuff ask for everything and so people become more ermm more into self-harm because that is how they cope with it all" (Poppy, Service User)

"We are making it more restrictive when in reality when our patients go back outside then they will be open to that sort of stuff and ultimately we are meant to be we are meant to be gearing them to go back out for a life in the community and yet we are removing any aspect of a community life from them" (Sadie, Clinical Team Leader)

It is possible that the women and staff perceive means restrictions as creating a sense of dependency on mental health services because unlike within community settings, means of

harm are *removed* and not only restricted. Consequentially, unlike literature that supports that means restrictions helps interrupt the decision process to select higher lethality methods (Yip et al, 2010), within forensic mental health services means restrictions takes away choice, which the staff and women in the current study reported can be experienced as controlling and disempowering. This aligns with literature from Bloom & Farragher (2013), which report that aspects of the healthcare environments can be detrimental to the well-being of its service users.

8.5 Theme 2 - The Power of Control

As cited within the previous theme, the staff and women frequently described the negative emotional impact of restricting access to means. The women and staff explained how many women perceive means restriction as a controlling experience, primarily because the process involved staff taking away a woman's possessions (normally from their bedroom). This refers to the process whereby all items are removed or locked away in an attempt to stop women using their possessions to harm themselves with and is known as a 'stripped' or 'sterile room'. This can be difficult to cope with as many women in forensic mental health services often have very little possessions. The women and staff explained how this had a negative emotional impact, which caused sadness and frustration, and a perception that they have no control over what is happening to them or their possessions. This aligns with the findings from Langan & McDonald (2008) who also report how restrictive self-harm management approaches increase levels of emotional distress and can cause service users to feel angry towards their caregivers. This is important considering the findings outlined in Chapter 7 (The functions of and pathways to life-threatening self-harm), which identify women who feel angry and controlled at increased risk of life-threatening self-harm (The Angry-Controlled-Aroused).

8.5.1 Theme 2 - Category 2a: Powerlessness

"It can get dangerous as they won't stop they need to do it, it is their things isn't it and I mean they don't have a lot anyway so the little things mean a lot and we are taking them away so they are going to get possessive of their possessions and so the little things mean more so us taking them away means nothing to us but it does to them and it stresses them out and they go off... but I mean what else do we do" (Lorraine, RMN)

According to the women and staff, being in a situation whereby they have no control over what happens to them can increase levels of distress. Amongst the women and staff there was the perception that many women perceive restricting access to means as a controlling

experience, which can trigger memories of traumatic experiences. The staff and women reported that feeling controlled can make women felt powerless, unheard and vulnerable, which for some, reminds them of past traumatic experiences. This aligns with literature that demonstrates how some practices within care environments can inadvertently recreate conditions that can active memories of traumatic events (Bloom & Farragher, 2013). These findings are particularly important considering those documented in Chapter 7, Functions of and Pathways to Life-Threatening Self-Harm, which evidences that for some, the function of life-threatening self-harm is to cope with and stop flashbacks and intrusive thoughts of traumatic experiences (The Trauma-Threat-Responder). Arguably therefore, means restrictions can contribute to women enacting life-threatening self-harm.

"For many control is a really big thing and that is very trauma related and it goes back to the idea of the environmental escalation of risk and for some of them, if she feels like things are being taken away from her even though they think it might be the best way to manage the risk if she feels like its a controlled experience and she doesn't feel like she needs it can relate massively back to her trauma so yeah that is the restriction stuff again" (Paula, Forensic Psychologist)

"Yeah it does make a difference that is when it will get bad [the lethality of self-harm] they are going to start looking for things like in the living room when they haven't got their stuff or like looking in the day room or something like that to find something they can self-harm with when they haven't got their own stuff...it makes it worse" (Ava, Service User)

Instead, literature posits that services ought to take a trauma-informed approach and acknowledge that care environments can inadvertently recreate conditions that activate the memories of traumatic events (Bloom & Farragher, 2013). Re-creating conditions that activate traumatic memories have practical implications as literature shows that experiencing a care event as traumatic can significantly limit the ability of service users to engage in future treatment (Amaro et al, 2002). Consequentially, the literature, which relates to trauma-informed care, suggests that services must acknowledge how its day-to-day operations can impact its service users, and actively avoid re-traumatisation (Hales et al, 2018). Fallot & Harris (2009) posit a trauma-informed care approach can be achieved through fostering feelings of safety, trustworthiness, choice, collaboration and empowerment. The findings from the current research are however in conflict with the suggestions of Fallot & Harris (2009) and indicate how restricting access to means can create the opposite effects to trauma-informed care (i.e. feeling controlled, powerlessness, and unable to make decisions).

The findings presented within this theme align with the Power Threat Meaning Framework (PTMF) (Johnston & Boyle, 2018), which posits that behaviours such as life-threatening self-harm are learnt survival or coping responses used to help manage with distressing and disempowering experiences such as restricting access to means. As outlined in Chapter 7, Functions and Pathways to Life-Threatening Self-Harm, the PTMF conceptualises emotional distress as a response to four key factors; the negative operation of control (e.g. restricting access to means), the type of treat negative operation of power poses (e.g. distressing emotional responses, and flashbacks and intrusive related to past traumatic experiences), the perception of what negative power operation means to an individual (e.g. I am powerless and I am a victim), and the learned threat responses that individuals draw upon to ensure emotional, physical and social survival (e.g. life-threatening self- harm). In line with the PTMF, it is therefore important for forensic mental health services to acknowledge that restricting access to means can act as a negative controlling experience, and that life-threatening self-harm can be a behavioural response to such experiences.

"So yeah sometimes I think what have I got to loose because I haven't got any community leave... they can't take anything else away from me because everything restricts you and makes you think what have I got to loose. You just think differently here" (Poppy, Service User)

8.5.2 Theme 2 - Category 2b: Handing back control

"To have some sort of form of control especially in secure environments because we control everything that is in their rooms in their lives what is going on what, phone calls they can make you know if they can have a knife and fork absolutely everything even to the point of whether they can have toilet roll you know" (Lorraine, RMN)

Whilst many staff spoke of how the perception of losing control played an important role in the escalation of life-threatening self-harm, they also cited how regaining a sense of control can help to reduce the risk of life-threatening self-harm. It was explained how involving women in their care plans and allowing them to take ownership of what items posed a risk, helped them to regain some level of control over what restrictions were used to keep them safe.

"Lots of them taking responsibility and handing their stuff and saying like this is too tempting or they utilise 1:1s with staff so they come and grab you and want to talk to you so they can off load… working with them collaboratively" (Rose, Clinical Nurse Practitioner)

The process of taking ownership for their risk items and being able to choose when to utilise restrictions was described as a challenging but empowering process. This aligns with literature that demonstrates the importance of helping service users to foster a sense of control within self-harm prevention strategies (Morgan, 2004). This, in turn, is thought to help reduce the risk of self-harm and aligns with literature advocating the important of working in a trauma-informed approach (Hales et al, 2018; Bloom & Farragher, 2013; Fallot & Harris, 2009).

"I mean we have some women who have a personal statement when they go into seclusion so they cant hurt themselves so they choose to do that and as you have been able to intervene early and give them options to discuss what we are going to do and how we are going to deal with it and manage themselves so its their choice... so choosing it and having a bit of self-management means they are able to take control... you know … help keep them safe but her recognising it again and having the input to do it you know its the choice again" (Lilly, HCA)

" So does restriction help or hinder, depends on the individual... it does give you that opportunity to engage and talk... and helps you to hand that power back so if you can get people to the point where they say I self-harm by breaking biros and stabbing myself with them its like okay and you say can we get to the point where if you feel like that you are going to give me your biros so its another way in for us to share responsibility... to the point where you can give some of the power back so erm its still restrictions in that it is removing things but it is sort of a mutual risk assessment in that you are agreeing to share risk and that is the best sort of way" (Jamie, RMN).

The findings therefore highlight the need for forensic mental health services to consider ways in which they can increase service user's involvement in their self-harm care plans, in a bid to increase the feeling of control. In doing so, it may be possible to reduce the risk of service users experiencing means restrictions as traumatic and prevent life-threatening self-harm.

8.6 Theme 3: Adaptive Species – method substitution

"We are adaptable species of animals so if one thing doesn't work we try to adapt to a new one and like well if that adaptation doesn't work then you will revert back to the old one or a new one" (John, HCA)

When discussing the impacts of restricting access to means, almost every woman and member of staff referred to the idea that women receiving forensic mental health care were able to adapt to the restrictions placed upon them and find new ways to self-harm. The women and

staff explained how women are able to adapt to their environment and change their methods of self-harm when their preferred or usual methods are removed. Typically, the women and staff believed the ability to adapt and find new methods of self-harm was driven by an intense need to self-harm, which was not alleviated by restricting access to means. In fact, in many instances, it was felt restricting access to means heightened the situation and intensified their impulses to self-harm. This chimes with literature that has reported the greater the environmental restrictions, the greater the risk of self-harm (Bowers et al, 2008; Drew, 2001).

"Well I was going to say to be honest any patient that wants to self-harm will do it and find a way to be honest. You can remove every single avenue but our patients are very clever and they will find the means around that and they will find a way if they are intent on doing it (Sadie, Clinical Team Leader)

"Erm they [means restrictions] do play a big role in what they can and can't use and I mean sometimes it wont stop it anyway if they want to they will find anything if they need too... so staples are a great example they find them or remotes and swallowing batteries... we take one so they use another... (Lorraine, RMN)

The accounts from the staff and women in the current study resonate with literature from Fish et al, (2012), Holly & Horton (2007) and Harker-Longton & Fish, (2000), who all report service users can become fixated on finding alternative methods of self-harm when access to other methods are restricted. In relation to literature from the general population, this process is referred to as method substitution (see chapter 2, method selection, method substitution and restricting access to means). It is possible that the findings outlined in chapter 7, (section 7.10), 'The Taught' sub-group, may help to explain how women adapt to their environment. The findings in chapter 7 posit that some women learn that life-threatening methods of self-harm are an effective way of managing distress. The process of learning can occur through witnessing the methods that other people utilise, or through women sharing tips and stories of methods they have used. Consequentially, when placed within a restricted environment, women can draw upon their previous experiences, and those of their peers, and utilise methods they have witnessed or have been taught to use when access to their normal methods are restricted.

"When you bring them into a different environment and restrict the items they have you then have to think about well what effect does that have I mean people who have never head banged before, if they have got nothing else to use and yet they struggle with help seeking and

they struggle to make their needs known and don't feel they are deserving of care then head banging actually very quickly becomes a very effective way of working with your new environment" (Francis, Clinical Psychologist)

"So restriction is the main thing there, I mean if someone goes to seclusion it is a completely sterile area and they get stripped of their clothes and put in strong clothing… so there is literally nothing in there for them to use so in that sense they are swayed or forced into using something else [their own body] so that is what we tend to see if we restrict things" (Lilly, HCA)

Amongst the stories told by the women and staff it also appeared that restricting means of self-harm can result in women being nursed in seclusion, which involves isolation from their peers and everyday activities. The staff and woman explained how with isolation comes time to think, which it was suggested creates a space for women to assess their new environment and consider what they could use to self-harm.

"If you have got a women who is desperately and actively erm engaging in life-threatening self-harm … their environment will be completely stripped so … with a stripped environment it's like okay what have I got, more time to think because you have got nothing to stimulate you … nothing to distract you have got hours I mean our girl ate a seclusion room, she went through the walls she managed to unscrew screws, why because she was in there for months and months and she had nothing so you adapt " (Faye, RMN)

During time spent away from the wards in isolated, restricted environments, the staff and women reported people become far more creative with their means of self-harm. Consequentially, the lethality of their self-harm can progress into life-threatening self-harm using methods that are uncommon within community populations, including occluding the airways with waste body products and/or food. This aligns with research from James et al, (2012); Klein (2012) and Sarkur et al (2011), who all suggested that means restrictions might be partly responsible for the use of unusual methods amongst women in forensic mental health services.

"You know you are leaving the patient kind of isolated and isolation away from other people and you know they are BORED they are bored … they become more creative, definitely I think they have to become more creative you know if someone has a history of legating we are going to take their shoe laces off but of course they do other methods and I think in a forensic setting you know people are so creative " (Marie, Assistant Psychologist)

"I mean some of the some of the behaviours are informed by what the women have access to so if they don't have anything to cut with for example the behaviour might shift depending on that because ermm well you only need clothes to be able to ligate for example erm so I think that sometimes the behaviours can shift in response to sadly often what we are placing on the patient which is difficult" (Michael, Speciality Doctor)

Reviewing the findings outlined in chapter 7, which report two functions of life-threatening self-harm are to elicit care from others (see section 7.11), and to feel like they are worthy of saving (see section 7.12), it is also important to consider the impact isolative restrictions could have on people's need to elicit a response from other people. The stories told by the women and staff that describe method substitution to more lethal methods during times of seclusion, may represent an increased effort to elicit social interaction and care from others. In other words, women may enact life-threatening self-harm to remove the physical barrier between them and staff (i.e. a seclusion suite door) and meet the underpinning need of being cared for. As outlined in chapter 7, (section 7.11), as staff have to respond to incidents of life-threatening self-harm, the women learn that it is an effective way to elicit care, particularly when they are isolated from other people. The findings from the current research may therefore offer a new insight into why literature reports that those who are secluded or nursed in segregation at greatly increased risk of self-harm behaviours (James et al, 2012; Mannion, 2009).

The findings from the current research therefore confirm that method substitution can and does occur within forensic mental health services. Unfortunately, however, unlike literature that suggests means restrictions causes method substitution to lower lethality methods (Yip et al, 2010), the findings from this research indicate that for women in forensic mental health services, means restriction can in fact cause substitution to higher lethality methods. Such findings conflict with that from community populations, whereby means restrictions are viewed as an effective way to reduce the lethality of self-harm and suicidal behaviour (Yip et al, 2010; Hawton, 2002).

