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_____ **Research Report** _____

**Staff Perspectives on Working with
Aboriginal Offenders who Self-Injure:
What Works, What Doesn't, and the
Role of Culture**

Ce rapport est également disponible en français. Pour en obtenir un exemplaire, veuillez vous adresser à la Direction de la recherche, Service correctionnel du Canada, 340, avenue Laurier Ouest, Ottawa (Ontario) K1A 0P9.

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**Staff Perspectives on Working with Aboriginal Offenders who Self-Injure:
What Works, What Doesn't, and the Role of Culture**

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Executive Summary

Key words: *Aboriginal offenders; interventions; correctional staff; self-injurious behaviour; mental health.*

Self-injurious behaviour (SIB) is complex and poses considerable challenges for those who self-injure and those who work with individuals who engage in this behaviour. SIB may be defined as any type of direct bodily harm or disfigurement that is deliberately inflicted on oneself that is *not* considered to be socially acceptable (Favazza, 1998, 1999; Simeon & Favazza, 2001; Walsh & Rosen, 1988). Self-injury that is undertaken without suicidal intent is called non-suicidal self-injury (NSSI). Although mental health professionals rate SIB as one of the most distressing, stressful, and traumatizing behaviours to work with (Gamble, Pearlman, Lucca, & Allen, 1994), there is limited research regarding how staff can effectively interact with offenders to promote better outcomes.

Using a culturally-informed approach, the present study was designed, to determine what strategies or interventions staff working with Aboriginal offenders with a history of SIB found to be effective. Fourteen CSC staff members working with Aboriginal offenders in the community and correctional institutions participated in focus groups or individual interviews. The focus groups and interviews addressed: 1) experiences working with Aboriginal offenders and offenders who engage in SIB; 2) challenges that arise when working with these populations; 3) treatment of self-injury; and 4) the role of culture in self-injury desistance. All interviews were recorded and later transcribed. Responses were categorized into themes and categories to demonstrate the commonalities between the participants' experiences.

There were two interrelated themes evident in all of the interviews and focus groups: (1) treat the whole person, not just the NSSI; and (2) the importance of establishing positive therapeutic relationships with offenders is fundamental to the treatment of NSSI. Responding in a supportive and direct way to an individual's NSSI was identified as an effective method of intervention that also contributes to the establishment of a positive therapeutic alliance. Most participants reported that a team approach is the most effective method of working with offenders who engage in NSSI, although in identifying the team members, it is important to include staff who do not respond negatively to NSSI, which can trigger increasingly negative reactions. To help support positive staff reactions, realistic goals must be set for the individuals receiving the intervention. While some study participants did mention using skills they learned in training, most staff did not feel that training on a specific intervention model was required.

Given that Aboriginal culture is different in many ways from the main stream culture, recognising the impact of this difference can be important when working with Aboriginal offenders. Many Aboriginal offenders have complicated backgrounds that influence their behaviour that must be taken into consideration. Culturally-based interventions, such as ceremonies and working with Elders, may be particularly helpful for this population. Approaches that involve fostering supportive and compassionate relationships between staff and offenders, however, are likely to be helpful for most offenders who engage in NSSI, and may be particularly important for offenders who have not had success with mainstream treatment.

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Introduction

Self-injurious behaviour (SIB) is complex and poses considerable challenges for those self-injure and those who work with individuals who engage in this behaviour. Within a correctional context, SIB results in considerable human and monetary costs (Dehart, Smith, & Kaminski, 2009) and therefore is an important issue for correctional systems. SIB may be defined as any type of direct bodily harm or disfigurement that is deliberately inflicted on oneself that is *not* considered to be socially acceptable (Favazza, 1998, 1999; Simeon & Favazza, 2001; Walsh & Rosen, 1988). The use of a variety of terms and definitions has been, and continues to be, used despite efforts in the literature to establish consistencies. The inconsistencies not only make finding information on this issue challenging but the use of different definitions makes comparisons between studies problematic (Nock, 2010). In this paper, three distinct terms will be used: (1) *non-suicidal self-injury (NSSI)* will refer to SIB in which there is no suicidal intent; (2) *SIB* will be used when suicidal intent is unknown or ambiguous; and (3) SIB in which there is suicidal intent will be called *suicide attempts*. Considerable research has been conducted on the origins, motivations, and nature of NSSI within the Correctional Service of Canada's (CSC) population.

Staff Working with Offenders who Self-Injure

Psychologists have rated SIB as the most distressing, stressful, and traumatizing client behaviour (Gamble, Pearlman, Lucca, & Allen, 1994). As a result, staff who work with offenders who engage in SIB may be at increased risk of burnout, a psychological syndrome characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach & Goldberg, 1998). The stress caused by NSSI is particularly concerning in correctional facilities, where staff already face a variety of high-stress situations and challenging behaviours on a regular basis (for a full review of this issue, see Power & Usher, 2010b). Given the often repetitive nature of SIB and the difficulties in effectively treating the behaviour, staff may feel a lack of personal accomplishment, or even a sense of failure, when the SIB continues, an experience associated with reduced job satisfaction among correctional officers (Griffin, Hogan, Lambert, Tucker-Gail, & Baker, 2010). Low job satisfaction is, in turn, associated with a number of negative outcomes, such as absenteeism (Lambert, Edwards, Camp, & Saylor, 2005), turnover (Dennis, 1998; Robinson, Porporino, & Simourd, 1997), low staff morale (Lambert,

2001), and burnout (Griffin, Hogan, Lambert, Tucker-Gail, & Baker, 2010; Whitehead & Lindquist, 1986; Whitehead, Lindquist, & Klofas, 1987). In addition to the likelihood of a decrease in the quality of work when job satisfaction is low, the financial costs are also readily apparent given the high costs of recruitment, testing, selection, and training of new staff (Gilbert, 1988; Stohr, Self, & Lovrich, 1992). These staff stressors are also unlikely to facilitate effective or supportive treatment environments for the offenders who require help.

