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Painful lives: Understanding self-harm amongst care-experienced women in prison

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Abstract

Self-harm incidents in custody in England and Wales recently reached a record high, increasing particularly in women's establishments. This article explores experiences of self-harm by drawing on interviews with care-experienced women in prison in England. Using prior care experience as the underlying thread enables us to explore this topic through a different lens. Considering the functions of self-harm that women described, including the communication, alleviation and ending of pain, highlights the painful lives of those experiencing both state care and control institutions. This reveals that women have often been failed across different systems, sometimes with devastating consequences. Urgent attention must be paid to the system failures affecting those previously deemed by the state to require welfare and protection.

Keywords

Care-experienced, imprisoned women, self-harm, system-failures, trauma

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Introduction

In her pioneering work on embodying punishment, Chamberlen (2018: 167) observes how coping strategies for women in prison 'reveal the body as a vessel of survival'. This finding was powerfully highlighted by care-experienced women in prison in our recent interviews, and starkly evident in many of our face-to-face encounters. Whilst Chamberlen's participants frequently came from traumatic backgrounds, her study did not explore prior care experience among those previously in care[1] as children. This article builds on Chamberlen's (2018) call to re-focus on the body as a site of pain and punishment among criminalised women, while extending our knowledge by considering self-harm in prison among those previously deemed by the state to be in need of welfare, protection and support.

Ministry of Justice (MoJ) (2020) data reveal that self-harm incidents in custody in England and Wales reached a record high of 63,328 incidents in the 12 months to December 2019, up 14% on the previous year. These figures highlight that self-harm trends differ considerably by gender, with a rate of 3,130 incidents per 1,000 prisoners in women's establishments, compared with 650 incidents per 1000 prisoners in men's establishments (MoJ, 2020). While self-harm in prison is not a new issue (Carlen, 1988; Corston, 2007), this evidence is deeply concerning and highlights the need for urgent action.

While it has long been recognised that care-experienced women are particularly over-represented in prison (and more so than care-experienced men and boys), identifying the exact numbers is challenging (Innovation Unit, 2019). One study found that 24% of adult males and 31% of adult females in custody had been in the care system as a child (MoJ, 2012). However, these are highly likely to be underestimates due to the difficulties in identifying prior care status amongst those in locked institutions (Fitzpatrick, 2020).

This article uses care-experience as the underlying thread to connect women's experiences in the past and present, with a specific focus on understanding self-harm. Drawing on semi-structured interviews with imprisoned women, we argue that care-experience provides crucial contextual information for understanding the lives of some criminalised women who self-harm. Exploring the various functions of self-harm revealed by women, including the communication, alleviation and ending of pain, enables us to highlight themes of continuity and change in the stories of those who navigate both state care and control institutions. Importantly, this allows us to move beyond a sole focus on the narrow lens of the criminal justice system (Carlen, 1988), supporting both a deeper understanding of women's lives and highlighting how they may have been failed across different systems.

Messages from research

As Chandler (2013: 717) notes, '(t)he terminology around self-harm is highly contested'. She defines self-injury as 'cutting, burning or hitting [of] the body' (2013: 717), and a distinct corporeal practice from self-poisoning (overdosing). Similarly, Agenda (2020: 7) define self-harm as 'self-inflicted injury without suicidal intent'. We share this view of self-harm while considering both self-harm and suicidality. While recognised in much

literature as distinct entities, research highlights a strong association between self-harm and past or current suicidality among prisoners (Favril et al., 2020). Indeed, suicide attempts may exist along a continuum of self-harm behaviours within the prison context. Chamberlen (2018: 169) describes self-harm as 'a conflictual form of coping and self-expression' for women in prison, conceptualising this as 'emotion work' which is often directed at the body (p. 183) – an account which certainly resonates with our findings.

Despite long-standing interest in the links between self-harm and being in care, and between self-harm and experiences of imprisonment, little is known about the interconnections between all three. We seek to bridge insights from these separate literatures here. Despite growing recognition across different countries of the relationship between childhood adversity and self-harming and/or suicidal behaviour by individuals in prison (see, for example, Angelakis et al.'s, 2020 international review) most studies have not focused on care experience. However, a case study of 50 prolific self-harmers for the Corston Review (2007) showed that a third of the imprisoned women had been in care as children. Given that children in care are more likely to self-harm than other children (Wadman et al., 2018) and previous self-harming behaviour is one of the strongest predictors of future self-harm (Favril et al., 2020), care-experienced prisoners may be at an even greater risk. There is stark evidence that imprisoned women are more likely than imprisoned men to self-harm and to be repeat self-harmers (Chamberlen, 2018; Corston, 2007); therefore, a focus on care-experienced women's specific experiences is vital.