"I think there is something about the sometimes a pattern of kind of escalation, my experience has always been quite a lot of ermm attempt to put in place harm minimisation with the recognition that sometimes with a lot of restrictions it escalates the severity so I think that quite often the women who are engaging in the really life-threatening dangerous self-harm it seems to be that it is the last possible way they can do it with what they have accessible and what they have available so it feels like there has been a progression there based more on the restrictions" (Francis, Clinical Psychologist)

"Yeah because we restrict so much so much anything they can do we find a way to stop and move away so then they have to find a way to get something desperate. If you are in a blue sack with nothing what do you create every day that you can shove down your throat... a poo yeah so they get weirder and more wonderful but I think that is due to resources and what is available, you know what have I got? "(Faye, RMN)

"If you don't have anything if you are in anti-tear wear and you have a stripped room and you do not have access to sharps… ermm it almost shapes the environment almost shapes well what have I got access too … I mean I wonder even about occluding airways you know people have done it with you know sandwiches or their hair... so people have got nothing else so these methods are one way that they do have …so yes I think restriction of the environment absolutely would play a role in shaping peoples behaviour as much as we wouldn't want to think that" (Francis, Clinical Psychologist)

8.7 Conclusion

Restricting access to means, or means restriction, is a suicide prevention policy adopted in the community, prisons and forensic mental health hospitals (Preventing Suicide in England, 2012). As outlined in Chapter 2, section 2.7 (method selection, substitution and restricting access to means) means restrictions involves making access to potentially lethal means more difficult, by substituting high-risk means with ones that pose lower risk to life and limiting the volume or quantity of means available (Yip et al, 2012). It is believed that through restricting access to means, serious self-harm and suicide can be prevented as it may help to delay the process of thinking about harming oneself and acting on suicidal thoughts (Florentine & Crane, 2010; Hawton, 2002). Literature demonstrates that means restrictions have been successfully used within community populations (Mohamed et al, 2009; Ozanne-Smith et al, 2004; Haw et al, 2004; Bridges et al, 2004; Gunnell & Eddleston, 2003; Kreitman, 1976). The impact of restricting access to means have however not been explored within forensic mental health services (James et al, 2012), meaning there is a current gap in academic understanding. It is therefore important to explore the impact of restricting access to means within forensic mental health hospitals, as currently, literature relating to community populations underpins the justification of its use within forensic mental health hospitals, without understanding whether the findings are generalisable.

The findings from the current research evidence that whilst the staff and women believed that, whilst at times, restricting access to means was necessary to uphold safety, often is not an overly effective management response within forensic mental health services. In fact, the findings indicate that restricting access to means can contribute to the worsening of self-harm, and the enactment of life-threatening self-harm. Most commonly, the findings report that restricting access to means can increase women's levels of distress, which is one of the most commonly cited reasons, for self-harm behaviours (Nock, 2009; NHS England, 2013; NICE, 2013). Furthermore, the findings evidence that, for some, restricting access to means reinforces the reasons why women enact life-threatening self-harm (see chapter 7).

The findings report that restricting access to means may contribute to life-threatening self-harm in three main ways. Firstly, the women and staff explained how restricting access to means causes increased levels of distress and described how having their personal possessions removed can act as a significant life event. The relationship between significant life events and self-harm are well evidenced amongst the general, prison, and mental health populations, and was discussed within Chapter 7, Section 7.4 (Isohookana et al, 2012; Fleige et al, 2009; Beer et al, 2009; White, Leggett & Beech, 1999). However, it is important to note that within forensic mental health hospitals, significant life events will not always appear 'significant' to members of staff (see chapter 7, section 7.4). Therefore, it may easily go unnoticed that the removal of personal possessions can in fact cause significant distress to some women in forensic mental health hospitals. This finding is important as it highlights a different impact of means restrictions when compared to the general population, and it is unlikely that the same emotional impact would be found when access to everyday means such as paracetamol or jump sites are restricted. The findings from the current study also show how restricting access to means can be detrimental to women's' well-being as the removal of means fails to provide alternative coping strategies, meaning their increased levels of distress can be overwhelming. As reported within chapter 7, (section 7.4), feeling overwhelmed and unable to resolve negative emotional states can trigger life-threatening self-harm.

Secondly, for many women, restricting access to means can be perceived as a controlling experience, which can trigger memories and flashbacks of traumatic experiences. These findings are particularly important, as chapter 7 (section 7.13), reports that a function of life-threatening self-harm is to cope with and stop flashbacks and intrusive thoughts associated with past traumatic experiences. The findings are therefore supportive of Bloom & Farragher (2013), and Holly & Horton (2007) who report care environments can inadvertently recreate conditions that activate the memories of traumatic experiences. The findings also show how

feeling controlled can foster a sense of frustration and anger, which again relates to the pathways to life-threatening self-harm. As detailed in chapter 7, (section 7.15), for some women, life-threatening self-harm is enacted as a means of dealing with extreme anger and high arousal. This aligns with literature that evidences a relationship between emotional agitation, anger and over-arousal and self-harm (Johnston & Boyle, 2018 Ramirez & Andreu, 2006).

Finally, the findings indicate how social isolation and being nursed in seclusion can prompt life-threatening self-harm in a bid to elicit care from others. As detailed within chapter 7, an alternative function of life-threatening self-harm is to elicit care from other people (section 7.11), and to clarify whether a woman is worthy of saving (section 7.12). These findings align with the work of Nock (2009), who noted eliciting care from others plays an important role in the motivation and maintenance of self-harm. The findings form the current study suggest that by removing women's' ability to elicit care from people (i.e. they are placed behind a locked door in a seclusion suite), life-threatening self-harm becomes a viable option to remove the physical barriers that separate women from their care givers, and achieve the appropriate care or medical response they desire.

The findings presented in Chapter 8 also confirm that method substitution can and does occur within forensic mental health hospitals in response to restricting access to means. Unfortunately, unlike within community populations whereby restricting access to means causes substitutions to lower lethality methods (Yip et al, 2010; Hawton et al, 2002), the findings demonstrate how restricting access to means can in fact cause substitution to higher lethality methods. The women and staff who took part in the current research reported that method substitution to higher lethality methods occurs as, unlike within the community, access to many means are completely *removed* and not restricted within forensic mental health hospitals. Consequentially, unlike within the community where less harmful methods are employed (Hawton et al, 2002), women enlist the only recourses they have available to them to help manage their distress, which normally includes using bodily by-products or fixtures and fittings to occlude the airways, and interfering with pre-existing wounds (see chapter 8, section 8.6.1). These findings align with claims from The National Institute for Health and Clinical Excellence (NICE, 2004), who note, attempting to prevent an individual from self-harm may in fact increase the frequency, and potential lethality of the behaviour. Therefore the findings have explanatory value as to why previous literature has noted the variability and use of unusual methods of self-harm within forensic mental health services (James et al, 2012; Klein, 2012; Sarkur et al, 2011).

The findings from the research are therefore able to expand the current understanding about the impacts of restricting access to means. The findings have important implications, as unlike within community literature, it is suggested that restricting and removing access to means in forensic mental health services can increase the lethality of self-harm. As a result, the findings indicate that restricting access to means plays a role in life-threatening self-harm and contribute to it occurring. These findings are important, as currently restricting access to means within forensic mental health services has been justified and informed by community literature, which seems to be in conflict with the findings from this forensic mental health population. It is, however, recognised that as the research did not directly test the impact of restricting access to means, and it is the first to shed light on the consequences of means restrictions in forensic mental health services, further research is required. This presents an important direction for future research.

8.8. Critical Reflections

It is apparent from the findings presented earlier in the chapter that most of the women hold a negative perception of means restrictions. Reflecting on why this may be, I think it is important to emphasise again the differences between means restrictions in the general population and the forensic mental health population. As detailed in chapter 2, (section 2.6.2), means restriction in the general population involves restricting access or removing means of potentially lethal self-harm. Typically, such restrictions include limiting the availability of large quantities of medication, preventing access to known jump sites or changing the type of gas used within cars or household appliances. Comparatively, within forensic mental health hospitals, the range of items that are restricted is vast and includes everyday items (such as razors, chewing gum, and, in some cases, pens), and personal possessions if they offer a potential means of harm. Therefore, unlike the general population, when risk is considered to have heightened, women in forensic mental health hospitals are restricted from accessing their own belongings and are not allowed to have them back until a member of staff deems it safe to do so. Clearly, the emotional response in this situation is going to be different to a member of the general population who experiences means restrictions. I therefore am led to believe that the women's' negative description of means restrictions is likely to relate to the fact that they have little control, power and choice over their access to their own personal belongings, and perhaps not of means restrictions as a whole.

This may explain why many described means restrictions as a controlling experience, which as suggested in chapter 7, can act as an overwhelming significant life event, trigger flashbacks

and intrusive thoughts of past trauma, and cause anger, frustration and arousal – all of which can trigger life-threatening self-harm. Importantly, many of the women noted that during means restrictions or means removal, items that are protective (i.e. pictures of their family or a cuddly toy that helps them to cope) are also removed. For me, this seems counter productive and highlights the use of blanket restrictions. This reinforces the importance of establishing collaboratively which personal items pose a potential risk to women (based on past and current behaviour) and identifying items that serve a protective purpose. This may therefore explain the shared negative perception of means restrictions and may have caused the results to be skewed towards individuals who feel disempowered and frustrated at the system. However, it is also important to recognise that all of the women could understand the utility of means restrictions for those at particularly high risk of dying because of their behaviour and could empathise with staff just 'doing their jobs'.

I also wondered whether the negative perception held by staff might be related to feelings of guilt about taking away the limited possessions of the women in their care. I reflect on four members of staff who spoke of their sympathy towards the women who have so little, and could empathise with the distress they must feel when they removed the things that represented them as a person, or reminded them of life before forensic mental health care. I think it is important to consider this alongside the stories that described the impossibly difficult position staff find themselves in, whereby they are trying to respond to incidents in the most therapeutic way possible, whilst also balancing their legal obligations to keep people safe. I therefore wondered whether staff might at times also feel as though they powerless over how they respond to incidents of self-harm, and feel as though they are not in control, or able to decide to respond in the way they felt would be most beneficial. Sadly, this reinforces the perception that forensic mental health services can disempowered those they care for, and now also their staff.

It was also clear that some staff were reserved when discussing their thoughts on means restrictions and I believe this was related to their concerns over saying something that might make them appear less competent at their job, or too much in favour of positive risk taking. In a number of instances staff provides a caveat their statements with statements like 'I shouldn't probably say this...' or 'I always make sure I follow the rules, however...' and 'please don't think I don't do my job properly, but...' suggesting they were concerned about being truthful and expressing their opinions. For me, this is recognition of the blame culture that continues to exist amongst NHS and wider healthcare organisations and highlights the fear that exists within services. This raises difficult questions regarding who safety procedures such as means

restrictions are designed to protect and leaves me in favour of understanding more coherently whether there are more effective, alternative way to safety manage risk.

Reflecting over the findings from chapter 8 as a whole, I am confident that means restrictions within forensic hospitals is a distinctly different process to that used within the general population, on both a practical and psychological level. Consequently, it is my opinion that means removal is a more appropriate term that better reflects the processes being utilised. I also believe that the identification of this difference warrants further exploration, and future research to be conducted within this area.

Chapter 9: Summary and Recommendations

9. Overview

The aforementioned chapters of this thesis highlighted a paucity of literature relating to life-threatening self-harm amongst the female forensic mental health population. Whilst literature has started to outline some of the emerging reasons for life-threatening self-harm amongst the male and female prison populations, it remained unclear whether the current understanding was applicable and generalisable to the forensic mental health population. Therefore, in response to the gap in literature, this thesis aimed to explore the differences between self-harm and suicidal behaviour amongst women with complex mental health needs, with a specific focus on better understanding the functions of and reasons for life-threatening self-harm. This thesis was novel through being the first to explore life-threatening self-harm across a range of secure settings within the female forensic mental health pathway, and it was the first study to utilise a Participatory Action Research framework to study self-harm within the forensic mental health population. It was envisioned that through developing a better understanding of why women enact life-threatening self-harm, and how the behaviour develops, the findings detailed within this thesis may serve to assist with the identification of those at risk and offer practical clinical recommendations to help with prevention. The aim of this research was further explored by addressing the following research questions

- Is life-threatening self-harm enacted with suicidal intent?
- What are functions of, and pathways to, life-threatening self-harm?
- Does restricting access to means of self-harm play a contributory role in the development of life-threatening self-harm?

9.1 Summary of thesis findings

The following section provides a summary of the main findings of the research.

9.1.1 The Experience of Life-Threatening Self-Harm

Chapter 6, The Experience of Life-Threatening Self-Harm, aimed to present an overview of life-threatening self-harm within women's forensic mental health services. Unlike previous research, the findings presented within chapter 6, offer a rarely unseen perspective of a relatively unexplored behaviour, in a hard to access population. In doing so, the chapter aimed

to explore the severity of self-harm within forensic mental health services, and to highlight the unique nature of the behaviours. As detailed within chapter 6, (section 6.5), the staff and women who took part in the research reported an overwhelming emphasis on the frequency and severity of self-harm within forensic mental health services. Furthermore, in line with Dyke et al (2014), Klein (2012) and Sakur (2011), the findings highlight considerable variability in methods employed by women in forensic mental health services. The findings also align with research from James et al (2012), who reported women in forensic mental health services often employ unusual methods, including insertion or occluding the airways, and the use of everyday items such as hairclips, watch faces and pieces of building or furniture fabrications. The findings also act as confirmation for research from Chester & Alexander (2018), who noted the high prevalence of head-banging amongst women cared for in higher security mental health services. Consequentially, the findings from the current research demonstrate clear differences in the self-harm behaviours of women in forensic mental health hospital settings compared to members of the community, whereby common methods of harm include overdosing, cutting and burning (Hawton et al, 2015). In doing so, the findings raise important questions as to why such variability and severity is noted amongst the self-harm of women in forensic services, which will be answered below in section 9.4, the impact of restricting access to means.