In dealing with offenders who engage in SIB, role conflict (when an individual experiences conflicting job demands that have to be met) and ambiguity (when the information and clarity required to do a job well is lacking) may be of particular concern. There is strong empirical evidence supporting the significant relationship between role conflict and ambiguity with decreased job satisfaction and burnout in correctional staff (Hepburn & Albonetti, 1980; Hepburn & Knepper, 1993; Lindquist & Whitehead, 1986; Schaufeli & Peeters, 2000; Van Voorhis, Cullen, Link, & Wolfe, 1991; Whitehead & Lindquist, 1986) as well as mental health treatment staff (Price & Spence, 1994; Prosser et al., 1997). Correctional officers are required to maintain the safety and security of the institution while also contributing to the treatment and rehabilitation of offenders, creating great potential for role conflict. Staff may also feel ill-equipped to work effectively with offenders who self-injure, given the complexity of dealing with SIB. This uncertainty can even be experienced by mental health professionals.

Research suggests that improving attitudes and understanding of SIB and psychological distress can increase the confidence and self-efficacy of front-line staff (McAllister, Moyle, Billet & Zimmer-Gembeck, 2009), which in turn leads to increased job satisfaction. A perceived feeling of efficacy in dealing with offenders has been found to be the strongest predictor of job satisfaction among health care practitioners in correctional settings (Garland & McCarty, 2009). Employees who work with individuals who self-injure often have little understanding or training in the area of self-injury, and the majority indicate a desire for more training (Fish, 2000; Gough & Hawkins, 2000). While some research suggests that training is beneficial to mental health professionals generally (e.g., Huband & Tantam, 2000), one study reported that registered nurses and nursing aids working with young offenders who self-injure found that those who had received education in SIB (e.g., workshops, higher education courses) held an improved understanding toward self-injury than those who had not been educated in this area (Dickinson, Wright, & Harrison, 2009). No research has been conducted regarding training on SIB to

frontline correctional staff who are not trained mental health professionals. More information on SIB and how to effectively interact with offenders could lead to better outcomes for staff.

Treatment and Desistance

While the information available on the origins, motivations, and nature of NSSI has improved, little is known about the process by which an individual desists from NSSI. Longitudinal research is exceedingly rare and research on NSSI desistance generally focuses on specific treatments. A systematic review of the effectiveness of treatments that aim to reduce SIB and completed suicides in individuals with a history of this behaviour was published by the Cochrane Collaboration and concluded that more research is required to determine what interventions are most effective, particularly in the form of large-scale clinical trials (Hawton, Fagg, Simkin, Bale, Bond, 2000). They did, however, indicate that promising results were found for some therapies including Dialectical Behavior Therapy (DBT) for female patients with borderline personality disorder and recurrent SIB (Linehan et al., 1991). DBT is likely the most widely studied intervention for SIB. Other intervention models have been evaluated for use in the treatment of SIB. They typically involve establishing a positive therapeutic alliance.

Some information is known about what offenders report to be useful in reducing or ceasing their NSSI. In studies of federal Canadian offenders with a history of NSSI, the most common method they reported using to avoid engaging in NSSI was finding an appropriate release of emotions, such as seeking emotional support or help from another individual (Power & Beaudette, in press a; Power, Beaudette, & Usher, 2012; Power & Usher, 2010a). Other methods reported in previous studies included using relaxation or distraction techniques (e.g., writing, reading, creating artwork, exercising, engaging in cultural activities), engaging in positive self-talk, behavioural substitution (e.g., snapping elastic bands, holding ice cubes), and speaking to a psychologist or attending programs. This research, however, did not explore the process by which an individual initiates the recovery process and what interventions and techniques individuals found to be most helpful in facilitating their healing journey.

Aboriginal People in Canada

The term *Aboriginal* is defined as “the collective name for the original peoples of North America and their descendants” (Aboriginal Affairs and Northern Development Canada, 2013). In Canada, and within the CSC, the term is used to refer to individuals who identify as First Nations, Inuit, or Métis.

Many Aboriginal peoples are disconnected from their cultural traditions yet do not feel part of mainstream culture, resulting in difficulties for some, particularly in urban environments (Bracken, Deane, & Morrissette, 2009). The marginalization of Canada's Aboriginal peoples has been linked to a range of negative health and social indicators. For example, compared to the general Canadian population, life expectancy at birth for the Registered Indian population is 6 years shorter for women and 8 years shorter for men (Indian and Northern Affairs Canada, 2001).