Walker et al. (2020) found that 57% of those involved in their study of self-harm were care-experienced, although the latter issue was not specifically explored (see also Marzano et al., 2011). Favril et al.'s (2020) systematic review of 35 studies across 20 countries, noted 3 studies (Godet-Mardirossian et al., 2011; Liebling and Krarup, 1993; Rivlin et al., 2013) identifying experience of care as a significant risk factor for self-harm, although all focused on males.

However, exploring themes common to both children in care and care-experienced women illuminates how self-harm in prison may be the continuation of a behaviour that started in care and/or the result of failures to address existing trauma. Imprisonment itself can have a re-traumatising impact on women (Corston, 2007) which may reinforce feelings of loss and isolation experienced while in care, which could result in self-harm. Furthermore, self-harm may fulfil similar functions for both children in care and care-experienced women in prison, such as an expression of self-hatred or punishment (Furnivall, 2013; Kenning et al., 2010) or an act of survival where the body becomes a site of resistance to actively confront systems (Evans, 2018).

Self-harm as a coping strategy may be a particular issue for those with care-experience, who may have been unable to develop secure attachments to others (family, friends, school), which can be protective and reduce the risk of self-harm (Furnivall, 2013). For care-experienced women in prison, self-harm may continue to be, or become, a mechanism to exert control and to resist dependence on others (Evans, 2018; Liebling, 1994). Women in prison may experience multiple moves within the prison system, with concomitant changes in environment and regime, which have been associated with increased risk of self-harm (Kenning et al., 2010). Again, this may echo experiences in care where instability is prevalent, and self-harm may be experienced as a choice over which

individuals have control, within the context of placement moves and change (Wadman et al., 2018).

Children in care with a history of being let down, poor or abusive parenting, and experiences of rejection may be understandably reluctant to share intimate information about their emotional state (Stanley, 2007) or to ask for help while in care (Wadman et al., 2018). This may be pertinent for care-experienced women in prison who fear further rejection, particularly if they lack trust in prison staff and/or have fragmented relationships with birth families or previous carers. A difficult relationship with family members, and the associated lower levels of visits, letters and calls while in prison, can increase the risk of self-harm (Marzano et al., 2011).

Despite important exceptions (e.g. Chamberlen, 2018; Liebling, 1994), there is a tendency in the literature to focus on individual-level determinants of self-harm (e.g. Favril et al., 2020), highlighting what individuals lack, rather than what is lacking in the systems designed to support them. However, evidence shows that care-leavers in the criminal justice system often fall through the gaps of fragmented and underfunded systems (Innovation Unit, 2019). Moreover, a woeful lack of mental health support for care-experienced girls in the community severely limits the care system's ability to respond appropriately to trauma, and provide a supportive and compassionate response to self-harm. Indeed, some of the most vulnerable care-leavers in England are being failed by mental health services (Innovation Unit, 2019). In a High Court judgement in 2017, Sir Justice Munby criticised the 'disgraceful and utterly shaming lack of proper provision' for children in care with acute mental health needs[2]. Such failings place care-experienced girls and women at a greater risk of justice system involvement, and links with current concerns about their unnecessary criminalisation (Fitzpatrick, 2020), exploitation (Shaw and Greenhow, 2020) and possible abandonment to unregulated accommodation (Children's Commissioner, 2020) – all issues associated with the problem of instability in care (Staines, 2016).

There are also fundamental challenges in providing a supportive response to self-harm within custodial institutions, despite ongoing efforts to ensure prisons are trauma-informed. Indeed, recent evidence highlights that peer-led trauma-informed groups with women may provide a supportive and safe space in what remains an otherwise unsafe environment (Petrillo, 2021). Nevertheless, and similarly to some care settings, a lack of access to mental health support combined with inadequately trained staff (Corston, 2007) means that dismissive and reductive individualising responses to self-harm may be more rather than less likely.

Having sought to bridge insights from the care and prisons literatures, we pay particular attention in the discussion that follows to some of the system-level failures that may have affected women's lives.