The findings from chapter 6 also highlight how the frequency and severity of life-threatening self-harm contributes to a sense of frustration, powerlessness and hopelessness regarding the potential for women to desist from their self-harm behaviours. The findings therefore align with literature by Marzano, Alder & Ciclitria (2012) who also report a sense of frustration and powerlessness amongst custodial staff. Whilst both the women and staff reported feelings of frustration, powerlessness and hopelessness, it was recognised that the source of such feelings stemmed from different sources. Amongst the staff, many reported feelings defeated by the system they worked in, as they believed they were often unable to support the women in their care outside of enlisting restricting practices. This aligns with findings from Beryl et al (2018) who found members of staff from forensic mental health environments often report that the distinct focus on upholding security hinders their ability to adapt their care to the needs of their patients. The findings indicate that restrictive practices also facilitate a sense of frustration and powerlessness amongst women in forensic mental health services, as they too reported feeling as though they are restricted within an environment that subjects them to other people's self-harm. Such findings raise important questions regarding whether the

design of forensic mental health services limits women's exposure to other people's life-threatening self-harm.

Finally, chapter 6 also aimed to clarify the most appropriate language to use when describing self-harm that poses either high or low risk to life and emphasizes the need to use terminology that is specific to the functions of life-threatening self-harm. Finally, the chapter aimed to highlight the impact witnessing self-harm has on both members of staff and the women forensic mental health services care for. This is important as the findings from the current research indicate witnessing life-threatening self-harm can be traumatic for women and staff. The findings therefore offer a novel and unique insight into the nature and impact of self-harm within a population that is known to be particularly challenging to access (Livingstone et al, 2012).

9.1.1.1 Language - "one size does not fit"

As has been previously reported within the literature, there are fundamental issues with the definitions used to describe self-harm and suicidal behaviour (Silverman, 2006). Notably, there is heavy criticism relating to the use of inconsistent terminology, meaning multiple terms are used interchangeably to describe a single concept, whilst broader terms describe multiple behaviours (Andover et al, 2012; Silverman, 2007). Arguably, the use of multiple definitions and interchangeable terminology can lead to confusion when interpreting research findings and theoretical modals (Silverman & De Leo, 2016). Furthermore, inconsistent terminology is thought to have practical implications, in terms of accurate assessment and implementing the most appropriate treatment, as the range of behaviours considered being self-harm or suicidal behaviour differs within, and between populations (Slade, 2011). Achieving consensus on the language used to describe behaviour that is suicidal and non-suicidal in nature is therefore crucial. Despite self-harm being the most reliable risk factor, beyond all others, for future suicide (NICE, 2013; Bergen et al, 2010; Cooper et al, 2005), there are important differences between the behaviours that blanket terminology is unable to capture (Andover et al, 2012; Nock, 2009; Klonsky et al, 2008; Fliege et al, 2008; Silverman et al, 2007; Nock et al, 2006; Muehlenkamp et al, 2005).

The terms 'near-lethal' or 'near-fatal' self-harm have previously been used to describe self-harm that poses a high risk to life, amongst both the general and prison populations (Fox et al, 2018; Marzano & Colleagues, 2009; 2011a; 2011b; 2012; 2013; Douglas et al, 2004). The findings from the current study strongly support that such terms are not however, considered

appropriate for the forensic mental health population, as the findings from the research evidence that, in almost all instances, the women and staff were unaware of the terms, or found them uninformative. This highlights a disparity between the current study and previous literature and reinforces the ongoing debate that there is a distinct lack of consensus as to how self-harm behaviours should be best defined (Gratz, 2003). Instead, the women and staff who took part in the current research posit that the terms 'life-threatening' and 'non-life-threatening' ought to be used to describe and categorise self-harm amongst women in forensic mental health services. Collectively the women and staff defined 'life-threatening self-harm' as an incident of self-harm that had the potential to be lethal. Those who took part in the research stated that typically life-threatening self-harm included any behaviour that restricted breathing, blood-letting and vein-popping, cutting near main arteries, and any behaviour that makes a pre-existing vulnerability (for example open wounds or brain injuries) more likely to be lethal. Comparably, the women and staff believed the term 'non-life-threatening' was helpful to define all other self-harm that was not dangerous enough to cause death or pose a high risk to life. Therefore, the findings offer clarification as to what terminology ought to be used when describing self-harm that poses high risk to life amongst the female forensic mental health population. In doing so, using appropriate language may serve to reduce the documented confusion regarding interchangeable and inconsistent definitions (De Leo, 2016; Andover et al, 2012; Silverman, 2007). This is important for forensic mental health services, as practically, inconsistent terminology has been shown to impact the accuracy of assessment the implementation of appropriate treatment and interventions (Craigen et al, 2010; Gratz, 2001).

To the author's knowledge, it is the first time that differing terms used within the research have been suggested as more appropriate to describe different types of self-harm behaviours. The terms life-threatening and non-life-threatening self-harm therefore contributes to academic knowledge, and they are the first definitions to be suggested, that are specific to the female forensic mental health population. Arguably, the suggested terms will better capture the needs of women in forensic mental health services, as unlike previous research, the terms outlined within the research have been offered directly by both women with lived experiencing of enacting life-threatening self-harm, and the staff who care for them. Consequentially, the terms capture a shared understanding between service users and staff, which aligns with guidelines from NICE and the Care Quality Commissioners regarding collaborative care and treatment.

Whilst the findings indicate that it is helpful to adopt terminology that reflects the specific understanding of a population, one of the most important findings of this thesis relates to the understanding that the women and staff who took part strongly believe that, in almost all instances, life-threatening self-harm occurs without suicidal intent. Therefore, the findings argue it is essential not to assume suicidal intent, even when behaviour *appear*s to look similar to a suicide attempt. These findings are distinctly different to the current body of literature, where it is understood that near-lethal self-harm is enacted with suicidal intent (Marzano & Colleagues, 2009; 2011a; 2011b; 2012; 2013; Douglas et al, 2004). This has significant research, practical and conceptual implications, and the findings strongly support that using terminology that describes behaviour that is suicidal in nature, will fail to capture the underlying non-suicidal motivations of life-threatening self-harm. It is therefore essential for future research adopt the appropriate terminology when describing different types of self-harm that poses high risk to life (i.e. near-lethal self-harm which is driven by suicidal intent, and life-threatening self-harm which is not), as the terms describe two distinctly different behaviours.

Crucially, the findings from the current research emphasise the importance of revisiting the current application of knowledge to suicide prevention strategies, as survivors of near-lethal self-harm are viewed as valid proxies to develop our understanding of why people die by suicide (Rivlin et al, 2012; Marzano et al, 2009; Fortune et al, 2007; Mosciki, 1995). Whilst such an approach may be suitable for some, the findings from this research indicate that not all individuals who enact behaviour dangerous enough to bring about death have suicidal intentions. This aligns with other literature that issues caution to using survivors of near-lethal self-harm as proxies for suicide, and questions whether they can provide accurate insight into the intentions of those who die by suicide, (Ciuhodaru et al, 2013; Andriessen, 2006). The findings therefore raise important questions in terms of understanding and preventing suicide, as recent suicide prevention strategies have been informed by literature that enlists survivors of near-lethal self-harm (Preventing Suicide in England, 2012).

The findings also highlight important practical considerations when using survivors of near-lethal self-harm as proxies for suicide prevention. In doing so, preventative strategies and treatment pathways for those who enact near-lethal self-harm are currently designed to target suicidal behaviour. Whilst using such literature to inform treatment and prevention strategies may be appropriate for some individuals, (i.e. those who are suicidal), the findings from the research indicate the current strategy is unsuitable for women from the forensic mental health population, as they will not capture the needs of women enacting life-threatening self-harm

without suicidal intent. Instead, the findings indicate it would be more suitable to acknowledge the different functions of life-threatening self-harm amongst the forensic mental health population and use them to further inform treatment and prevention that targets self-harm.

Consequentially, the findings from the research align with the notion that self-harm enacted without suicidal intent ought to be separate from suicidal behaviour (American Psychiatric Association, 2013; Klonsky & Muehlenkamp, 2007; Nock et al, 2006; Whitlock et al, 2006). Unlike before however, the findings contribute to literature, and bolster our understanding, as they offer a new perspective from women in forensic mental health care. The findings do however raise questions as to the effectiveness of the current categorisation approach adopted by the DSM-5 (2013), whereby non-suicidal self-injury and suicidal behaviour are separated on the basis of suicidal intent, and the frequency, severity and lethality of behaviour (see chapter 2, section 2.2). Clearly, on account of the findings, life-threatening self-harm falls outside of either category (i.e. it appears similar to suicidal behaviour, however is not enacted with the desire to end life), reinforcing the idea that self-harm and suicidal behaviours do not fit within homogenous groups (Ward, 2012). Consequentially, the findings offer support for self-harm and suicide to be viewed upon a continuum of behaviours (Kapur et al, 2013; Butler & Malone, 2013; Klonsky, 2013; Muehelenkamp & Gutierrez, 2007; O'Carroll et al, 1996; Stanley et al, 1992), as such an approach is able to recognise both the similarities and the distinct differences between the behaviours.

9.1.1.2 Being Traumatised – Witnessing "haunting" self-harm

The findings from the current research demonstrate how witnessing life-threatening self-harm on a regular basis can be traumatising for both staff and women in forensic mental health services. Within the findings there was a unanimous description between staff and the women, of how living amongst, or caring for women who self-harm is emotionally challenging. The findings also highlight how the costs of witnessing life-threatening self-harm can be high, and many report lasting impacts. For women, witnessing life-threatening self-harm can be re-traumatising, as their peers' self-harm reminds them of their own distressing experiences. Comparably, the findings show that for staff, the personal costs can also be high, and witnessing life-threatening self-harm frequently can cause staff to experience flashbacks of serious incidents. The findings are similar to that of Beryl et al (2018), and Wright et al, (2006).

Most notably, the findings indicate that being present during an incident of life-threatening self-harm can in fact trigger other women's life-threatening self-harm. The findings indicate that witnessing others life-threatening self-harm reminds the women of the reasons why they utilise self-harm behaviours, which can make them experience urges to self-harm. Unfortunately, the findings are supporting of previous literature that identifies in some instances, aspects of forensic mental health services can be re-traumatising for service users (Sweeny et al, 2015; Smith, 1995). As described within chapters 6 and 7, witnessing an incident of life-threatening self-harm can also trigger multiple other incidents of life-threatening self-harm (described as the domino effect), as women can experience resentment towards their peers when they are receiving support and care from members of staff. As the need for care can be so strong, the women and staff described how many women enact life-threatening self-harm to divert care from their peers. This creates serious managerial issues, and makes it particularly challenging to effectively and safely manage multiple incidents of life-threatening self-harm.

The findings which report that witnessing incidents of life-threatening self-harm can be traumatising, appears to be at odds with the aforementioned aims of forensic mental health services, and does not chime with the notion of recovery (see chapter 1, section 1.6). Indeed, Standard 4 of the Care Quality Commissioners (CQC) fundamental standards state that service users must not be given unsafe care or treatment or be put at risk of harm that could be avoided. Whilst witnessing life-threatening self-harm is unlikely to be considered directly as unsafe care or treatment, since the findings indicate witnessing life-threatening self-harm causes distress and can trigger further life-threatening self-harm, it is important to consider whether the current design of forensic mental health services indirectly puts those it cares for at risk of harm that could be avoided. It is particularly important to consider this, as the findings from the current study indicate that the physical layout of forensic mental health wards, make it difficult to avoid incidents of life-threatening self-harm. The women and staff reported how even when women actively try to avoid incidents, the sounds, and managerial response to an incident can be heard around the ward even, when an event does not occur within eyesight, or occurs during the night. Understandably, the findings suggest that the increased levels of distress that are the result of witnessing life-threatening self-harm can cause a deterioration in the mental well-being of service users. For some, this could be construed as putting service users at risk of harm that could be avoided. Ultimately, the findings raise an important question as to whether forensic mental health services are able to keep women safe, (a fundamental aim of secure services). In doing so, the findings highlight

the need for future research to explore whether the long-term nature of forensic mental health care contributes to the continued exposure to others self-harm, and therefore the re-traumatisation of the women they are designed to care for.

The findings also highlight the need to consider whether forensic mental health services play enough attention to protecting staff well-being. It has been suggested that witnessing frequent self-harm can cause staff to hold negative attitudes towards individuals who enact self-harm (Boarderman & Rayner, 2018; Dickinson et al, 2009; Thompson e al, 2008; Willstrand et al, 2007; Hopkins, 2002). Previous literature posits that for some, viewing those who self-harm negatively can act as a coping mechanism, to help manage the traumatising effects of frequent exposure to self-harm (Salston & Figlet, 2003; Figley, 1995). Interestingly however, the current research found members of staff hold a positive, caring attitude towards women who enact life-threatening self-harm. Even though the findings report that, at times, staff can feel frustrated not being able to prevent women from enacting life-threatening self-harm, the staff explained how their emotional response stemmed from a desire to help and a willingness to support the women towards their recovery. A possible explanation for the findings from the current research is likely to relate to the discrete differences in the relationships that are formed between staff and forensic mental health service users, compared to other environments such as prisons or A&E departments. Unlike services that offer short-term care, forensic mental health services offer long-stay admissions, meaning over time, members of staff get to know their patients well. Additionally, it is important to remember that whilst forensic mental health services are designed to protect the public from individuals considered high risk of causing harm, first and foremost, forensic mental health hospitals aim to offer a caring and contained environment and treat people's mental illness. Therefore, it is acceptable, and expected that staff will be understanding towards people's distress and feel empathy towards them. This is however different to the 'feeling rules' that exist within custodial environments, whereby prison staff are expected to be less empathetic and more punitive with their approach to prisoners (Crawley, 2013; 2004). Considering the literature discussed within chapter 6, section 6.5, that evidences the relationship between empathizing with service users and symptoms of trauma, (Ludick & Figley, 2016; Craig & Sprang, 2010; Figley ,2002a; Figley, 1995), it is possible that feeling empathy towards women who self-harm, may explain why the findings report that witnessing frequent life-threatening self-harm can be traumatising for members of staff. Furthermore, the findings from the research may therefore provide an explanation as to why forensic mental health services have a reputation for high levels of staff burn out (Garcia, 2017; Happell, Pinikahana & Martin, 2003).