Related to the cultural disconnect and marginalization of Aboriginal peoples, they are considerably overrepresented in the federal correctional population compared to their general community population in Canada. While Aboriginal people comprise approximately 3% of the Canadian adult population, they represent 19% of CSC's population (Public Safety Canada, 2011). While little is known about NSSI in Aboriginal populations, the rate of suicide is two to six times that of the general Canadian population (Canadian Institute for Health Information, 2004) and research has found that while NSSI and suicide attempts are distinct, they are correlated (Power & Beaudette, in press b; Power & Usher, 2011; for a review see Power & Usher, 2010b). A study of SIB in 573 Canadian federal offenders found that Aboriginal offenders were more likely to have engaged in self-injurious incidents, with 25% of the offenders who self-injured being Aboriginal compared to 20% of the sample as a whole (Gordon, 2010). Given their unique cultures and the challenges faced by Aboriginal peoples in Canada, and the importance of considering NSSI within a cultural context (Favazza, 2009), an examination of SIB in Aboriginal populations must be culturally-appropriate.

Present Study

The present study was designed, using a culturally-informed approach, to determine what strategies or inventions that staff working with Aboriginal offenders with a history of SIB found to be effective. Results will inform treatment and intervention strategies for Aboriginal offenders who self-injure.

Method

Participants

Participants were 14 staff members working in CSC correctional institutions ($n = 12$) and the community ($n = 2$), with varying levels of education, experience, and distinctive functions in the intervention of offenders who engage in SIB. Participants were recruited from Aboriginal healing lodges, medium and maximum security facilities, a psychiatric treatment centre, and a community correctional centre.

In total, six Elders, two parole officers, two Aboriginal Liaison Officers, a psychologist, a psychiatrist, a clinical team leader, and one occupational therapist took part in the study. Each of them shared their personal experience in working with offenders who self-injure and the treatment of SIB and suicidal behaviours. All of the staff had worked closely with Aboriginal offenders.

Procedure/Analytic Approach

A designated staff member at each of the participating institutions and sites was contacted before the study began. A summary of the purpose of the research was provided to them for distribution to other staff members. Those who met the inclusion criteria (i.e., had experience working with Aboriginal offenders who self-injure) were eligible to participate. The researchers also attended the morning meeting at the majority of the sites to explain the study and to engage any staff who might be interested in participating. The researchers were also available to answer any questions regarding the study during or after the meeting. Interested staff approached researchers to indicate their interest and scheduled a time to participate. Some staff who were known to work with this population were recruited by the researchers.

Interested staff were provided an informed consent form and were required to sign it before participating. Participants also had the opportunity to ask questions about the consent. When more than one staff member was available to participate at a time, a focus group session was held; otherwise, individual interviews were scheduled. The interview guide remained the same regardless of interview format (see Appendix A for the script). The way in which questions were asked, however, was modified to correspond with the type of session. For instance, during the focus groups, prompts were less frequently used as this format did not require it because participants usually expanded on the topics without much guidance from the moderator.

An Elder was present for each of the focus groups and the use of an eagle feather to represent a talking stick was used. Participants and moderators sat in a circle, in a designated Aboriginal healing centre in the institution, and the person holding the feather was allowed to speak; others remained silent during this time. In Aboriginal cultures, this form of group discussion is often referred to as a sharing circle and is used as a form of communication, storytelling, problem solving, and community assembly (Lavallée, 2009). Moderators began the session by explaining the guidelines of the focus group (i.e., one person to speak at a time, all answers remain confidential, respect others). The first topic of discussion was introduced by the moderator and then the first participant could begin speaking to the subject. Prompts or follow-up questions were asked by the moderator only when clarification or contextual information was needed. Participants would each have a turn to speak and any additional comments could be added at the end of the round before the next topic and questions were introduced. During the one-on-one interviews, more prompts and follow-up questions were required. The one-on-one sessions took place in a private office or boardroom.

All interviews were recorded using a digital recorder and then later transcribed verbatim by one of the authors (J.B.). Transcripts were analyzed by another author (JP) using a phenomenological approach. Phenomenology is a qualitative form of data analysis that often states “the obvious and the necessary” (Sokolowski, 2000) and typically involves revealing accepted assumptions (Stark & Trinidad, 2007). To do this, a phenomenon is examined through the descriptions of those who have lived it. The responses are then classified into clusters or themes that, when considered as a whole, illustrate the structure or commonalities of a phenomenon (Stark & Trinidad, 2007). This technique allowed for a greater understanding of what staff members perceive as effective and ineffective in the treatment of SIB with Aboriginal offenders.

Measures/Material

Interview protocol/focus group guide. An interview protocol or focus group guide was created for the study based on the research questions and suggestions that arose in consultations with stakeholders prior to the study. The following sections were included: 1) experience in working with Aboriginal offenders and offenders who self-injure; 2) challenges that arise when working with these groups; 3) treatment of self-injury; and 4) the role of culture in self-injury desistence.

Results

Treating NSSI: What Works?

NSSI is a symptom, not a disorder: treating the whole person. Participants consistently emphasized the importance of treating the entire person rather than trying to focus on their NSSI behaviour in isolation. While NSSI is a particularly problematic behaviour and it is desirable to address it directly, participants recognized that it was a symptom of other issues, often histories of abuse and trauma that may have existed since childhood but have not been addressed. The NSSI was symptomatic of offenders' inability to manage their emotions related to these issues and until they were addressed, and resolved at some level, the NSSI would continue. Individuals who engaged in NSSI also often face a myriad of additional mental health problems that need to be considered when treating the NSSI:

P014: Well, you got to get to the root of the problem first off. I mean, if you're going to help that person you got to be able to make that commitment that you're going to go through it from A to Z [and] on all points in between. In order to get to the root of the problem you have to talk to that person to find out what it is that caused them to do that. Because then your work is effective.