Methods

We conducted 37 semi-structured interviews with care-experienced women across three closed women's prisons in England between September 2019 and February 2020. The interviews are part of a study funded by The Nuffield Foundation, which includes interviews with professionals and girls and young women in the community. Our focus here

is on the prison interviews. This research was approved by the Lancaster University Ethics Committee and Her Majesty's Prisons and Probation Service's National Research Committee. The British Society of Criminology's Statement of Ethics (2015: 5) requires researchers to 'strive to protect the rights of those they study, their interests, sensitivities and privacy'. We were acutely aware of this and maintained a flexible, respectful and non-judgemental approach throughout our research.

Interviews ranged between 20 minutes and 112 minutes, resulting in over 33 hours of audio material. Women received a £20 gift voucher to thank them for their time, accessible on release from prison. All interviews were transcribed and anonymised, with participants assigned a pseudonym, and thematically analysed using NVivo 12. Following team discussions of emerging themes, a detailed analytic framework of nodes and sub-nodes was created in NVivo. Each team member participated in the coding of transcripts, which led to further discussion and refinement of the overarching framework for analysis. Our findings on self-harm emerged organically, as this was not something initially asked about in interviews. However, we were struck by how many women chose to discuss their self-harm, as well as the visible signs of self-harm on other interviewees. In keeping with a Feminist approach that prioritises lived experience, amplifying the voices of marginalised women so often unheard (Burman and Gelsthorpe, 2017), it feels appropriate that our first article written on these interviews reflects a theme that many wanted to share.

Setting the scene

Most women described backgrounds of abuse, serious violence and trauma, and had multiple experiences of victimisation throughout their lives. Their biographies were filled with loss, pain and despair. Substance misuse and mental health issues were common themes. Of our 37 women, 17 raised self-harm and/or suicide as an issue: 14 reported self-harming and/or attempting suicide, and 6 women mentioned being 'suicidal', but it was unclear if they had attempted to take their own life. Visible signs of self-injury were also evident in our face-to-face encounters with others. The women reported being imprisoned for a range of offences, including Benefit Fraud, Dangerous Driving, Drug offences, Theft, Robbery and Violence Against the Person, which broadly reflected the overall sample. Of the 17 women, most identified as White British with two identifying their ethnicity as Mixed and one identifying as Black British. Research suggests that rates of self-harm are highest among Black women (Al-Sharifi et al., 2015), but this was not the case in our study. However, the ethnic minority sample was small overall, and the White research team may have influenced women's decisions to disclose self-harm. Among the sub-group of 17, 10 women were mothers and eight had had children taken into care and/or adopted. While not a focus of this article, we recognise that self-harm may be a collateral consequence of the painful experience of child removal (Broadhurst and Mason, 2020).

Exploring the early experiences of care-experienced women in prison highlights that self-harm does not always begin in prison. For some, it begins beforehand, including prior to or while in care. When the care system fails to equip girls with alternative coping strategies, it may continue in prison. Ten women noted when their self-harming

commenced, with four commenting that this occurred prior to entry to care and three starting while in care[3]. One woman started after leaving care but prior to prison and a further two started in prison. These numbers are small but indicate some continuity in experiences across state care and control systems. With this in mind, we now explore the various functions that self-harm may serve for imprisoned women.

Functions of self-harm

Communicating pain

A key theme to emerge was that self-harm served as a method of communication for some, described here as 'Communicating Pain'. This links to Chandler's discussion of self-harm as a 'visible signifier for unseen and inexpressible emotional pain' (2013: 723). As Marlene (38) explained, some women may struggle to communicate their pain in words:

> . . . it'll generally take an officer to say "right, behind your door" or something before I'll start crying and then I'll self-harm and then I'll explain. But I don't know how to say, 'look I'm feeling really low, I'm struggling, I need help', like verbally. I do that through actions.

For Marlene, self-harm became the method of communicating to prison officers that she was struggling and in need of support. However, for some women, self-harm also had an expressive function beyond individual pain and became an expression of collective anguish and the shared 'pains of imprisonment' (Chamberlen, 2018: 178), with recipients of this communication extending beyond staff to include other imprisoned women:

> There's a lot of self-harm in this prison, a lot. Because they don't feel heard, you know they don't get dealt with in the right manner. They just get locked away and fucking labelled. (Leanne, 32)

Not feeling listened to was a common theme among women relevant to both care and prison experiences, which could be compounded by difficulties articulating pain. Self-harm may be a practical alternative to verbal communication for women who are suffering in some way – and care-experienced women with a history of being let down may be particularly reluctant to trust the latest authority figures involved in their lives. Mandy (46), who entered care aged 11 following sexual abuse by a family member, noted that after being 'passed from pillar to post' in care, and sexually abused by a support worker in one children's home, 'I didn't want to work with any authority figures at all'. Mandy describes both her self-harm and offending as 'a cry for help' and a way of communicating trauma:

> I was a traumatic child, a traumatic teenage life, very out of control. . .I didn't know how to ask for help. Because in the care system I was never shown all that.