9.1.2 The functions of, and pathways to, life-threatening self-harm

Chapter 7, 'The functions of, and pathways to, life-threatening self-harm' aimed to describe the reasons why women in forensic mental health services enact life-threatening self-harm. Chapter 7 addresses a central aim of this thesis, which was to better understand the functions of life-threatening self-harm. Addressing such an aim was important as currently literature assumes that self-harm which poses high risk to life is enacted with suicidal intent (Marzano & Colleagues, 2009; 2011a; 2011b; 2012; 2013; Levi et al, 2008; Douglas et al, 2004). However, to date, there is yet to be a study that explores whether the functions of the behaviour reported amongst the prison and general population are generalisable to the female forensic mental health population. Therefore, without adequately understanding whether the same functions exist between populations, arguably it is unclear whether any prevention or intervention for life-threatening self-harm are able to meet the needs of female forensic mental health patients. The findings in chapter seven therefore expand upon the literature outlined in chapter 2, section 2.4, that posits for most, life-threatening self-harm is not enacted with suicidal intent, and clarifies the position for women in forensic mental health services.

Considering a fundamental finding of the current research was that in the majority of instances, life-threatening self-harm is believed to be enacted *without* suicidal intent (see Chapter 7), each of the proffered sub-types are discussed within the context of the Four Functional Model of Non-Suicidal Self-Injury (FFM) (Nock & Prinstein, 2009). The FFM (see chapter 3, theoretical frameworks) is a theoretical model that details self-harm that is enacted without suicidal intent. It suggests that non-suicidal self-harm is reinforced by a range of interpersonal and intrapersonal factors. Chapter 7 therefore aims to confirm where the findings of the current research fit amongst current theory, whilst highlighting where the new knowledge differs to what literature has already shown about self-harm.

Unlike current literature that posits near-lethal self-harm is suicidal in nature, in a novel approach, seven alternative functions of life-threatening self-harm are offered for women in the female forensic mental health population. A summary of each function is detailed below.

1) The Overwhelmed: A women who engages in life-threatening self-harm during a time of overwhelming distress, whose behaviour is normally triggered by a significant life event.

2) The Taught: A woman who engages in life-threatening self-harm to manage emotional or cognitive distress, using methods she has been taught, or has observed being used by other people.

3) The Care Eliciting: A woman who engages in life-threatening self-harm to elicit a care response from members of staff.

4) The Am I Worth Saving: A woman who enacts life-threatening self-harm with the aim of creating a situation whereby they require saving, so they can question whether a care giver is capable of saving their life, and to determine whether their life is worthy of saving.

5) The Trauma-Threat-Responder: A woman who enacts life-threatening self-harm to try and cope with intrusive thoughts and flashbacks associated with their past traumatic experiences, or to attempt suicide.

6) The Progressive: A woman whose self-harm has become progressively worse, and who enacts life-threatening self-harm as she believes non-life-threatening methods are no longer able to help her to cope with or release distressing emotions, or to 'feel something'.

7) The Angry-Controlled-Aroused: Women enact life-threatening self-harm to demonstrate the internal frustration, anger, and over arousal they are experiencing.

The research therefore confirms that whilst there are a number of important similarities between the functions of life-threatening self-harm in the female forensic mental health population, and those for near-lethal self-harm amongst the prison and general population, in general, the functions of life-threatening self-harm for women in forensic services appear fundamentally different. The findings of this thesis are therefore novel and understanding that life-threatening self-harm serves an alternative purpose for many women in forensic care outside ending life, has important practical implications. Namely, it is impactful as it can help to better inform self-harm care plans and highlight the need to give more consideration as to whether those who enact life-threatening self-harm uncritically inform suicide prevention strategies.

The findings of the current research are therefore novel, as unlike the work conducted by Rivlin et al (2013), who provided the characteristics of each type of individual who enacts life-threatening self-harm, the sub-types identified within the current research have explanatory value, as they are able to explain how life-threatening self-harm develops amongst different groups of women. Whilst Rivlin et al (2013) provided valuable insight into the function for male prisoners, which unlike the sub-types detailed within the current research, included a

number of common characteristics that overlap between each sub-type. This limits the potential utility of their work, as individuals could easily be mistaken for the wrong sub-type, meaning the ability to identify those at risk is hindered. In contrast, the functions presented within this thesis are able to distinguish women in each sub-group because of the ability to explain the functions behind life-threatening self-harm and demonstrate how the behaviour develops. Arguably, this means the findings from the current research may be more useful in developing a rich understanding of the functions behind life-threatening self-harm and identifying the reasons why certain women are at increased risk. This is important as without understanding the different functions of, and pathways to, life-threatening self-harm, it is difficult to prevent or treat this complex behaviour. Therefore, by being able to distinguish women who enact life-threatening self-harm based not only on their shared characteristics, but also on the reasons why the behaviour occurs, we are able to develop more effective understanding and treatment to help prevent life-threatening self-harm.

9.1.2.1 Theoretical impact of the findings

The sub-types outlined within the current research have some alignment with the Four Functional Model of Non-Suicidal Self-Injury (FFM), (Nock, 2009). As outlined in Chapter 3, the fundamental assumption of the FFM is that people enact non-suicidal self-injury as a result of early life experiences and stressors (see chapter 2, risk factors for self-harm), which has limited their ability to cope with stressful situations in an adaptive way. Therefore, for many, non-suicidal self-injury offers a viable way to manage negative emotional and/or cognitive experiences (Nock, 2009). The FFM suggests non-suicidal self-injury is motivated and maintained by one of four reinforcement processes: intrapersonal-negative reinforcement, intrapersonal-positive reinforcement, interpersonal-social-negative reinforcement, or interpersonal-social-positive reinforcement (Nock, 2009). In other words, people enact non-suicidal self-injury to alleviate negative emotional or cognitive states; to generate positive emotional or cognitive states; to escape from social situations and interpersonal demands; or to elicit a positive care response from others.

The FFM has been tested amongst the adolescent and adult population (Bentley et al, 2014; Klonsky et al, 2014; Muehlenkamp et al, 2012; Turner et al, 2012; Nock 2008), and is widely considered an acceptable theory of self-harm. However, the findings from the current research contribute to academic understanding of the FFM, as to date, the FFM has remained relatively untested amongst the forensic mental health population (Chapman et al, 2013).

Although the current study did not directly test the FFM, it acts as validation for the different reinforcing factors, and highlights how they are applicable to the functions of life-threatening self-harm amongst the female forensic mental health population. In particular, the findings highlight the important role that interpersonal-social positive reinforcement (i.e. obtaining a response from others), and automatic negative intrapersonal reinforcement (i.e. escaping internal cognitive states and negative emotions) plays in the functions of life-threatening self-harm. This aligns with findings from research that has tested the FFM amongst the prison population, which evidenced the applicability of all aspects of the FFM, and highlighted a particularly important role of eliciting a response from others (Dixon-Gordon et al, 2012; Siebery, 2012; Klonsky, 2007). It is likely that as Fallon (2003) suggested, the findings may be explained by the high prevalence of personality disorder found amongst the forensic mental health population, which are characterized by a need for validating responses from others.

However, when considering theoretical models of suicide, it is clear that the findings from the current research do not align as succinctly. Fundamentally, the findings from the current research differ to widely accepted theories of suicide, because the women and staff who took part, understood life-threatening self-harm to be motivated by something distinctly different to suicidal intent. Instead, life-threatening self-harm is thought to be motivated and maintained by the seven functions as outlined in chapter 7 and summarised above. However, like many theories of suicide, the findings align with the idea that people who enact life-threatening behaviour will have experienced a number of life events and stressors that predispose them to life-threatening self-harm (Mae et al, 2016; Cukrowicz et al, 2013; Szanto et al, 2012; You et al, 2011; Van Orden et al, 2010; 2008; Hill, 2009; Joiner, 2005). In the case of the women from this study, such events typically include experiencing sexual, physical or psychological abuse, neglectful childhoods, and having been looked after children. Similarly, as outlined in the Integrated Motivational- Volitional Model of Suicidal Behaviour (IMV), the findings posit that women who enact life-threatening self-harm experience deficits in communication skills and coping strategies (i.e. threat to self moderators), which contribute to a sense that the only way to manage their distress is to enact life-threatening self-harm. There is also congruence with the idea that a lack of social support and exposure to attitudes that justify self-harm may also play a role in the development of life-threatening self-harm (i.e. motivation moderators). Finally, the findings from the current research align with the notion that social learning, impulsivity and access to means (i.e. volitional moderators) contribute to life-threatening self-harm.

There are however distinct differences in the development of life-threatening self-harm, which do not align with accepted theories of suicide. Most notably, this relates to the idea that suicidal ideation develops prior to the occurrence of behaviour that is dangerous enough to bring about death. In the instance of life-threatening self-harm, the women and staff who took part in the current research posit that in almost all instances, women do not experience suicidal ideation prior to life-threatening self-harm, nor do they enact such behaviour with the intention of dying by suicide. This, therefore, highlights a fundamental gap in theoretical understanding, as there is yet to be a model that adequately explains why people enact life-threatening self-harm without suicidal intent. Whilst there are undoubtedly similarities between the development of life-threatening self-harm and suicidal behaviour, and indeed life-threatening self-harm and non-suicidal self-injury, (see chapter 3, theoretical frameworks), further research is required to develop a new model that incorporates the development of life-threatening self-harm. The findings of the current research therefore offer an opportunity for future research to validate the experiences of the women and staff and use them to inform a new theoretical model for life-threatening self-harm.

9.1.3 The Impact of Restricting Access to Means on Life-Threatening Self-Harm

Chapter 8 aimed to present the findings from the semi-structured interviews with staff and women, that were analysed and used to inform and improve our understanding of the impact of restricting access to means on life-threatening self-harm. It is important to note that the research did not directly test whether restricting access to means predicts or contributes to life-threatening self-harm. Instead, the experiential knowledge of the women and staff who took part was combined and used to present their understanding and lived experience of how restricting access to means impact the self-harm behaviours of women receiving forensic mental health care.

Restricting access to means, or means restriction, is a suicide prevention policy adopted in the community, prisons and forensic mental health hospitals (Preventing Suicide in England, 2012). As outlined in Chapter 2, section 2.7 (method selection, substitution and restricting access to means) means restrictions involves making access to means of self-harm and suicide more difficult, by substituting high-risk means with ones that pose lower risk to life and limiting the volume or quantity of means available (Yip et al, 2012). It is believed that through restricting access to means, serious self-harm and suicide can be prevented as it may help to delay the

process of thinking about harming oneself and acting on suicidal thoughts (Florentine & Crane, 2010; Hawton, 2002). Means restriction is thought to be most beneficial when access to lethal means are restricted as literature suggests it changes the context of a potentially fatal incident and forces the use of a less lethal method (Yip, 2010; Hawton, 2007; 2005). As outlined in Chapter 2, section 2.7.3, this process is known as 'method substitution'. Literature demonstrates that means restrictions have been successfully used within community populations, and are thought to be responsible for the reduction in suicides involving paracetamol overdoses, poisoning using pesticides and household gasses, and suicides involving firearms (Mohamed et al, 2009; Ozanne-Smith et al, 2004; Haw et al, 2004; Bridges et al, 2004; Gunnell & Eddleston, 2003; Kreitman, 1976). The impact of restricting access to means have however not been explored within forensic mental health services (James et al, 2012). It is therefore important that research addresses the gap in current understanding. Despite little evidence to support the use of restricted access to means, within forensic mental health hospitals access to a wide range of methods that pose both a high and low risk to life are restricted, and in many instances completely prohibited (Tromans et al, 2019; Sarkur, 2011).

9.1.3.1 Creating a beast – "a necessary evil"

Whilst the staff and women understood and believed that, at times, restricting access to means was necessary to uphold safety, the findings evidence a general consensus regarding restricting access to means as a not an overly effective management response. In fact, the findings indicate that restricting access to means can contribute to the worsening of self-harm, and the enactment of life-threatening self-harm. Most commonly, the findings report that restricting access to means can increase women's levels of distress, which is one of the most commonly cited reasons, for self-harm behaviours (Nock, 2009; NHS England, 2013; NICE, 2013). Furthermore, the findings evidence that, for some, restricting access to means reinforces the reasons why women enact life-threatening self-harm (see chapter 7).

Firstly, the women and staff reported how restricting access to means often involves taking women's possessions away, in a bid to prevent them from using them to self-harm. Whilst this appears to be a logical prevention strategy, the women and staff report how for some, this can act as a significant event. It is likely that the increased levels of distress may in part explained by the fact that restricting access to means in forensic mental health hospitals removes individual possessions that belong to service users. This is different to means restrictions

within the community, whereby access to things such as paracetamol or high-rise buildings are restricted (Mohamed et al, 2009; Ozanne-Smith et al, 2004; Haw et al, 2004; Bridges et al, 2004; Gunnell & Eddleston, 2003; Kreitman, 1976). In doing so, unlike within the community, means restrictions within forensic mental health hospitals involve items that are personal, individual, and often of high sentimental value. Such a suggestion would ring true to additional findings from the current research which report that women and staff do not believe that restricting access to means offers a therapeutic intervention, as taking people's possessions away does not help to manage or alleviate urges to self-harm, or offer an alternative way to cope. As a result, those who took part reported that as women in forensic mental health services have very few possessions, taking away their belongings can make women feel powerless, which was reported in chapter 6 (section 6.6), to increase levels of distress. Therefore, as means restrictions does not offer alternative coping strategies, the findings indicate that when access to lower lethality means are restricted, the women can feel overwhelmed and unable to cope with their distress. This is concerning considering a function of life-threatening self-harm can be to deal with overwhelming distress following a significant life event (The Overwhelmed sub-type) (see chapter 7, section 7.4).