P010: You know, you have an Aboriginal person, first and foremost who's come into contact with the justice system who has mental illness, addictions, trauma, brain injury, FASD, and, you know, I think to effectively address suicide and self-harming behaviours, you can't focus on any one of those stems. And that's been sort of my approach in working with the offenders here...I think to appropriately assess and intervene in a suicidal ideation or self-harm framework, you really have to address not just one thing but everything...And certainly within that array of factors there's going to be a couple that are more pertinent or more salient at that specific moment. So I think identifying what the salient stressors are is important but not forgetting all the other things that are happening.

Establishing positive relationships. Treating the whole person includes establishing a positive relationship with the offender. Establishing these relationships is vital in being able to address all of the offender's needs, including the issues that are spurring the NSSI. Chaotic and abusive childhoods may have limited offenders' ability to forge positive relationships with others, making them all the more valuable to the offenders when they are established:

P013: Knowing somebody cares and spending that time with somebody and building those relationships has another huge impact. Because a lot of these women have never

actually developed a healthy relationship with anybody their entire lives. So, they finally get to experience that, which is positive.

P003: A lot of issues that they have are of a growth type, growing as a human being in a community setting, a family setting. They're missing all of that...One of the [reports] I like reading the most is the initial Elder interview. They share lots about their upbringing and everything so that gives me a good idea where they have been, what has happened to them, why they're here. Following that I sit down with them and say 'well, what's it been like for you, what have you gone through?' So they tell me about it. But when you treat them like human beings, they really respond very, very well.

Establishing a positive therapeutic relationship stems from a place of genuine caring and compassion. Participants emphasized that offenders can tell when the intentions are genuine:

P010: But being as authentic and genuine and empathetic with the offenders in this time is hugely helpful. If they know that I as a person, on a person-to-person basis, not professional versus offender, on a person level I'm concerned about you.

P013: Time. Time, patience, and having that listening and going through it and doing it step-by-step helping them or try to understand...Caring. Being genuine. They know whether you're just doing your job or whether you actually care. And that makes a huge difference.

Establishing positive relationships may be challenging, especially with offenders who have limited interpersonal skills and may display difficult and resistant behaviour. While it is important to acknowledge the difficulties that may arise when working with some offenders, particularly those who can be negative to staff, who are "violent", "obnoxious", and "pushing you away", staff emphasized that continuing to work on establishing these relations despite negative behaviour was key to progress in treatment. Indeed, some staff perceived that for some offenders working through very negative behaviour was necessary to establishing positive relationships and thereby being able to provide good clinical care. This commitment to continuing to work with the offender can be viewed as akin to "unconditional love" and is illustrative of good clinical practice, which forms the basis of effective treatment:

P004: Well, I think it's the integrated approach, the focus on building a relationship with people who are not used to having people forge relationships with them and not rejecting them when they're easy to reject...we're just doing 'meat and potatoes' good clinical work. There's nothing high-flying about what we're doing. It's just good clinical work... it's intensive, it's hard work and some of these guys you really got to cut through a lot of

stuff before you get to the nice piece. So at the end of the day it's kind of like an endurance run, you've got to stay in the game. And that's one of the things that in my mind these guys, that's where we start making our gains. You don't run away when they try to push you away and push you away. Low and behold after all the [abuse] you're still there saying 'ok, we need to get things on track' so there is nothing that we do that isn't just plain and simple good clinical practice and solid relationships.

Addressing past trauma may even involve a sort of "reparenting" by providing the sort of support and teachings that a parent would have, because, although the offenders are adults, the staff stated that they believed that they require this type of relationship to heal:

P004: And one of the things that I think [the Elder] and I have done... is sometimes we end up in reparenting roles...that from time to time we become, we really fulfill some of the things that were missing in their child, and I think that there's an advantage in that I'm a middle aged woman and [the Elder] is a middle aged man. But I find that, part of it feels like reparenting people that really didn't have that parental experience in their younger years.

One specific approach to establishing positive relationships with offenders was illustrated by the story of a correctional officer who asked the offenders to teach her about their cultures. This method allowed the offenders to contribute to the relationship and as well provided a demonstration of the officer's interest in the individual. Undoubtedly, the officer gained valuable information that will help her in other correctional settings as well:

P001: But there's some very accepting people. I can think of one, [officer name]... She would engage the guys by admitting a lack of knowledge about their Aboriginal spirituality and would invite the men in the evening hours to teach her. And she was open to it and she would say, 'I need to learn, I want to learn, explain to me how this works', and to a certain degree she would get a bit of harassment from some of the other staff that are, 'What are you doing?' But that can happen anytime somebody engages in a fashion that someone else thinks is not appropriate. So, you know, some resistance that way but on the opposite end of that resistance is somebody who is quite enthusiastic and has put it out there and invited the learning in.

You need the right people and the right organizational culture to establish positive relationships with offenders who repeatedly self-injure. This culture is influenced by the staff, including management. Highlighting the gains achieved with difficult cases is often encouraging

to staff and reinforces their efforts. Once the staff see success, they are motivated to continue working with the difficult cases:

P004: Well, to say that it wasn't difficult would not be true. But I think that the way it happened is the, you only need a couple successes for staff to want to keep doing the work... And like I said, after we had a few successes, the staff come together more than ever when we're challenged with a problem that other people haven't been able to handle, there's a certain pride in saying 'we can do it'. I think that there's mileage in that.