Of the 37 women we interviewed, 25 reported being sexually abused as a child, 12 of whom were abused in care placements. Indeed, these individuals endured further harm

and abuse in the very system supposed to protect them. Mandy's suggestion that this system also fails to teach traumatised children how to seek help highlights how abuse may endure in some care settings.

Recognising that self-harm is a collective/shared activity for some women led to interviewees comparing their experiences with others. For example, Kayleigh (32) distinguished her self-harm from the 'little scratches' of others as something much more serious, and distanced herself from those she perceived as 'attention seekers' by withdrawing into a more private space. This perception of attention-seeking perhaps reflects an absorption of wider narratives around self-harm that tend to be dismissive and reductive. Others also highlighted different levels of personal commitment to self-harm:

> I don't cut like Steph, she cuts to really hurt herself. I cut 'cos watching the blood and I've got thin blood. . .so a little cut and I piss out. And it takes everything off my mind. Steph means to hurt herself . . . when I heard her scream that other day you could smell the blood, it's a metallic smell and it was all over her hatch and she's another care, you get me, another self-harmer. (Joanne, 39)

In Joanne's account, she cuts to watch the blood which serves as a distraction, which contrasts to Steph who intends to 'really hurt herself'. Joanne's comments also highlight that self-harm may often be a sensory experience shared with others (cf. Herrity, 2020) – where other residents may hear the screams and smell the blood.

Both residents and staff are exposed to the sensory effects of self-harm, including the associated sights, smells and sounds. The traumatic impact of this should not be underestimated, but there is also a serious need to guard against the normalisation of self-harm. The Corston Report expressed shock at the apparent acceptance that self-harm is the norm for incarcerated women, along with the expectation that 'insufficiently trained' and 'sometimes uncomprehending' prison staff should deal with this 'as part of their normal daily (and nightly) routine' (Corston, 2007: 12). The normalisation of self-harm was certainly highlighted during our fieldwork, raising questions about how much has been achieved since this report was published. Moreover, comments about 'insufficiently trained staff' describe a situation equally applicable to some care and prison settings today (Innovation Unit, 2019).

Alleviating pain

A further function of self-harm highlighted by women was to 'alleviate pain' (see also Chamberlen, 2018; Chandler, 2013). An absence of timely mental health support could lead to an increase in individuals attempting to alleviate psychological pain. Indeed, those with care-experience may have learnt to turn feelings of anger or distress inwards, to avoid harming others or getting into trouble (Kenning et al., 2010; Wadman et al., 2018). Understanding how self-harm might serve to alleviate pain highlighted how it could be a very personal, often private, practice (despite the collective communication discussed earlier) that functioned variously as relief, control, distraction, and/or habit as well as a method of self-punishment and as a coping mechanism in difficult situations (Liebling, 1994).

Joanne (39) entered care aged 13 following domestic violence at home, and experienced six different foster care and children's homes placements. She described her self-harm as a 'control thing' for when she got 'angry or agitated' and felt that she had more control over life in prison than she had in care:

> I have got a bit of control in here . . . I can still say to them put me behind my door and they'll do it. I can still if I get angry and I want to cut up, I can cut up. . .you're telling me don't, but I can . . .I've still got choices in here. In the care system when you're a kid you've got no choices. Nobody asks you what you want . . . You never get taught how to cope with stress, the stress you're being put under being put in a new house or in a new group home.

Joanne's comments highlight something of the damage caused by multiple placement moves, and how the lack of agency that comes with not being consulted about decisions affecting their lives may ultimately lead care-experienced women to reflect that they have more control in prison. The suggestion here of a care experience that has created further trauma rather than helping her 'cope with stress', echoes Mandy's earlier comments about not being taught how to ask for help. Under these conditions, perhaps it is inevitable that individuals in care will develop their own coping strategies and ways of exercising agency.