Secondly, the findings indicate that, for many, being restricted from accessing their possessions can be perceived as a controlling experience, which can trigger memories and flashbacks of traumatic experiences. This aligns with previous literature that suggest that some elements of care environments can inadvertently recreate conditions that activate the memories of traumatic events (Bloom & Farragher, 2013). These findings are particularly important considering those previously documented in chapter 7 (section 7.8), which evidenced for some, the function of life-threatening self-harm is to cope with and stop flashbacks and intrusive thoughts of traumatic experiences. Arguably, the findings relating to the potential for restricting access to means to re-traumatise women, offers further evidence that some elements of forensic mental health care can be detrimental to the well-being of its service users (Sweeny et al, 2015). It is therefore important to consider the practical implications of the findings from the current research, as previous literature shows how experiencing elements of care as traumatic, can significantly limit the ability of service users to engage in future treatment (Amaro et al, 2002). Consequentially, the literature, which relates to trauma-informed care, suggests that services must acknowledge how its day-to-day operations can impact its service users, and actively avoid re-traumatisation (Hales et al, 2018). Fallot & Harris (2009) posit a trauma-informed care approach can be achieved through

fostering feelings of safety, trustworthiness, choice, collaboration and empowerment. The findings from the current research are however in conflict with the suggestions of Fallot & Harris (2009) and indicate how restricting access to means can create the opposite effects to trauma-informed care (i.e. feeling controlled, powerlessness, and unable to make decisions).

For others, restricting access to means can induce feelings of frustration and intense anger, which can, for some, trigger life-threatening self-harm. The women and staff explained how disempowering situations (like restricting access to means) can foster a sense of injustice regarding the deprivation of their liberty, and towards mental health providers. As outlined in chapter 7 (section, 7.10), for some women, their sense of frustration, disempowerment and anger can cause heightened levels of arousal, which they feel only able to cope with way by using life-threatening self-harm. This confirms literature that evidences a relationship between anger, and heightened arousal with self-harm (Harmon-Jones, Summerelle & Bastein, 2018; Rogers et al, 2015; Ramirez & Andreu, 2006; Baron, 1971). Therefore, the findings evidence how restricting access to means can play a role in the pathway to life-threatening self-harm for The Angry-Controlled-Aroused sub-type (chapter 7, section 7.10).

Finally, the findings evidenced that restricting access to means can also play a role in life-threatening self-harm for women who enact life-threatening self-harm to elicit care from others (see Chapter 7, section 7.6). At times, when risk is considered particularly high, some women are nursed in seclusion or sterile areas; meaning contact with other people is restricted. This extends to members of staff and their peers, as care is delivered to women through a locked door of a seclusion suite. Therefore, the women and staff who took part in the current research explained how life-threatening self-harm offered an effective way to bring staff into the seclusion suite (to allow for medical intervention), and in doing so, provide the women with care. Whilst it is accepted that at times some women may benefit from the containment secluded nursing provides, the findings from the current research indicate that the isolation that occurs as a result of restriction to people and means may increase risk of life-threatening self-harm. The findings may therefore explain why previous literature has identified people in seclusion or segregation at high risk of self-harm and suicide (Hilton, Ham & Seko, 2019; Vakiparta et al, 2019). Additionally, the women explained how being restricted from people and physical means, during times of seclusion, gives women time to think about how they can self-harm using what they have in their new environment. This may explain why previous literature has noted the use of unusual methods of self-harm within forensic mental health services, including occlusion of the airways with bodily by-products (Sarkur et al, 2011).

9.1.3.2 Adaptive Species

The findings also evidence how in the absence of alternative coping strategies, when access to lower lethality methods are restricted and to cope with increased levels of distress, women will seek alternative methods to enact self-harm, (see chapter 8, section 8.6). Importantly, these findings evidence that method substitution does occur within forensic mental health hospitals as a result of restricting access to means. Unfortunately, however, unlike within community literature whereby restrictions cause substitution to lower lethality methods (Yip et al, 2010; Hawton et al, 2002), the findings demonstrate how restricting access to means can in fact cause substitutions towards higher lethality methods. The women and staff who took part in the current research reported that method substitution to higher lethality methods occurs as, unlike within the community, access to many means are completely *removed* and not simply restricted within forensic mental health hospitals. Consequentially, unlike within the community where less harmful methods are employed (Hawton et al, 2002), women enlist the only resources they have available to them to help manage their distress, which normally includes using bodily by-products or fixtures and fittings to occlude the airways, or interfering with pre-existing wounds (see chapter 8, section 8.6.1). These findings align with claims from The National Institute for Health and Clinical Excellence (NICE, 2004), who note, that attempting to prevent an individual from self-harm may in fact increase the frequency, and potential lethality of the behaviour. The findings from the current study therefore have explanatory value as to why previous literature has noted the variability and use of unusual methods of self-harm amongst forensic mental health services (James et al, 2012; Klein, 2012; Sarkur et al, 2011). Furthermore, it confirms that means restrictions are in part responsible for their use (James et al, 2012; Klein, 2012; Sarkur et al, 2011).

The findings from the research are therefore able to expand the current understanding about the impacts of restricting access to means. The findings have important implications, as unlike within community literature, it is suggested that restricting and removing access to means in forensic mental health services can increase the lethality of self-harm. As a result, the findings indicate that restricting access to means plays a role in life-threatening self-harm and contribute to it occurring. These findings are important, as currently restricting access to means within forensic mental health services has been justified and informed by community literature, which seems to conflict with the findings from this forensic mental health population. It is, however, recognised that as the research did not directly test the impact of

restricting access to means, and it is the first to shed light on the consequences of means restrictions in forensic mental health services, further research is required. This presents an important direction for future research.

9.1.4 Novel Contributions to knowledge

In summary, the current research has offered a unique insight into the self-harm behaviour of women in forensic mental health services. It has provided an overview of the severity, frequency and variability of methods that are used by the female forensic mental health population and has demonstrated the negative impacts witnessing life-threatening self-harm has on both staff and patient well-being. These findings have important implications and raise questions as to whether forensic mental health services adequately protect the well-being of staff and service users, and consider whether they are able to keep women safe. The research also offers guidance as to the most appropriate language to use when describing life-threatening and non-life-threatening self-harm amongst the female forensic mental health population. In doing so, crucially, the research expands our understanding of the functions of, and pathways to, life-threatening self-harm, and offers an alternative explanation to current literature, by evidencing that life-threatening self-harm is not motivated by suicidal intent. Instead, the research posits there are seven functions of life-threatening self-harm, and seven different ways that the behaviour develops. As a result, the findings highlight an important need to consider the development of a new theoretical framework, as currently no models of self-harm or suicidal behaviour adequately explain the development of life-threatening self-harm. Finally, the research also explored the impact of restricting access to means. Unlike within community populations, the findings indicate that restricting access to means can cause method substitution to higher lethality methods. This raises important questions as to the effectiveness of current prevention strategies, and highlights and important area for future research.

Therefore, the findings from the current research were able to answer the following research questions.

- **Is life-threatening self-harm enacted with suicidal intent?**

Unlike within community and prison populations, in most instances, life-threatening self-harm was understood to be enacted without suicidal intent. Instead, the women and staff

understood life-threatening self-harm to be motivated and maintained by seven functions that are more aligned with self-harm.

- **What are functions of, and pathways to, life-threatening self-harm?**

The findings posit there are seven functions of, and pathways to, life-threatening self-harm. These include:

1) The Overwhelmed sub-type, who enacts life-threatening self-harm to manage overwhelming distress in response to a significant life event;
2) The Taught sub-type, who enacts life-threatening self-harm using methods that have been learnt from others to improve their ability to manage distress;
3) The Care Eliciting sub-type, who enacts life-threatening self-harm to elicit the care of members of staff;
4) The Am I Worth Saving sub-type, who enacts life-threatening self-harm to test whether care providers are able to save their lives, and to determine whether their lives are worth saving;
5) The Trauma-Threat-Responder sub-type, who enact life-threatening self-harm to cope with intrusive thoughts and flashbacks associated with past experiences;
6) The Progressive sub-type, whose life-threatening self-harm develops as part of a continuum, whereby it is believed that non-life-threatening methods are able to adequate manage distressing emotions;
7) The Angry-Controlled-Aroused sub-type, who enacts life-threatening self-harm to articulate the internal frustration, anger and over arousal they are experiencing.

- **Does restricting access to means of self-harm play a contributory role in the development of life-threatening self-harm?**

The findings indicate that restricting access to means can play a contributory role in the development of life-threatening self-harm. Restricting access to means can act as a significant life event for some women in forensic mental health services, which increase levels of distress. This can result in feelings of powerlessness and being overwhelmed by the situation, which can trigger life-threatening self-harm. For others, having their possessions removed can be perceived as a controlling experience, which can trigger flashbacks and intrusive thoughts related to past traumatic experiences and life-threatening self-harm. Restricting access to means also facilitates frustration, intense anger, and disempowerment, which can lead to

heightened arousal. For some, the only way to manage and reduce heightened arousal is to enact life-threatening self-harm. Means restrictions also contribute to method substitution, which unlike in community settings can increase the lethality of self-harm. It is thought that the findings relating to means restrictions can explain the considerable variability and severity of self-harm methods in forensic mental health services.

Consequentially, the findings of the research are novel in that:

- To the authors knowledge, it is the first study to explore life-threatening self-harm within the female forensic mental health population
- It is the first study to utilise a Participatory Action Research framework to study self-harm and suicidal behaviours within the female forensic mental health population
- It is the first study to provide an in-depth account of the functions of life-threatening self-harm, and the seven functions provided are unique to the female forensic mental health population.
- It is the first study to advocate that life-threatening self-harm amongst the female forensic population is for the majority, not motivated by suicidal intentions. This is distinctly different to the prison population, which highlights the need to recognise forensic mental health service users as a distinct population.
- It is the first study to provide the lived experiential knowledge of both women service users and members of staff in one study. In doing so, the findings offer an exclusive picture of life-threatening self-harm in forensic mental health services.
- To the authors' knowledge, it is the first study to preliminarily explore the impact of restricting access to means on the severity of self-harm within forensic mental health services.

9.2 Considerations for Research

9.2.1 Validate the findings amongst the wider female forensic mental health population

Chapter 2, section 2.4, identified a lack of evidence pertaining to the functions of life-threatening self-harm. The literature was limited across both the prison and general population; however, the understanding was significantly lacking for the forensic mental health population. Therefore, the current study aimed to address the gap, and explore the

functions of, and pathways to life-threatening self-harm. As previously discussed in section 9.2, those who took part in the current study reported they believed that in the majority of instances, life-threatening self-harm amongst women in forensic mental health services is enacted without suicidal intent. Instead, the women and staff reported that there are seven functions of life-threatening self-harm, which have been presented as sub-groups (see Chapter 7). As detailed above in section 9.4, the findings from the current research also show how restricting access to means plays a role in life-threatening self-harm. Until now however, there has been little research that explores the impact of restricting access to means amongst forensic mental health services (James et al, 2012; Klein, 2012; Sarkur et al, 2011), meaning literature pertaining to restricting means in the community, has informed and justified their used.

Collectively, the findings from the current study therefore extend our understanding of life-threatening self-harm amongst the female forensic mental health population. However, given the lack of other literature, to confirm the existence of life-threatening sub-types, and to fully understand the impact of restricting access to means, it is necessary for future research to validate the findings from the current study across the wider female forensic mental health population. Through validating the findings, future research will assist with the development of a new theoretical model, which adequately explains why people enact life-threatening self-harm, and how the behaviour develops. Such literature would also help to clarify how forensic mental health services can increase their responsivity to the needs of women. This is important; as previous literature has shown how often forensic services do not capture the vulnerabilities and mental health needs of women (Corston, 2007).

As the findings from the current research were informed by the lived experiential knowledge of women and staff, to assist with triangulation (and therefore the validation) of the findings, it would be helpful for future research to consider how they can directly test the presence of sub-types, and of the impacts of restricting access to means. Collectively, if the findings from the current research were validated, it would be necessary and warranted to review current prevention strategies and consider alternative ways to prevent life-threatening self-harm.

9.2.2 Explore the findings amongst the male forensic mental health population

Considering literature that highlights the discrete gender differences between self-harm and suicidal behaviour (Bresin & Schoenleber, 2018; WHO, 2018; Bresin & Schoenleber, 2015;

Hawton, 2008), it would also be interesting for future research to explore whether the findings from the current research are applicable to male forensic mental health patients. This would be important, as life-threatening self-harm is not an exclusive behaviour to females (Fox et al, 2018; Rivlin et al, 2012; Douglas et al, 2004). Furthermore, whilst the findings from the current study found some similarities between the sub-groups of men that enact near-fatal self-harm (Rivlin et al, 2013), and women who enact life-threatening self-harm, it also identified a number of differences. Therefore a more comprehensive evidence base could broaden our knowledge about whether there are gender differences in the functions of, and pathways to life-threatening self-harm, the impact of restricting access to means, and the experiences of men who enact life-threatening self-harm and the staff who care for them.

9.2.3 Explore the findings amongst the wider mental health population

Although there are many differences between forensic mental health patients and those from the wider mental health population, chapter 2 highlights how there are many shared risk factors for self-harm and suicidal behaviour (see chapter 2, section 2.4). Furthermore, chapter 2, (section 2.4) identified there are also shared risk factors between members of the general population and the prison population who enact life-threatening self-harm. Therefore, whilst the current research was conducted with a sample of female forensic mental health patients only, considering the known overlaps between features of their non-suicidal self-injury and suicidal behaviour, it would be interesting to explore whether the findings from the current research are generalisable to the wider mental health, and general populations. If future research identifies similar, or the same sub-groups amongst other populations, the findings could help have a significant impact on national self-harm prevention strategies.