These successes are important to creating a positive culture in which challenging offenders can be treated. There is a need, however, to recognize that individuals who engage in repetitive, serious NSSI have complex needs and an immediate goal of absolute cessation of these behaviours is not usually realistic. A negative treatment environment can result in feelings of failure that are not helpful for staff or offenders and can contribute to staff overlooking what is actually considerable progress with some very challenging offenders. Instead, setting realistic interim goals may be more appropriate. In a sense, what constitutes a "success" may need to be redefined based on the individual offender:

P001: The Warden has started to say we need to talk about some of the successes. Some of them are little and it's a one-off. You know, to have [one offender] go for months without an arterial bleed where he's counting his hemoglobin and whatnot, is a success. To have him stand up and speak at his graduation was an enormous success for him. [Another offender] that went out at one point, and yeah he's had a slip and he's back in again, but he had quite a few months of doing well. You know, the use of Pinel restraints is down, the use of force and extractions and OC spray is down [at our institution]. But people don't talk about that, they don't come in and say 'where are the individual successes?' ... There have been individual kinds of successes that are maybe harder to measure but I would like it if we talked up some of those successes rather than 'oh great he cut up again' ... sometimes you can feel like you know what about the fact that there were nine others over there that didn't do anything or that managed to get up and walk to the sweat and calm themselves, straighten themselves, did ok that day. So, sometimes I think we have to measure our small successes, too...

P004: For these guys the grass is always greener on the other side. They're always looking for a move because if I go somewhere else it'll be better. And you know, it's not better and so you're right we stop the moves and we hang in there... You know it might be nice to say that we have this unique skill set, we can't be replaced and our work can't be duplicated because no one out there can do it, it's just not true.

Team approach. Most participants felt that a team approach is the most effective method

of working with offenders who engage in NSSI. Participants also emphasized the importance of making staff and team members feel included and valued. Staff recognized the differing strengths that each staff member brought to the group and that most successful work can be done together:

P004: What we have worked very hard at doing is that, to have a partnership with the Elder, with the officers, so I think that when we come to the table and we're problem solving, everybody at the table feels that they got a right to be there. They're not just, they're not invited guests, they're part of the group that needs to solve the problem and the officers know through experience and lots of discussion, they know that these, our officers know these guys really, really, really well and they know what works and what won't work. And I think they go in with a lot of confidence that 'oh I'll go and have a chat with him' and so I think part of it is they, they're part of it, they know the cases really well and they want a good outcome. So they're part of the decision making.

P010: Accessing supports and working as part of a team. I work really closely with [parole officer] and [psychologist] on guys that we have a concern about suicide for. And just like suicide doesn't operate as an independent factor, I don't think us as professionals can operate independently. So those are practical things.

Many participants emphasized the value of working with the Elders. Note that this discussion was not simply one recommending that Elders work with the offenders, but that Elders be integrated into the case management or treatment team. Working with Elders can bring a unique perspective and skill set that is particularly effective with some offenders. Additionally, some experiences that are considered 'normal' within the cultural context can be misinterpreted as a mental illness by someone who does not understand:

P004: Well, I have to say that I have been exceptionally reliant on the Elders. So, so I don't think it's been particularly a challenge for me because I always feel that I have a good partner and I like the way the teaching is done...I just recognize where my limitations are and defer to the Elder that I'm working with to address the what needs to be done to, the tools that they work with.... So I start sitting in with [the Elder] when he would be doing some of the sessions about trauma and, you know, how to stay on the path and things like that. I just recognized that there was something that I didn't know and I went looking to the Elder and then I realized that I was learning a lot from the Elder so it just became a partnership that evolved over time. In a lot of ways I see the Elder as a clinical partner where we have different skill sets.

One unique aspect that Elders can bring to the group is the freedom from some of the restrictions that other health professionals must abide by. This freedom may provide them more latitude to establish deeper personal connections with the offenders:

P003: And they feel it when they come in here, when the smudge is burning and the biggest difference, I guess, is I can hug these guys, where you can't, as professionals you can't do that, I can do that and say "I love you". And the first time that I started working with [offender name] here, after a while, he said "you know [Elder name], I really love you". When did he ever say that before, something like that?

P005: What we find here are trust and relationships, they phone us right at home, some of the guys. 'Cause we do work out in the community so a lot of times they feel that comfortable to continue their work with us and it's not something that we promote it's just that it works out that way. We never self-promote, but you know, but we don't push people away either. A lot of times guys leaving will ask for our phone numbers and where we work and then we have no problem doing that and there's no fear with us.

Skill-based approach. While effective strategies primarily focused on establishing positive relationships rather than a specific treatment model or approach, a few staff members did discuss their use of skill-based approaches in helping offenders to desist. The skills being taught were skills for emotional regulation, which is consistent with the understanding that offenders primarily use NSSI as a method of coping.