Kayleigh described her self-harm, which began when she went into a children's home, as a release: 'I suppose with the self-harm and that it was a way of release, how other girls were releasing it, but then obviously it got into a habit for me'. (Kayleigh, 32) Paradoxically, self-harm may serve to alleviate one type of pain (emotional), but cause another (physical). From an embodied perspective, the effects of the physical may last for a long time as scars slowly heal and skin sores persist, particularly for those unable to access suitable treatment such as cream to help heal and soothe the subsequent discomfort. Consequently, a woman may find herself simultaneously alleviating psychological pain by creating physical pain, highlighting the contradictory experience of punishment and self-harm (Chamberlen, 2018).

Furthermore, while self-harm may begin as a method of alleviating pain, it could become something quite different:

> it's an addiction now, I could be in an alright mood, any mood, even like I just woke up and I just self-harm, but it's getting worse, it's getting really worse, I'm sticking like blades in me face at the minute. Like I haven't done it for two weeks which is really good, but I've got a pen and a screw stuck in me arm still . . . it won't come out. (Faye, 30)

The 'addiction' that Faye describes was very visible, including mutilation of her face. While this particular form of self-harm was only mentioned by one participant, prison staff we spoke to informally indicated that this type of self-injury was not uncommon. Faye notes that her self-harm began in a children's home. 'There was another lad he was cutting himself so I used to copy it off him, that's how I first started'. However, her observation that this has progressed to 'an addiction' implies that this practice is moving beyond her control – with a clear distinction between the factors underpinning onset and maintenance (Chandler, 2013). Faye's story powerfully highlights the fragility of agency within prison for those who feel they have lost control of their self-harming.

The discussion so far highlights the possibilities for continuity and change within and between individuals who self-harm, and across different state care and control institutions. The practice may continue, while the function it serves may alter. While self-harm may serve to alleviate pain in various ways, the alleviation of pain could ultimately be fatal.

Ending pain

Despite the distinction between non-lethal self-harm and self-harm which is suicidal in nature (e.g. Agenda, 2020), much evidence indicates that non-suicidal self-injury is an important risk factor for suicide attempts (Favril et al., 2020), and there is a 'stronger than normal relationship' between self-harm and suicide in the prison context (Corston, 2007:31). Given that suicide attempts may exist along a continuum of self-harm behaviours, 'ending pain' was identified as another function of self-harm among interviewees:

> I had a little wobble where I come off my meds just like that and then I tried to kill myself . . . I just wanted things to end. (Sophie, 24)

> I tried to commit suicide a couple of times, tried to take me own life where I succeeded but he brought me back three times. (Lynne, 43)

Indeed, five women reported attempting to take their own life on at least one occasion[4]. Among these women there was a clear theme of wanting 'things to end' when pain became unbearable. The methods used for such attempts included overdosing and ligature, but no participants mentioned cutting as a method of suicidal self-harm. This distinction was apparent in Kerryann's discussion:

> I was 11 when I first started cutting myself, then I started taking overdoses, the cutting wasn't to die but the overdoses were. (Kerryann, 34)

Kerryann's self-harm began prior to entering care at 13, but she observed this was something 'you see . . . quite often in children's homes', highlighting the care system's failure to encourage alternative coping strategies. Kerryann was placed in care after running away from home following sexual abuse by her brother. However, rather than experiencing care as a place of safety and protection, she also experienced sexual abuse by staff in the children's home and ran away again. This led to her being returned home for a period. The children's home was later shut down. Meanwhile, her self-harm continued well into adult life, including in prison.

Between March 2007 and March 2018, 37 women in prison in England and Wales took their own lives (INQUEST, 2018). Women in prison are nine times more likely to die by suicide than women in general (Fazel et al., 2017). Kayleigh, a long-term prisoner, highlighted the prevalence of suicide attempts:

> . . . there was one girl that's on my landing . . . literally every 20 minutes the officers was at her door "cos she was ligaturing to the point where an officer said . . . 'get up off the floor and take

> that ligature off your neck'. And then . . . someone was found hanging in their room and they're actually dead. That's what irritates me sometimes with people that do it for attention, when you've actually got people that are dead . . . who didn't do it for attention but actually want to die. (Kayleigh, 32)

Kayleigh's comments also suggest a potential blurring of the lines between the functions of self-harm. It is not always possible to determine whether an individual intends to communicate, alleviate or end pain which further complicates the issue (cf. Marzano et al., 2011). However, it is dangerous to assume self-harm is non-lethal (Liebling, 1994). The pervasiveness of self-harm and mental health issues within the prison setting make it extremely difficult for women to access timely support, resulting in some reaching crisis point:

> it is terrible here mental health wise . . . trying to see a doctor for mental health, or when you come in and your medication comes through, and they don't give you your meds for days . . . it's a long process that and it shouldn't be 'cos a lot of people were self-harming . . . trying to take their own lives. 'Cos they're not on the right medication or they can't get to see the mental health 'cos there's months and months waiting list'. (Lynne, 43)

Lynne's bleak depiction of mental health support was also apparent in the stories of others. In some ways, such accounts echo what is known about the insufficient support available in the community for girls in care, with increasing concerns that girls in distress may be deprived of their liberty in unregulated placements due to a severe shortage of appropriate secure accommodation[5]. Certainly, a lack of proper care and support could exacerbate issues for already vulnerable women. This is particularly worrying given the record level of self-harm incidents in custody (MoJ, 2020), and the strong evidence of a relationship between exposure to suicide and suicidal behaviour among those in institutional settings (Slade et al., 2019). The combined impact of poor mental health provision, proximity to self-harm behaviours and other stressors that care-experienced women are subjected to, can have devastating consequences.

Inadequate support in traumatising institutions

Inadequate support in care and custody was evident in many interviews, highlighting how responses to self-harm in prison may repeat experiences of movement and instability that women experienced in care. Inadequate and inappropriate mental health support, the absence of emotional support for the long-term impact of self-harm and the inability of the care system to provide safety were also common themes.

Self-harm may be responded to by movement within both care and prison settings. It can lead to girls in care having to move placement if there are fears for their safety or the safety of other children they live with, while women in prison may be moved onto a specific prison wing or a 'crisis wing' and placed under greater staff surveillance.

Cameron (25), who entered care aged 13, viewed care and prison as parallel systems characterised by movement and instability. Cameron reported having had 'loads' of placements, with many ending due to behavioural difficulties linked to their mental

ill-health and ADHD. Cameron was nevertheless critical of social workers who just 'blame the child' when a placement goes wrong and felt strongly that social workers should make more time to understand children in the same way that prison officers should take more time to understand suicidal prisoners – with a key focus being on making connections that focus on people as individuals:

> Out there is a system, in here is a system, and it's all the same. Social services is no different to prison. In prison you can move from prison to prison, that's like moving placements. . .It's a big fucking care home with loads of women . . . When your behaviour's disruptive you move to a next one . . . go all the way up the country, all the way down the country. And all they lack, the same thing is what they lack, the connection side. Get them to see the person. No one is the same. (Cameron, 25)

The contradiction is that stability and a settled placement is often exactly what is required to enable individuals to access mental health support and make connections with carers and staff. Movement and instability may be the opposite of what is needed but, for some women, is a continuous feature of their journeys from care to custody.

Some of our participants highlighted the particular challenges for imprisoned women:

> . . . (H)ealthcare's terrible. You ask for a mental health appointment and you're still sat waiting for the referral five months later. . .The medication queues don't help as well. I took myself off me anti-depressants because of how long the medication queues were . . . I was waiting like up to an hour and a half after work was called to get me anti-depressants . . . So I just decided to take myself off me meds and since then I just went downhill and I've had psychotic episodes . . . and it just sent me over the edge one day and I just slashed up. (Emily, 21)

Women may not only experience delays in accessing their medication on entry to prison but also in obtaining a mental health appointment and in collecting medication when it does become available. Such delays directly impacted on Emily's ability to get to her on-site job on time and ultimately led to her decision to stop taking her medication. Her comments about 'the medication queues' paint a painful image: 'there's roughly about thirty, forty girls a day in that queue'.

Some participants alluded to the difficulties of moving on from the effects of self-harm when the scars left behind may be long-lasting – following some women well beyond their departure through the prison gates (Chamberlen, 2018).

> I've self-harmed a lot since I've been in here, I've got scars on me arms I'll never be able to get rid of. (Emily, 21)

> I think I'm ugly anyway, so all these scars, I mean me legs are covered, it's not going to matter. (Marlene, 38)

Long-lasting scars caused by self-harm could inevitably impact on women's self-esteem – serving as memories of pain etched into the body. As Tyler (2020:199) observes in her discussion of stigma and self-harm, the 'body is a witness statement'. Moreover, '. . . scars and psychological wounds . . . testify to how stigma emerges

within wider degrading systems of social classification' (Tyler, 2020: 199). Within these systems, women commented on what were often contradictory and conflicted experiences of care and punishment. Some directed strong criticism for those entrusted to support them:

> . . . when a person wants to kill themselves, these officers half of them don't even give a monkey mate . . . when they're crying out 'I need help, I need help', no one's helping them. (Cameron, 25)

However, others were able to identify staff in both care and prison settings who had 'gone the extra mile' to support them, and who had held their hand when they cried. We certainly witnessed instances of such care during our fieldwork, and reiterate the comments made by Carlen (2001:467) that 'time-consuming but life-supporting responses involving listening, kindness and comfort' may be 'good in themselves'.