Furthermore, validating the findings of the current research amongst other populations would help to reinforce the suggestions that self-harm and suicidal behaviours do not fit within homogenous groups (Ward, 2012), and that life-threatening self-harm falls outside of either category offered by the DSM-5 (2013) (i.e. non-suicidal self-injury or suicidal behaviour). Such a body of literature would therefore serve to bolster previous suggestions that self-harm and suicide ought to be considered as existing upon part of a continuum of behaviours (Kapur et al, 2013; Butler & Malone, 2013; Klonsky, 2013; Muehelenkamp & Gutierrez, 2007; O'Carroll et al, 1996; Stanley et al, 1992).

Finally, the findings from the current study are concerning as currently, means restrictions are widely adopted as a self-harm and suicide preventative strategy across many mental health services including: forensic mental health wards; prisons; inpatient units; psychiatric intensive care units; acute mental health wards; learning disability services; residential accommodation; rehabilitation services; and to some extent, older adults mental health units (Preventing Suicide in England, 2012). It is therefore warranted for a wider exploration of the impact of restricting access to means, and for research to clarify whether the same findings from the current study are noted in other populations in receipt of mental health care. Collectively, a body of knowledge on the impacts of restricting access to means would help to clarify whether there is a need to make changes to current self-harm and suicide prevention policies for mental health service users.

9.3 Considerations for practice

As this study was the first to explore the functions of, and pathways to life-threatening self-harm amongst the female forensic mental health population, this research can broaden knowledge and understanding and inform current practice. The findings have clearly shown to have relevance to understanding the experience of working or living within an environment where women enact serious self-harm behaviours. The findings, which posit life-threatening self-harm occurs without suicidal intent, have clear relevance in better understanding the functions of, and pathways to life-threatening self-harm. Furthermore, given that restricting access to means has been shown to have a role in the occurrence of life-threatening self-harm, continuing to understand how to best protect the safety of women in forensic mental health units is vital.

Therefore, it is essential to apply the knowledge generated in this research to the forensic mental health population and consider how this may be best achieved. In doing so, forensic mental health services may be able to identify the functions of life-threatening self-harm with more ease and deliver appropriate interventions that aim to reduce the behaviour. It is however important to recognise the challenges that forensic mental health services face when trying to prevent life-threatening self-harm, as for some women in their care, their self-harm behaviours are significantly engrained and have been life-long behaviours.

9.3.1 Make changes to current training

The findings from this study supports the need for changes to the current training of staff, so that they can better understanding the functions of, and pathways to life-threatening self-harm. The integration of the findings into staff training would aid in the identification of those at risk of life-threatening self-harm, and assist with assessment, treatment and formulation. In addition, a more in-depth understanding of the impacts of restricting access to means would be beneficial, as it may encourage staff to consider what alternative preventative strategies may help to manage risk before enforcing restrictions. Training should also include an emphasis on using appropriate terminology to describe and report incidents of life-threatening and non-life-threatening self-harm. In doing so, the use of appropriate language may assist with developing a shared understanding between staff and women about their self-harm behaviours.

The benefits of integrating the findings of the current research into staff training may be particularly impactful for staff with limited experience of working with life-threatening self-harm. This is on account of literature that has documented that less experienced members of staff are at increased risk of developing symptoms of trauma through frequent exposure to self-harm behaviours (Abendroth & Figley, 2014; Craig & Sprang, 2010; Figley, 1995). Therefore, offering comprehensive training to newer members of staff offers a valid way to build resilience, as literature reports members of staff who have a good insight into the reasons for self-harm are more likely to be resilient to the effects of witnessing serious self-harm (Ludick & Figley, 2016).

The findings of the current research also suggest that it may be helpful for secure forensic services to provide training to women regarding the risks associated with life-threatening self-harm. The findings show that some women enact life-threatening self-harm to articulate their overwhelming distress (see chapter 7, section 7,4), to elicit care from others (see chapter 7, section 7.6) or to cope with flashbacks and intrusive thoughts related to past trauma (see chapter 7, section 7.8). Therefore, helping women to develop alternative coping strategies and teaching them how to improve their ability to communicate distress and ask for help, may help to reduce the frequency of life-threatening self-harm. Improving communication skills, developing alternative coping strategies to manage distress, and teaching people how to ask for help, have both been shown as effective ways of reducing self-harm (Muehlenkamp, 2006; Linehan, 1993).

9.3.2 Limiting exposure to life-threatening self-harm

The findings from the current research indicate that frequently witnessing life-threatening self-harm can be detrimental to both staff and patient well-being. As outlined in chapter 6, some women and some staff report experiencing symptoms of trauma, as a result of their exposure to life-threatening self-harm. Worryingly, the findings report that such exposure can trigger life-threatening self-harm amongst women (see Chapter 7, The Trauma-Threat-Responder). Furthermore, exposure can provide an opportunity for women to learn new methods from each other (see chapter 7, The Taught and The Progressive), and to learn that life-threatening self-harm is an effective way to elicit care from members of staff (see chapter 7, The Care Eliciting, and The Am I Worth Saving). These findings present important areas for clinical consideration, as they are at odds with the aim of secure mental health services, which are designed to provide a safe, therapeutic environments, in which service users are able desist from self-harm and recover from mental illness (Vollm, 2017). Therefore, considering the findings from the current research which outline the consequences of exposure to life-threatening self-harm, forensic mental health services ought to consider ways to limit women's exposure to other people's life-threatening self-harm, and protect the well-being of staff.

To achieve this, it may be helpful to draw practical ideas from prison literature that evidences how creating therapeutic communities (which focus on developing a shared goal of desisting from adverse behaviours), can help to promote and increase recovery (Aos et al, 2006; Mitchell et al, 2006; Lipton et al, 2002). Literature suggests that through developing a climate whereby a reduction in adverse behaviour is encouraged, people can positively influence each other, and reduce exposure to individuals who justify or encourage the maintenance of adverse behaviour (Grace et al, 2016; Swann & James, 2002). The findings from the current research, when considered alongside prison literature, may suggest a need for specific areas of wards that provide an enhanced focus on self-harm recovery.

9.3.3 Reducing the need to elicit care

The findings from this research also indicate that a proportion of women enact life-threatening self-harm with the aim of eliciting care (see Chapter 7, section 7.6 and 7.7). For some women,

they enact life-threatening self-harm to obtain emotional and psychological support, whereas others seek a medical response. In some instances, enacting life-threatening self-harm can also be used to direct care from other women on the ward. Therefore, women who seek care from others learn that enacting life-threatening self-harm is the most effective way to elicit care from members of staff, compared other forms of communication, or lower lethality self-harm.

Therefore, it is important for forensic mental health services to consider how they can meet the emotional, psychological and medical needs of women who desire care from staff, so that they do not feel the need to enact life-threatening self-harm. As previously suggested, a way to achieve this may lie in developing the communication skills and help seeking strategies of women who enact life-threatening self-harm to elicit care. This is because the findings evidenced that some women do not develop the necessary skills to elicit care in an appropriate way, as many have had experiences of neglectful caregivers, who did not recognise or meet their care needs when asked. This aligns with literature that highlights how experiences of neglectful caregivers can result in deficits in communication skills and help seeking strategies amongst those who self-harm (Nock, 2009). Developing communication and help seeking behaviours alone will not, however, meet the function of life-threatening self-harm amongst those who seek to elicit care. Instead, any steps to reduce the risk of life-threatening self-harm must include opportunities for women to also receive emotional and psychological support and feel cared for by their caregivers.

Literature has demonstrated that 'checking in' with patients who self-harm can help to validate their distress and build a therapeutic alliance between staff and service users (Nafisi & Stanley, 2007). In doing so, Nafisi & Stanley, (2007) posit that improving therapeutic relationships can help service users feel able to share their distress with staff and notify them when they have urges to self-harm. Forensic mental health services may therefore want to consider how they can designate time to 'check in' with women who enact life-threatening self-harm and provided them with designated time to discuss their well-being and self-harm behaviours with a member of staff. In conjunction with communication and help seeking skills development, it may be possible that providing designated time to receive emotional and psychological support from staff, may help to meet the function of their life-threatening self-harm without women having to engage in the behaviour.

9.3.4 Post-incident response

Considering the findings that evidenced how frequently baring witness to incidents of life-threatening self-harm can be traumatic, (see chapter 6, section 6.5 and Chapter 7, section 7.8), it is important for forensic mental health services to consider how their post-incident response can limit the impacts on service users. This is on account of the findings that demonstrate how witnessing life-threatening self-harm can be emotionally taxing and can trigger life-threatening self-harm in women. This is, in part, due to witnessing other people's self-harm leading to increased levels of distress (see chapter 7, section 7.4), and partly because it can remind people of their own traumatic experiences whereby they used self-harm to cope (see chapter 7, section 7.8). Furthermore, when incidents occur, the increased levels of support afforded to the individual enacting life-threatening self-harm can result in other women feeling compelled to enact life-threatening self-harm to redirect care towards themselves (see chapter 7, section 7.6). This is important, as the findings from this research, and of previous literature (Ortiz & Khin Kihn, 2018; Berman & Walley, 2006; Taiminen et al, 1996), may explain why forensic mental health services report a 'contagion' or 'domino effect', whereby multiple service users enact self-harm in quick succession. It is therefore important that forensic mental health services consider how the well-being of other service users is given due consideration following an incident of life-threatening self-harm.

One such example may be the introduction of a debrief protocol, whereby staff can monitor the well-being of women following an incident of life-threatening self-harm and determine whether she is experiencing any urges to self-harm. Whilst the effectiveness of single psychological debriefs following traumatic incidents has been contested within the general population (Atwater, 2016; Rose, Bisson & Wessley, 2003; Rose et al, 2002), debriefing has been shown to be effective amongst those who self-harm (Holley et al, 2012). The findings from this research may help to explain the differences found between populations. Firstly, it is possible that enlisting something similar to a debrief would assist forensic mental health services to identify, and proactively support women who have been triggered by their peers self-harming behaviour. This may include increasing levels of observations or assisting a woman to utilise alternative coping strategies. Secondly, by affording women time to speak about the experience of witnessing life-threatening self-harm, it may remove the need of some women to enact life-threatening self-harm to elicit the care and support of others.

Considering this research found that the traumatising effects of witnessing life-threatening self-harm also extend to members of staff (see chapter 6, section 6.5), there is also a need for forensic mental health services to consider how they can better manage the well-being of its staff. As described in Chapter 6 (section 6.5), it was common for the staff who took part in this research to report that they believed they had personally, or had known a colleague, who had experienced symptoms of trauma as a result of witnessing frequent life-threatening self-harm. The staff described the high personal costs of working with women who enacted life-threatening self-harm, and gave examples of times where they have avoided situations outside of work, or have been triggered by everyday activities that remind them of incidents at work (see Chapter 6, section 6.5). Arguably, these findings may in part offer an explanation as to why forensic mental health services experience staffing shortages, and why those who do work within them experience high rates of burnout (Garcia, 2017; Happell, Pinikahana & Martin, 2003).

Considering these findings, it may be advantageous for forensic mental health services to review the current system in place to support staff and introduce additional measures to help reduce the risk of staff experiencing symptoms of trauma. This is because currently, literature posits that there are not enough systems in place to protect the psychological well-being off staff that experience traumatic incidents (Graham, 2012). Consequentially, literature reports that members of staff often feel unable to report their own trauma due to shame (Rubino et al, 2009; Shubs, 2008), stigma (Linton, 1995), and fears surrounding professional implications (Miller, 1998). To overcome this, arguably, services must adopt a service wide acceptance that staff can and do become traumatized through the course of their work (Barid & Jenkins, 2003; Walsh & Clarke, 2003). Additionally, Beryl et al (2018) and Hartman (1995) suggest the symptoms of trauma should be addressed and alleviated through a focus on trauma specific supervision, which ought to be made accessible to all staff. Finally, Blore (2011) and The Red Poppy Company (2011) advocate the importance of staff being able to access independent organisations that are purchased privately to provide trauma support and counselling to staff. Therefore, in line with current literature, this research suggests it would be beneficial for forensic mental health services to pay closer attention to dealing with the impact of witnessing life-threatening self-harm through pro-actively making services available to staff in a non-judgmental, confidential way.

9.4 Methodological Strengths and Limitations of the Research

9.4.1 Strengths

A notable strength of the research outlined within the current thesis was the inclusion of women and staff as participants. This is novel in that to the authors' knowledge, there has not been a study that incorporates the lived testimony of both staff and women, to inform our understanding of life-threatening self-harm within forensic mental health services. It is important that both women and staff were included, as it is well documented that the forensic mental health population are difficult to access for the purposes of research (Livingstone et al, 2012). Consequentially, it is rare for research to hear the voices and experiential knowledge of women detained within forensic mental health services, and the staff who care for them. It is however acknowledged that the research only captured the cognitive perceptions and understanding of life-threatening self-harm (i.e. what the women and staff think or have experienced). In all likelihood, due to the complex nature of life-threatening self-harm, a more in-depth understanding could be achieved through capturing a range of biological and environmental factors, which the research was not designed to capture.

An additional strength of the research was the use of the women and staff as member checkers. Literature has previously argued that using participants as member checkers offers a method of data triangulation (Bekhet & Zauszniewski, 2012; Casey & Murphy, 2009), which can help to improve the validity of research findings (Bekhet & Zausziweski, 2012; Halcomb & Andrews, 2005). In the case of the current research, participants were enlisted as member checkers through a staff focus group and individual meetings with the women, whereby the main themes were presented to, and critiqued by the participants. Enlisting participants as member checkers aligns seamlessly with the Participatory Action Research framework, whereby participants ought to be involved at each stage of the research, including where possible, data analysis (Ward & Bailey, 2013). In doing so, the findings from the current research are more likely to accurately represent the experiences of the women and staff, and not the interpretations of the author.