P013: It is a form of emotional release...So it's a coping strategy, as unhealthy as it is, it is a coping strategy. Um, so what I do is I spend a lot of one-on-one time with these people teaching them DBT¹ skills, teaching them new coping strategies. We build a great rapport so the women, especially the women on my caseload that have had self-injury in the past, they know that they can, even if they have self-harmed, they know they can come to me and tell me they have self-harmed and then we can deal with it. Okay, 'what was leading up to it? What could we have done differently?' And then looked at the skill approach again....Because for them a lot of the times they don't even really understand why they do it. They just know they feel better when they do it, right? So, it's coming to, number one, helping them identify the emotions because a lot of them can't even tell the difference between, are they sad, are they frustrated, are they angry? Right, so for example if it's a family member that passed away, well, then we can identify that this is what it feels like to be sad, right? So then we start being able to identify the emotions. How can we, what can we do differently other than self-harming, what else can we do? And so then we go through a list of skills.

P010: What I've seen is an increase in problem solving skills, an increase in access and availability to resources. On site, I know we're really lucky here, we have psychology, we have programs, we have [occupational therapists], we have parole officers on site and that is so helpful. [One guy], when he came back to us, he has a lengthy, as you know, history of being in and out of suicide [watch], and everything you could think of, and when you talk with him now, he'll say 'I still have [suicidal thoughts] but I have no interest in acting on them'. And I think that's huge and, you know, he'll give you his

¹ DBT = dialectical behavior therapy, a therapy often used to treat SIB (see Linehan, 1993)

rationale behind that but what I see in him is an increase in problem solving skills, an increased ability to cope with stressors, because those stressors are still there, they haven't gone anywhere, he'll always have those, but an increased ability to address those that's positive instead of a way that resulted in harm to himself. And I think too, that development of self-efficacy, knowing that I don't have to, I don't have to make this choice, there's other choices out there for me instead of killing myself.

Treating NSSI: What doesn't work?

Negative or punitive responses. Negative or punitive responses were viewed as being exceptionally unhelpful and even damaging to offenders. Given that most offenders self-injure in response to negative emotions, these types of responses can lead an offender to increase his or her self-injury.

P013: Getting angry, putting blame on them, telling them it's wrong. Being negative about it, even though it's not a positive coping skill, it's still their skill. So, once you start putting blame and putting a negative spin on things they start feeling bad about themselves which then puts them back into the cycle of self-harm. So, yelling at them, telling them their doing something wrong, that always puts a negative spin on things and sends them back in a downward spiral...I mean, you get to know who your team members are and who you can bring in and who you should leave out. And for the most part that's what I do. 'Cause I know who the negative people are so...I'll pull somebody else in instead.

In addition to the potential to increase NSSI in the immediate future, negative responses can cause offenders to hide their behaviours or to keep their thoughts of self-injure to themselves instead of seeking help. Effective relationships involve establishing a rapport in which an offender trusts the staff person enough to admit when he or she is having self-injurious thoughts or urges without fear of a punitive or negative response.

P009: I can think of examples, in institutions or even in the community, the individual will make a comment about being suicidal or having suicidal thoughts, well, the knee jerk response is to throw them in a camera cell put them in a suicide smock, you know take away anything that can cause harm, but really that pushes them back because next time or another offender that's witnessing this, when they're having such feelings, they're not going to disclose those because they don't want to be placed in the same situation

Most participants reported that they did not view segregation as usually being helpful or even required in many situations.

P010: What I think is ineffective is segregation. I think that certainly removing items, everything that can be used in a self-harm or suicide act is important. But I think... I have mixed feelings. I understand the protocol and I understand the need to have them in a physically safe environment but removing them from human contact, regular life, removing, in a lot of cases what the stressors are, it's a temporary solution. And like I said, the guy I just worked with before I came down, he was in and out of suicide obs everyday. You know, and what does that tell you? You know, this is not effective. You are not addressing the cause here, you're putting a band aid on it and that band aid's going to fall off, quickly. So I have mixed feeling about that. You know, I think suicide observation cells in and of themselves in a physically safe environment, I understand the need for that from a safety perspective.

There are some instances, however, where segregation was required to maintain the offender's safety. Some participants identified these required placements as opportunities to connect with the offender and have meaningful conversations:

P013: Sometimes you do have to put people in those [segregation] cells because they are such a risk to themselves and you know that they're the kind, they're the ones that are going to go too far. However, having somebody there is important, not just putting them in that cell and then leaving them to rot and sit by themselves for 24 or 23 hours. That is more detrimental. It's actually having somebody go down there, and not just every half an hour and say "ugh are you alive" but to spend time and try to get through to them.

Avoidance. People may avoid addressing NSSI because they do not want to "cause" the person to self-injure, due to a lack of confidence in intervening or because they do not want to discuss the issue with the offender. This avoidance or "putting things off" is not effective in working with offenders who engage in NSSI.

P013: And so, when, the hard part, and when, we actually just went to a training that we talked about, um, people don't take the time, you can tell when somebody's going into a cycle. Like you know that they're building up and that, and if they're self-harmers, people are so scared to approach them and say, 'hey, come to my office, we need to sit down and we need to have a chat. I'm worried about you, have you self-harmed yet?' People get to the point where they're like, 'you know what, just do it and get it over and done with so that we can go back to normal', instead of actually taking the time to say 'hey'. And I'm one of those that go, 'hey'. And so, we then, we perpetuate the cycle and I think that's the hard part.

The most effective way to deal with NSSI is to directly address the issue. Specific training for suicide or NSSI prevention teaches people to directly ask the person about these behaviours.