A particularly heart-breaking comment was made by Joanne (39) when comparing her prior experience in care to her current experience in prison:

> I always ran, I never felt safe, I feel safe in here, it's the only place I do feel safe is here.

Having spent her early years moving between women's refuges with her mother, Joanne entered care aged 13; she noted some of her carers were better than others, but she always ran from her placements. She met a boy in foster care whose parent introduced her to heroin, which she was addicted to by age 16. She was later sexually and physically assaulted by another boy in a children's home, leaving her unable to have children. Her comments about feeling safer in prison than in care are a damning indictment of the support and protection she received in care and highlights how some women will feel safer in the familiar setting of jail (as highlighted by Bucerius et al., 2021), which has serious implications for resettlement.

Marlene (38) also entered care from a violent family home, aged six, and described being abused in care as well as at the 'special school' she attended while in care. The care system also failed to provide her with the support and protection she needed and was unable to offer a place of safety. She noted,

> I thought I'd be saved by going to foster care but it was quite horrific to be honest . . . a good few years ago it came out on the news and stuff that they were investigating abuse that went on at that school when I was there, but I felt ashamed to go forward, loads of kids did go forward, but I still haven't . . . I would have liked to have given my story but I didn't know how.

Marlene's comments return us full circle to the theme of communicating pain while powerfully highlighting how care-experienced women may have been failed by multiple systems. Women's stories of inadequate support across various state systems (Clarke and Chadwick, 2017) clearly indicate how individuals may be left with few other options than to develop their own coping strategies, and the potential impact of this across their lives. In this analysis, self-harm can be understood as embodying the impact of individual pain in the context of wider structural failings.

Conclusion

While some care experiences are positive and protective against offending (Taylor, 2006), this was overwhelmingly not the case for the women in our study. As children, they frequently came from backgrounds of abuse, violence and trauma and some participants felt that they had needed to be removed from home. Yet too many were removed into a 'care' system that failed to address past trauma, provide sufficient support or encourage healthy strategies for coping with stress and the inevitable uncertainty that came from being 'passed from pillar to post'. In the worst cases, women experienced further abuse in care, including at the hands of the individuals charged to care for them. Already with histories of being labelled and judged by the ever-changing number of professionals involved in their lives, some experienced prison as simply the next stage of 'the system'.

In reflecting on painful lives, self-harm emerged as a key theme that many women chose to raise, but there was a blurring of the boundaries between the different functions underpinning this practice. Sometimes this was a long-established practice that developed prior to or in care; less often it was a practice that developed in prison. Against the backdrop of the wider pains of imprisonment, inadequate mental health provision in prison could further exacerbate existing problems. Within this context, women frequently used self-harm as a method of expressing, and sometimes alleviating, their pain. In the most severe cases, it became an attempt to end pain as women tried to take their own lives.

In setting the scene for the original empirical material presented here, this article bridges insights from the literatures on care and punishment that often remain separate. There is a need for greater dialogue between researchers in different disciplinary domains, echoing the need to make connections in practice between stories of the past and present. Using care-experience as the underlying thread enables us to identify elements of continuity and change in the practice of self-harm among individuals, as well as across state care and control institutions, taking us beyond a narrow focus on the criminal justice system (Carlen, 1988). Understanding self-harm amongst care-experienced women in prison requires an appreciation of the harm that may have touched women's lives at various points, including within birth families, care and prison. While self-harm can be conveniently reduced to individual disposition, it is far more challenging to trace the legacies of harm over individual lives which provides vital contextual information. Doing so leads us to understand self-harm as embodying the impact of individual pain amid wider structural failings in systems of care and punishment.