The findings also recognise that populations who are often excluded from research possess valuable information that can help to enrich our understanding of complex behaviours. In particular, the research evidences that populations such as those in receipt of forensic mental health care offer academics a unique opportunity to study behaviours that are poorly understood over time, and from the perspective of both staff and women. Fundamentally, through educating people regarding the development of life-threatening self-harm, it is

possible to design appropriate prevention strategies to help stop the severity of self-harm escalating amongst many populations.

9.4.2 Limitations

Although the research was novel in that it was, to the author's knowledge, the first to adopt a Participatory Action Research (PAR) framework to engage women and staff from the forensic mental health population, there were limitations to the methodology. In particular this relates to the need for PAR projects to be designed with, and for the community under study. As detailed within chapter 5, although wherever possible the women were included in the initial design and refinement of the project, the opinions of the staff and wider stakeholders were more represented than those of the women. As reported in Chapter 5, this is because it was not possible to approach the women before obtaining ethical approval, meaning the study had to be designed without their explicit input. It would therefore be useful for future research to be conducted in populations were pre-existing professional relationships and access already exist, to ensure that service users can be more involved in the designing phases of future projects. This may identify clinicians as particularly suitable for research with vulnerable populations.

There are also a number of limitations related to the sample used within the study, including the small sample size of women service users that could be recruited. Additionally, the final sample of women across all studies only included those held within the high security hospital and not the medium or low secure services. Whilst the experiential knowledge was obtained from staff in all three settings, including the medium and low secure hospital sites, the inability to represent the voices of women impacts on the generalisability of the findings across the pathway. However, this is not unique to this study, as being unable to engage women resident within medium and low secure hospitals is likely to be symptomatic of conducting research with highly vulnerable, mentally unwell people. The mental illness and risk status of these women increases the likelihood of their being unable to engage, or staff indicating they are not suitable to take part in research at a particular time.

Secondly, the findings from the research were obtained from one forensic mental health pathway (one NHS trust), meaning it must not be assumed that the findings can be generalised to other NHS trusts or forensic pathways. Finally, the perceptions and accounts detailed within

the research include only included women who are currently detained within forensic mental health services. Consequentially, the research was unable to represent the experiences of women who no longer require the care of forensic mental health services. As a result, the research may have overlooked the valuable experiential knowledge of those who can now look back on their time as service users with the benefit of retrospect and hindsight. Collectively, the aforementioned methodological limitations mean the findings cannot be generalised to all women from the forensic mental health population who have enacted life-threatening self-harm. Therefore, to aid the validity of the findings, it would be important for future research to conduct a similar study with a larger group of women from different levels of security, (including the community forensic mental health population), and in different forensic pathways. Replicating the research would help to reinforce the recommendations detailed above, and act as evidential support for changes to the current forensic mental health system to improve the care of female service users.

Despite the need to validate the findings from the current research, it is likely that the findings will in fact prove useful to a range of populations. Although the research was conducted only with women from forensic mental health services, overall the findings offer an interesting perspective that may help to reposition self-harm that poses high risk to life, outside the realms of suicidal intent. Notably, this may apply to members of other populations who cite non-suicidal reasons for enacting potentially lethal self-harm (see chapter 2, section 2.4). It may be possible to generalize the findings to other people who self-harm, as whilst forensic mental health patients are unique in many ways, they also share many similarities with both the prison and general population in terms of proximal and distal risk factors for their behaviour (see chapter 2, section 2.4). Consequentially, it is possible that the functions of life-threatening self-harm may be shared by other people who have had similar life experiences, and who have struggle to communicate their distress or seeking care appropriately. Therefore, through recognising that not all life-threatening self-harm is suicidal in nature, the findings from the current research offer a new perspective, which may help to clarify why other people enact life-threatening self-harm and inform new prevention strategies.

9.5 Conclusion

Self-harm and suicide are major public health problems, which can contribute to many life-long adverse outcomes. The costs of self-harm and suicide are high at both an individual and societal level and have considerable financial implications for health services. In particular,

self-harm and suicide are known to be more prevalent amongst the forensic mental health population. Whilst some claim that self-harm and suicide are distinctly different behaviours, recent literature advocates that the separation of self-harm and suicide may be more challenging than originally thought, as an additional type of self-harm behaviour has been noted. Life-threatening self-harm refers to self-harm that without medical intervention, is serious enough to bring about death.

The literature review reported within chapters one and two highlight previous literature, which situates life-threatening self-harm within the context of suicidal behaviour. Therefore, survivors of life-threatening self-harm are considered the best proxies to inform research about suicide. However, as reported within chapter two, amongst literature, there is a proportion of people who enact self-harm without suicidal intent. Therefore, additional research into life-threatening self-harm was needed. This was particularly true for the forensic mental health population, as currently literature has only explored the behaviour amongst members of the general and prison populations. Consequentially, literature from the prison and general populations informs clinical practice for forensic mental health service users, without understanding whether the findings are generalizable. This includes self-harm and suicide prevention strategies, including restricting access to means. Therefore, the current literature aimed to address the current gap in literature, in a bid to better understand the functions of, and pathways to, life-threatening self-harm amongst women receiving forensic mental health care.

Sixteen members of staff and seven women from various levels of security were enlisted to take part in semi-structured interviews. The findings presented a unique picture of life-threatening self-harm amongst a rarely accessed population. The findings indicate that women receiving forensic mental health care do not enact life-threatening self-harm with suicidal intent. Instead, the women and staff who took part in the research posit there are seven alternative functions of, and pathways to, life-threatening self-harm. The findings also indicate that working with or living amongst women who enact life-threatening self-harm is emotionally taxing. Furthermore, the findings suggest that restricting access to means play a contributory role in life-threatening self-harm. The findings of the research have been discussed in with reference to future research, clinical implications and the methodological limitations.

9.6 Critical Reflections - Future Research Planss

As detailed within Chapter 5 (section 4.1), participatory action research posits that the community under study should collectively decide how the outcomes of the research and any health promotion efforts are disseminated (Kelly, 2005). The dissemination of the research findings are an important aspect of any PAR research project as they act as the last stage of a project and cause the final PAR cycle to close. When discussing dissemination, the women and staff felt it was important to share the findings of the research with the staff and senior management teams at their forensic mental health hospital. It was suggested that this could take place during the Trust research forums, or on the secure side of each hospital to facilitate the women who took part to attend and co-facilitate. A planning phase is currently underway with the forensic services to ensure this happens. Three members of staff and 2 women volunteered to take part in the dissemination plans.

It was also an important belief that the findings of the research ought to be published in academic journals to help develop a shared understanding amongst those who work within forensic mental health services. Therefore, in light of the feedback regarding dissemination, to help close the final PAR cycle, a publication plan is in place, and I plan to submit four main papers to academic journals. The first paper will consist of the findings detailed within Chapter 7 and will present the seven functions of and pathways to life-threatening self-harm. This paper will be submitted to The Journal of Suicide and Life-Threatening Behaviour. The second paper will present the findings from chapter 6, and focus on the experience of living amongst, or working with women who enact life-threatening self-harm. This paper will be submitted to the International Journal of Forensic Mental Health. The third paper will provide an exploratory overview of the findings from chapter 8, which will aim to highlight the issues with restricting access to means in forensic mental health services. This paper will be submitted to The Journal of Crisis and Suicide Prevention. The final paper will be a systematic review, which explores the evidence relating to life-threatening and near-lethal self-harm. This paper will be submitted to The Journal of Suicide and Life-Threatening Behaviour. In line with PAR, key stakeholders, and where possible, women will be invited to co-author the publications.

I feel strongly that the findings of the aforementioned research are used to inform and validate a completed draft assessment tool. After a phase of critical reflection, I felt the most appropriate way to ensure this happens was to make an application to undertake this research as part of my Doctorate in Clinical Psychology. To ensure the women, staff and wider stakeholders are included in this process their opinions and advice will be sought, and individuals who took part will be approached and offered a patient/public advisor role. This application is currently under review.

Appendices

Appendix A – Health Research Authority Ethical Approval

NHS
Health Research Authority

Miss Sophie Oakes-Rogers
PhD Student
Nottingham Trent University
Chaucer 3211
Goldsmith Street
Nottingham
NG1 4BU

Email: hra.approval@nhs.net

12 January 2017

Dear Sophie,

Letter of HRA Approval

Study title:	**Exploring the differences between self-harm and suicide in females with complex mental health needs.**
IRAS project ID:	**199758**
Protocol number:	**N0254525**
REC reference:	**16/EM/0364**
Sponsor	**Nottingham Trent University**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

Appendix B – Nottingham Trent University Project Approval

NOTTINGHAM TRENT UNIVERSITY

Miss Sophie Oakes-Rogers
18 Ware Road
Hertford
SG13 7HH

Professor Clare Brindley
Graduate School Administrator
Nottingham Trent University Graduate School
Tel: +44 (0)115 848 8124
Fax: +44 (0)115 848 8700
Email: clare.brindley@ntu.ac.uk

22 January 2016

Dear Sophie

Application for Project Approval for a Research Degree

I am writing to confirm formally that your research proposal has been accepted by the College Research Degrees Committee. Your research project has been registered for MPhil with possibility of transfer to PhD.

The title of your project is 'Exploring the Differences Between Self-Harm and Suicide in Female Offenders with Complex Mental Health Needs'. Your supervisory team comprises Professor Di Bailey as your Director of Studies, plus Dr Karen Slade and Peter Benbow as Co-Supervisors. If any of these details change in the future, please could you notify me at once, as we are required to keep the College Research Records up to date.

Please can you ensure that the supervisors sections regarding completions and training are fully completed on all future forms.

The date of your registration is 01 October 2015. This means that you have until 30 September 2019 to submit for an MPhil/PhD.

Yours sincerely

C.S. Brindley

Professor Clare Brindley
Chair College Research Degrees Committee

cc: Di Bailey

Nottingham Trent University
Burton Street, Nottingham NG1 4BU
Tel. +44 (0)115 941 8418 www.ntu.ac.uk

Appendix C – Nottinghamshire NHS Healthcare Honorary Contract

HONORARY CONTRACT
(Non-Employed Status)

Between:	**Nottinghamshire Healthcare NHS Foundation Trust**
	And
Name:	**Sophie Oakes-Rogers**
Address:	**Flat 3, Tudor Court, Walter Street, Nottingham, NG7 4GD**

A condition of being granted an honorary contract and/or key holder access to high and secure hospitals for individuals not employed by the Trust (whether acting in a legal capacity, on behalf of their employer, an agency or themselves i.e. self employed or on secondment, student placement etc.) is that the contract holder must at all times abide by the terms of this contract. You should note that the contract **binds you personally** to the conditions herein. Breach of contract may lead to legal action being taken against the individual, withdrawal of keys if a key holder and/or termination of the honorary contract or access to site. An honorary contract holder will not necessarily be permitted key holder access.

1. Honorary Contract/Access

1.1 The purpose for your honorary contract is – PHD Research Student

1.2 Your honorary contract/access will commence on 01 March 2017 and end on 31 September 2019

1.3 For the purpose of this honorary contract you will be given key holder access. In any event your access is restricted to those areas necessary to conduct your legitimate business/reason for attending site to facilitate the above.

2. Payment

2.1 No payment will be made to you by the Trust in regard of your contract. However, if, as part of your training scheme, you receive a training allowance paid on behalf of your training body by the Trust, you must complete and submit the relevant time sheet to your supervising manager on a weekly basis.

2.2 If, as part of your training scheme, you are required to travel to other locations within the Trust, approval may be given by your supervising manager to payment of these expenses at public transport rate.

3. Termination

Breach of the terms of this contract may lead to the immediate termination of the honorary contract and/or the facility to draw keys and/or access to premises. Termination in other cases will be consistent with the reasons for you no longer holding an honorary contract or requiring key holder access and may be with no or limited notice.

Appendix D – Nottinghamshire NHS Healthcare Letter of support

positive about integrated healthcare

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Associate Director of Nursing for Nursing, Quality & Patient Experience: Forensic Services
Philip Champ Management Centre
Rampton Hospital
Retford
Nottinghamshire
DN22 0PD

E-mail: louise.bussel @nottshc.nhs.uk
Direct Line: (01777) 247201

Tel: (01777) 248321
Fax: (01777) 247575

Our ref: LB/new
Your ref:

19th April 2016

To whom it may concern:

I am writing to confirm the Forensic Divisions support for the study being carried out within the Women's Service by Sophie Oakes-Rogers. Here aim is to *'explore the differences between their self-harm and suicide behavior. Enlisting Walsh's (2012) theory, the aim is to develop an assessment tool for healthcare professionals to better assess risk of self-harm and suicide based on lethality. The assessment tool will be designed based on the experiences and needs of women so it can also be used by themselves as part of the self-support and self-management of their self-harm.'* The research will span the Women's Services within the Division with Sophie holding an honorary contract with the Trust and completing any of the training required of her. Jane Jones, Advance Practitioner will be her main point of contact for the project and both Sophie and Jane will provide regular updates to the Division on the progress of the work.

Yours sincerely

Louise Bussell
Associate Director of Nursing, Quality & Patient Experience: Forensic Services

Copy to: Sophie Oakes-Rogers
Lynne Corcoran
Di Bailey

Appendix E – Nottingham Trent University Professional Indemnity Insurance

Hasilwood House
60 Bishopsgate
London EC2N 4AW
Tel: 020 7847 8670
Fax: 020 7847 8689

TO WHOM IT MAY CONCERN

20th July 2015

Dear Sir/Madam

THE NOTTINGHAM TRENT UNIVERSITY
AND ALL ITS SUBSIDIARY COMPANIES

We confirm that the above Institution is a Member of U.M. Association Limited, and that the following cover is currently in place:-

PROFESSIONAL INDEMNITY

Certificate of Entry No.	UM056/01
Period of Cover	1 August 2015 to 31 July 2016
Limit of Indemnity	£10,000,000 any one claim and in the aggregate except for Pollution where cover is limited to £1,000,000 in the aggregate.
Cover provided by	U.M. Association Limited and Excess Cover Providers led by CNA Insurance Company Limited

If you have any queries in respect of the above details, please do not hesitate to contact us.