P013: My approach is different than a lot of people. When people self-injure, people are scared to talk about it, I'm not. I mean we sit down and we talk right about it. The hard part is, um, once they are involved in that self-injury is to get them to stop. It's not just as simple as talking them down from doing it. For the most part you find that they actually have to follow through with the self-injury and come to their peace before you can actually sit down and talk about it. Some of them, I mean, are very serious, of course, and you have to use force in order to assist them in stopping but while they are thinking about it and they have started that act it's a matter of actually having to help them through it.

P009: One thing I took from that course too was that you don't tiptoe around the issue, it's not like, 'are you feeling ok?' or, 'do you feel like hurting yourself?' It's fine to say things like, 'do you feel like killing yourself?' or, 'have you had thoughts of killing yourself?', 'how are you?' and just really dive right into the subject instead of tiptoeing around it.

An open conversation in which the individual feels heard can be very powerful:

P010: I think just having an empathetic, open, non-judgemental conversation with the guy, whatever frameworks guide your questions or your listening throughout that, but just allowing them to talk and be heard and not interjecting, 'well it'll be ok'... And I think just validating, 'This is really tough for you, this must feel so lonely', and sometimes that's such a powerful thing for them to hear, 'Not everything's going to be ok, everything might not be ok, this is awful for you, I have no idea what you must feel like, no idea.' And sometimes people look at me and say, 'well you sort of know'. I know what you're going through from what you've told me but I don't know how you're feeling, I don't. And that can be really powerful for people. Because they've been through everything. The suicidal expression that you're seeing right now is not an expression of just present circumstance, it's everything.

P009: I feel like they're being heard, I think. We might not have the answers for them but I think they feel like they're being heard. So they've still, they're still hurting but they feel that they're on a path where they're starting to have some healing.

One specific strategy that some staff discussed using in their efforts to address NSSI directly was establishing a verbal contract with the staff member to not injure themselves for a specific period of time or to engage in a particular action, such as asking for help, before self-injuring.

P009: [A course I took previously] put a real emphasis on how to interact with people who are threatening self-harm, suicide, just you know the whole concept of making a contract or whether not they're feeling, like, if they're in a state where they are expressing that they want to harm themselves or kill themselves to try to focus on short-term plans. You know, we're not trained psychologists, psychiatrists, but as an officer just to get them to that next stage. 'Can you at least contract with me that you're going to be ok for the night? Can you at least contract that you're going to approach a staff if things get worse?' Try to find that little glimmer of hope in their life that can get them, until you can get them professional help.

For contracting to be effective, however, the individual must feel that the staff member genuinely cares about him or her. In essence, there has to be some kind of relationship established for the contacts to work:

P010: There's self-harm contracts. Contracting on a genuine basis, 'Will you tell someone if you have thoughts to hurt yourself', instead of 'oh, will you tell us if you kill yourself?' No. But if they know that I, as a person, am concerned for you, I want you to make me a promise that you're not going to slice your arm open tonight. I think using that language that they understand. I would never say to an offender, 'are you having suicidal ideation right now?' No. 'Are you thinking about killing yourself?' I think that's huge.

Working with Offenders who Self-Injure: What are the Challenges?

Only one staff member identified that the biggest challenge in working with offenders who engage in SIB is the emotional and personal drain on staff. The participant had a client who died by suicide and this experience was extremely difficult for her. Her experience highlighted the importance of also talking about these issues with other staff members:

P010: That was awful. As a professional that was awful...And as a professional, when that happened I was like, oh my gosh, what did I do?...And it was really tough, obviously. I found the most helpful way that I got through it, and obviously it still affects me, is that I knew that he knew where to come for help...I think in the event of a suicide or self-harm attempt, that as professionals we can be really hard on ourselves. You might have done everything perfect, and that still, it's a reality when you're working with independent human choice, that's a reality that is always there. Someone can kill themselves despite everything being done properly. So I think that's a huge piece of it, is professional self-care and personal reflection on the self-harm or suicide attempt...

Some staff specifically reported that they did not find it particularly taxing to work with offenders who engaged in NSSI, but rather that the lack of resources they sometimes faced in working with these offenders was challenging:

P009: Resources, by far. I can think of a case where we had, there's only so much money to go around, there are only so many psychologists, there are only so many Elders, we are a Monday to Friday operation. We had an individual who became very suicidal late in the afternoon on a workday, there was unfortunately no resources available for him at that time, we could not contact psychology, we could not contact an Elder so the only way we were able to ensure his safety at that time was to suspend his release and put him back into custody where he would be under 24 hours supervision in a suicide observation cell, or wherever they place him. I think that's the biggest hurdle right now, with us, is just money.

Resources that the staff identified as being very valuable (and sometimes inaccessible) included spaces to hold Aboriginal ceremonies and also the Elders themselves:

P010: I think that offenders needs to be given every opportunity to express [their culture], and that's something that I really see as a challenge is having a room with the proper ventilation and having access to that room, and having Elders on site, and I feel like that needs to be paramount. Just in the same way that we have a psychologist on site, like there needs to be an Elder on site, period. And in the same way, you know, in the traditional health care world, you address physical health, someone breaks their leg, you're going to put a cast on it. We're slowly starting to, I think, as a health care world to start addressing that mental health piece. You know, if someone has a mental illness, we're going to address that. I think we're still very far behind in addressing spiritual and cultural challenges. I think it's a hugely effective factor and I think it's one that can certainly help build that resiliency, and coping skills, and problem solving skills and give a person that inner strength that they can move forward from these thoughts.