There are numerous reasons why women engage in self-harm, as well as differing degrees of pain and injury. Consequently, mechanisms for tackling this must involve listening to women without judgement, paying attention to their individual feelings and experiences, and crucially not creating further harm. Nevertheless, the importance of recognising and responding to individual experiences should not be confused with an endorsement of self-harm as an individual pathology, which has been central to explaining self-harm (and suicides) in prison (Sim, 2019). Certainly, there is a danger that an over-identification with this model of behaviour fails to acknowledge the very real impact of being incarcerated for which acts of self-harm may be a natural response (Sim,

2019). Indeed, INQUEST (2018) describe imprisonment as a form of structural violence against women and we would further argue that for some care-experienced women, it forms a continuum of such violence. As children in the care of the state, they are entitled to welfare, protection and support (Children and Social Work Act, 2017(1)). Instead, many suffer neglect at the hands of a system that seems perennially unable to fulfil its 'parental' responsibilities.

In recognising the value of the sociological perspective of self-harm (Chamberlen, 2018; Liebling, 1994), we argue that women's thoughts, feelings and experiences are shaped by socio-cultural and structural factors that, far from being inevitable, are amenable to intervention at various points throughout their lives. As the traumatic events that lead to self-harm often begin in childhood, while living in the family home and/or after going into care, we must ensure that mechanisms exist to develop and encourage effective coping strategies for girls in care, rather than expecting them to navigate a failing system that causes further trauma.

The welfare system–including early help, support in and after care–has been decimated under a succession of austerity-focused governments (Tyler, 2020). This must be reversed urgently, enabling local authorities to fulfil their parental responsibilities by facilitating swift access to mental health services and/or appropriate therapeutic accommodation for those who need it. Ensuring care staff receive sufficient training on trauma and self-harm should also be prioritised. Equally important is ensuring that the default response of the care system to challenging behaviour is not one of criminalisation and/or placement movement, meaning that it becomes harder still for children to access mental health and welfare support.

Notwithstanding the women who acknowledged that prison could be a place of familiarity and stability, prison is not the place to deal with so much pain, trauma and disadvantage. There is overwhelming evidence for the need to divert women from custody wherever possible, particularly avoiding sentences which separate women from their children causing more long-lasting trauma. We therefore advocate for far more investment in community-based alternatives to punishment for women who would not otherwise present a danger to others (INQUEST, 2018). Prisons are not the place to deal with the issue of self-harm and, for various reasons highlighted by this study, seem at times to perpetuate it.

Systemic change is urgently required, however prison reform is also needed for women in prison today who need immediate support, particularly given the impact of the COVID-19 pandemic. Indeed, the first strategy of Her Majesty's Prison and Probation Service (HMPPS) (2019) for care-experienced people offers an opportunity to embed care issues far more clearly into prison practice (Fitzpatrick, 2020). This could improve understanding of the long-term impact of trauma (Our Care, Our Say Group, 2021) and the wider context of women's lives. For it to make a real difference, this work must be appropriately resourced, supported with robust staff training, including on self-harm and mental health needs, and prioritised from the top to the bottom of the service. Moreover, the development of care-experienced mentoring groups within prisons could offer women an opportunity to use their lived experience to support and empower each other. There was evidence that such informal support already existed for some women during our fieldwork, but this must be developed consistently across the prison estate.

Using care-experience as the underlying thread to explore self-harm among imprisoned women enables us to see connections between stories of the past and present. It also provides crucial information for understanding the lives of some criminalised women who self-harm. Moving from the individual to the structural level, these personal stories bring into sharp focus the harms that may be endured across state care and control institutions within systems that can perpetuate further trauma. Women's painful stories undoubtedly confirm the body as a 'vessel of survival' (Chamberlen, 2018: 167), but even for the most resilient, there may reach a point when painful lives become overwhelming and where survival becomes too exhausting to sustain. The legacies of harm that persist through life for criminalised women can have devastating consequences. And when these harms persist, in part, due to the failure of the state as parent to provide appropriate safety, stability and support, then these issues should be matters of huge concern to us all. Not only do we need to listen to the voices of those who have suffered harm across state care and control institutions, but we need to act on them now.

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Notes

1. Children in care include those under 18 who are in the care of the local authority subject to a full care order under s 31 or looked after by voluntary agreement under s 20 of the Children Act 1989, including those in residential, foster and kinship care in England.
2. [2017] EWHC 2036 (Fam) In the matter of X (A Child) (No 3) s. 30
3. Initiation of self-harm while in care was also described in our interviews with girls and young women in the community.
4. A further 6 women mentioned being 'suicidal' but did not disclose whether this had involved a suicide attempt.
5. [2020] EWHC 2828 (Fam).

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