Yours faithfully

Susan Wilkinson
For U.M. Association Limited

U.M. Association Limited
Registered Office: Hasilwood House, 60 Bishopsgate, London, EC2N 4AW
Registered in England and Wales No. 2731799

Appendix F - Women's Consent Form

positive

Nottinghamshire Healthcare NHS
NHS Foundation Trust

AUDIT REPORT

CONFIDENTIAL

AUDIT INFORMATION	
Audit Type	Research Project
Investigator(s)	Sally Morton/Kayley Whyatt Lindsey Peggs (Observing)
Title(s)	Research and Innovation Support Officers

AUDIT DETAILS	
Title of Study	Exploring the differences between self-harm and suicide in females with complex mental health needs.
Edge Id	88587
Audit Code	17004
Site of research	Rampton Hospital, Arnold Lodge and Wells Road.
Location of audit	Nottingham Trent University
Date & Time	12 July 2017 at 10am
Study team audited	Miss Sophie Oakes-Rogers Dr Di Bailey (Supervisor)

AUDIT REPORT DETAILS	
Date of Draft Report	12 July 2017
Date of Final Report	20 July 2017

A. AUDIT SUMMARY

No issues were identified during the audit which requires further action:

Appendix G - Women's Consent Form

School of Social Science
Nottingham Trent University
Burton Street
Nottingham, NG1 4BU

Title of Project: Exploring the differences between self-harming and suicidal behaviour in females with complex mental health needs.

Centre Name:

Study Number: N0254525

Participant Identification Number for interview:

Name of Researcher: Sophie Oakes-Rogers

WOMENS INTERVIEW CONSENT FORM

Thank you for agreeing to take part in an interview for this research project. So that we can start, it is important that you tick ALL of the following questions to show that you understand what the project is about, what you will have to do, and to show that **you** made the decision to take part. So that I can see that you agree to take part and agree with the information provided please tick each of the following statements and sign below.

Consent Statement		I agree
1	I confirm I have received, read, and understood the information sheet dated 01/11/2016 (version 4). I understand I am going to be taking part in an interview with the researcher and I have had an opportunity to ask any questions.	
2	I understand that it is my decision to take part in the study and that it is not part of any current programmes or treatment I am part of.	
3	I understand I am free stop the interview at any time and withdraw from the study without my medical care or legal rights being affected.	
4	I understand that I am able to withdraw my data from the project for up to 6 weeks after the interview has taken place. If I choose to withdraw my data the transcript from my interview will be deleted any information I provided during the interview will not be used to inform the draft assessment tool. I understand that after this period I will be unable to withdraw my data.	
5	I agree for my interview to be audio recorded, transcribed, analysed by the researcher, and anonymously quoted from in the writing up of this research.	
6	I understand that any personal information relating to my experiences is confidential unless I report any disclosure of criminal activity or information relating to safeguarding. I understand that Sophie has a duty to report any disclosures of this nature.	
7	I understand that other in order to help Sophie make sure she has correctly understood what you have said during your interview Di Bailey, Karen Slade and Peter Benbow may look at the data collected. Di, Karen and Peter work for Nottingham Trent University and their job is to supervise Sophie during the research. I give permission for these people to see my data.	
8	I agree to my Responsible Clinician being informed of my participation in the study.	
9	I confirm that I have been told what member of staff I should speak too in case I would like to talk to someone at any point after the interview has finished.	
10	I agree to take part in this research project.	

I understand that by signing below I am providing informed, voluntary content to take part in the research project above:

_____ _____ _____

Name of Participant Date Signature

Sophie Oakes-Rogers		
Name of Person	Date	Signature

taking consent

PLEASE TURN OVER

I understand that during the different stages of the research, if I become too unwell to take part, any data collected from a previous stage will be kept and used to inform the draft assessment tool.

Name of Participant	Date	Signature

Sophie Oakes-Rogers		
Name of Person	Date	Signature

taking consent

Appendix H - Staff Consent Form

School of Social Science

Nottingham Trent University

Burton Street

Nottingham, NG1 4BU

Title of Project: Exploring the differences between self-harming and suicidal behaviour in females with complex mental health needs.

Centre Name:

Study Number: N0254525

Participant Identification Number for interview:

Name of Researcher: Sophie Oakes-Rogers

STAFF INTERVIEW CONSENT FORM

Thank you for agreeing to take part in an interview for this research project. In order to take part it is important that you provide consent and answer the following questions to demonstrate you understand what the project is about, that you understand what you will have to do, and to evidence that you give voluntary consent to take part. To provide consent, please write your initials in each of the following boxes:

1. I confirm that I have read the information sheet dated 01/11/2016 (version4) for the above study and understand I am going to be taking part in an interview with the researcher. I have had the opportunity to consider the information, ask questions and have
   had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my employment or legal rights being affected.

3. I understand that I am able to withdraw my data from the project for up to 6 weeks after the interview has taken place. If I choose to withdraw my data the transcript from my interview will be deleted any information I provided during the interview will not be used to inform the draft assessment tool. I understand that after this period I will be unable to withdraw my data.

4. I understand that to ensure the researcher has correctly understood what you have said during your interview, relevant sections of my data collected during the study may be looked at by the Di Bailey, Karen Slade and Peter Benbow who make up the supervisory team for the research from Nottingham Trent University. I give permission for these individuals to have access to my records.

5. I understand that in order to keep my anonymity, I will be allocated a pseudonym which I will be referred to during the dissemination (writing up) of findings.

6. I understand that this research forms the basis of the researcher's PhD degree and therefore findings from the study will be disseminated in a final thesis. I understand that some anonymised quotations from my interview may be published in the thesis or journal publications.

7. I agree to my Manager being informed of my participation in the study so that appropriate arrangements can be made to ensure suitable dates are organised for my interview.

8. I can confirm that I have been given information of whom I should speak to should I feel I require additional support after the interview has ended.

9. I agree to take part in the above study.

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix I – Staff Interview Topic Guide

Intro questions:

Introduce self and remind that participation is voluntary – overview of the project and its aims.

Tell me a bit about yourself; what's your job role?

How long have your worked here?

How did you end up working here?

What made you decide forensics was for you?

Experiences:

So tell me about your experiences of working with women who self-harm.

- PROMPTS
- How do you look after yourself and your own wellbeing when working with these women?

Understanding:

So often as practitioners we talk about the 'lethality' of someone's self-harm, tell me about what you understand by this term and how you would define it.

- What do you know about the risk factors involved in near-lethal self-harm?
- Tell me about why you think women self-harm with methods that pose high lethality to life?
- And what about women who don't use potentially lethal methods what do you think is going on for them?
- Is NLSH enacted with to suicidal intent? Tell me about why you think this or what about your experience makes you think this?

What do you think the key difference is between women who self-harms using methods that pose low-risk to life and those who engage in near-lethal self-harm?

From your own experiences, what risk factors do you think are the key things we should be looking for when trying to understand who is at risk of engaging in near-lethal self-harm?

- PROMPTS
- This doesn't have to be from an assessment perspective, this could be from your experience in practise.
- So if you had to summarise your top 5/6/7/8/9/10 what would they be?
- What protective factors are there?
- What about triggers, is there any commonality between the women?
- So does this explain the pathway to near-lethal self-harm? Do you think there are varied pathways to near-lethal self-harm?

So I wanted to try and understand a bit more about if and how the restrictive environment of forensic services plays a role in the selection of methods that pose a high risk to life, what is your understanding or experience of this?

What do you think the women would think were their key risk factors of near-lethal self-harm?

- How do you think their understanding would be different to a member of staff?

Assessment:

1. Tell me about how you go about assessing risk of self-harm and suicide. Talk me through what you do any why.
   - PROMPTS
   - Do you have a particular tool you tend to use more often than any others?
   - Are there any key issues you have when using them on your women?

Okay so I wanted to show you some of the questions that are from the current risk assessment tools used across the trust.

2. Tell me about your initial thoughts of these.
   - PROMPTS
   - What do you make of some of the statements?
   - Do you think they are suitable for women receiving forensic services?
   - appearance, language, readability, length

Activity 1:

What I would like you to do is to sort these statements/ questions into three groups;

1. the first group to represent the questions you feel help to capture risk,
2. the second pile for questions/statements you think are kind of helpful
3. the third pile for the ones you think completely miss the point.

Can you tell me why you have grouped these like this

- What is similar about the questions in each group?
- So the ones that you think miss the point, how could we improve these?

So now would you be able to write on these blank cards what you think is missing.

Okay so as we know some of the assessments we use involve different method of obtaining information. For example some are self-report patient completed, others are staff led and some use a collaborative care approach. What do you think the benefits of each type of assessment are?

- How do you think an assessment tool should look like which meets the needs of collaborative care and risk management, and one where we can make defendable decisions by?

Concluding questions:

So to reiterate, based on your experience what do you think are the key risk factors for near-lethal self-harm?

Do you think I have missed anything during out discussion that could help me better understand near-lethal self-harm?

What other questions could I have asked, where there any you didn't understand or that seemed irrelevant?

How could the interview have gone better?, do you have any questions you want to ask me?

Appendix J – Womens' Interview Topic Guide

Intro questions:

Introduce myself- thanks for taking part. Talk about what the interview is going to cover (lived experience, personal expertise, hearing your story, no right or wrong answers, trying to learn the best I can from you). Explain withdrawal (interview can stop at any time just let me know, you do not need to explain why you want to stop and I am happy to come back another day if you want).

*Safeguarding - reiterate who to speak to if they want to discuss the interview, or feel like they might want some extra support.

Tell me a bit about yourself (how old are you, where are you from, what are your likes and dislikes)

How long have you been here?

Is this the first service you have been cared for in?

Experiences:

So a main focus of this interview is to try and understand self-harm and suicidal behaviour within forensic services a bit better – I think we can do this by hearing your story, so your personal experiences and the experiences you have of others self-harming. Would you mind sharing some of your experiences of self-harm within hospital with me?

- PROMPTS
- Personal / experiences of others
- How often does it happen?
- How does it make you feel when others self-harm?

Understanding:

So often, as practitioners we call different types of self-harm different things – could you tell me what words you have heard, and what these words mean to you? What do you think we mean we are describing when we say these terms?

- What do you call different types of self-harm?
- What are the differences between self-harm of different severities? So self-harm that doesn't pose a risk to life and that that does?
- Tell me why you think women engage in lower-lethality self-harm?
- And what about when they engage in self-harm that is risky to their life?

- Can you tell me from your experience whether women who engage in self-harm that poses a high risk to life can, and do, engage in self-harm that doesn't?
- What do you think are the differences between women who engage in lower lethality and higher lethality self-harm?
- Sometimes when women engage in self-harm that poses a high risk to like it can look as though they are trying to end their lives – can you talk to me about whether this is what is happening or not?
- What do you notice happens before the higher lethality self-harm happens? (triggers)
- What can you notice about their behaviour?
- Can you tell me how do you think they feel, and what is going on for them at that moment?
- What are the differences or similarities between the women who enact lower lethality and higher lethality self-harm?
- What you do think are the things that we should look for that would let us know a women was about to engage in self-harm that poses high risk to life?
- Can you tell me about how you think women chose their methods of self-harm?
- Can you tell me if any of the restrictions (either the hospital itself, or when staff are trying to keep you safe) play a part in how you choose how you are going to self-harm?
- Can you tell me about how you keep yourself safe, and what can help women not engage in self-harm?

Okay so lots of the things you have just told me about are called risk factors. What do you understand about the term risk factor?

- Are there any other terms we could use that would make more sense to describe 'risk factors'?
- So what do you think are the biggest risk factors for women engaging in dangerous self-harm?
- If you have to order them say 1-5, with 1 being the most important?

What do you think the staff who work here think are the key risk factors of self-harm that poses high risk to life?

- How do you think their understanding would be the same/different to yours?

<u>Assessment:</u>

3. From your experience, can you tell me about how a risk assessment happens when staff are trying to find out if a women is at risk engaging in self-harm?
    a. Do you do these together? What do you think about this?
4. From your experience, tell me about the current risk assessments – have you taken part in many, do you think they are helpful for finding out who is at risk?

    <u>PROMPTS</u>

    - What improvements would you like to see?

Okay so I wanted to show you some of the questions that are from the current risk assessment tools used across the trust.

5. Tell me about your initial thoughts of these.
    - PROMPTS
    - What do you make of some of the statements?
    - Do you think they are suitable for women receiving forensic services?
    - (appearance, language, readability, length)

Activity 1:

What I would like you to do is to sort these statements/ questions into three groups;

4. the first group to represent the questions you feel help to capture risk,
5. the second pile for questions/statements you think are kind of helpful
6. the third pile for the ones you think completely miss the point.

Can you tell me why you have grouped these like this?

- What is similar about the questions in each group?
- So the ones that you think miss the point, how could we improve these?

So, I wondered if you could write on these blank cards what you think is missing – if it helps you can tell me what you think and I will write them down.

How do you think is the best way to ask women whether they are thinking about self-harming?

- Are there any questions you might find it hard to answer? If so can you tell me why?
- What questions do you think staff might find it hard to ask? Why do you think this?
- What do you think about assessments where you have to choose a value for an answer like 1,2,3,4, or 5? Are they easy or hard to answer?
- Can you what you think would be the best way to do as assessment, should they be done by staff, should they be completed by the women, should they be completed together?
- How do you think our new draft assessment tool should look? How is it going to be completed?
- If you had the opportunity, would you like to help design the new tool (draw pictures etc.)?

Concluding questions:

So just to make sure I am clear, based on your experience what do you think are the main things we can look for which might tell us a women is going to engage in LTSH?

And to summarise you think our assessment tool should be completed like X, and should look like Y.

Do you think I have missed anything during out discussion that could help me better understand LTSH?

What other questions could I have asked, where there any you did not understand?

How could the interview have gone better?

Do you have any questions you want to ask me?

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