P001: There is one challenge that I can think of that's from an administrative point of view and that is the scarcity of the resources. [Our Elder] is spread so thin and we all fight over the availability of Elders....It happens all the time in this facility and I think across the region where they're shuffling and moving and trying to get a little but more here and a little bit more there and it's such a valued resource for us that I wish that it was more in the, that there was a greater proportion, I guess, of Elders available to the population.

One staff member reported that it is sometimes a challenge to address envy that arises from the other offenders due to a perception that they are provided an unfair amount of resources as a result of their NSSI, or because they are Aboriginal:

P001: Well, I think way back when, when we first started having Elders, and even to this day, you'll often hear other inmates envious of services or, you know, perks that the Aboriginal population perhaps gets. There's a double brand right now because if you do an activity for the [high-needs] people, well they get extra Aboriginal services or they get extra attention for the self-harmers and it can kind of put them aside, they don't

necessarily integrate into the population as much. I get it from staff and from offenders with 'how come they get x-y-z?' You know? In terms of that, integrating the Elders in has been going on for years now so I don't feel a resistance too much to that. Not anymore so than integrating the other professions.

Participants explained that staff can also perceive unfairness in the allocation of resources or the provision of "special treatment" to Aboriginal offenders or offenders who engage in NSSI, even though it is recognized that they do have special needs and therefore the special resources or treatment are necessary:

P010: I think, too, it seems at times that they're requesting differential treatment than other offenders and I think sometimes [people] get uptight about that because they want, as much as possible, to treat everyone the same. Which we know is not true. So I think that's an additional challenge.

Working with Aboriginal Offenders: What are the Challenges?

Aboriginal cultures are different in many ways from the main stream culture in Canada, and this difference can be important when aiming to work effectively with Aboriginal offenders.

P009: They come from a different cultural background. A different way of viewing certain parts of life that maybe the mainstream public does not share nor fully understand. You can be told in a classroom, read in a book about some of the lifestyles, you know the experiences of residential system and the school system but you don't know it. So, I mean to say that you've been taught about it, you don't fully understand it and where these guys are coming from and I think some people sometimes overlook that as just 'oh well there's lots of populations that have had difficult times or individuals who have had difficult upbringings' but the Aboriginal offenders, they truly have had a different upbringing for most of them.

Many Aboriginal offenders are disconnected from their cultures and addressing this disconnect can be challenging, yet important:

P003: It is a challenge in Aboriginal people because a lot of our people are lost. They've lost their culture, they lost their, first of all, we try to teach them a little bit about our ways, our culture and most important in our ways they talk about seven teachings and they talk about all the different ceremonies but these guys gotta understand the biggest part in healing is to be able to forgive. To be able to let go. To be able to move on. You see when we talk about Aboriginal people it is a challenge because, like I said, they're lost.

Additionally, many Aboriginal offenders have complicated backgrounds that influence their behaviour and their sense of identity. These must be taken into consideration because these complicated histories can also bring stigma with them:

P006: Well, I think that colonisation and the impact of residential school and the sixties scoop, but I think that the other challenge and I've come across this is perception from people who are not Aboriginal. People who lack the understanding of the generations that, you know, the negative behaviours or acts or, I don't even know how to say it, but just all these things that all come together that play a part in that person and who they become and why they behave the way they do and why do they react to the things that they do and why they cannot deal with the issues in their life. That I find is a big challenge when you have somebody say, 'well build a bridge and get over it'. That's not just in the residential school and the colonisation issue but it's just, in that person's whole life you cannot undo hundreds of years in two years of treatment. There's no quick fix. I think that is the biggest challenge that I find in working with Aboriginal offenders

P010: With Aboriginal offenders, I find more so than with other populations of offenders, that they have a lot more stigma associated with them. And it's very challenging because there's stigmas associated with almost all aspect of my clients. So the fact that they're Aboriginal, that's a stigma. The fact that they're associated with the justice system, that's a stigma. The fact that they have a substance abuse problem, that's a stigma. Mental illness, stigma. FASD, stigma. And I find that they have been so stigmatized for any one or all of those factors that their self-worth and their self-esteem and who they see themselves as has been incredibly damaged. When they are told and reinforced by society that you have all of these problems, I think that's incredibly damaging for our Aboriginal population. With Aboriginal offenders, and also with other races as well, but certainly I do find that the Aboriginal population has a distinct set of challenges that they encounter that lead them to self-harm or have suicidal ideation.

Working with Aboriginal Offenders who Self-Injure: What is the Role of Culture?

Cultural practices can provide a framework for establishing connections to others and can help an individual form a personal identity and a sense of belonging. One non-Aboriginal mental health professional discussed how she works closely with an Elder to work toward establishing this sense of self:

P004: I think that we see a lot of the effects of the residential schools, still very much a part of their lives, and their sense of who they are is often very fragmented, if it exists at all... I think [the Elder's] work with them has been quite remarkable and from my perspective I think that the ceremonies and the ritual and the sense of belonging and

sense of identity is what helps them form their sense of self and connection to others and I would like for us to be having more opportunities to have more ceremonies. And I think, if I look at my culture, the Western culture, there is some stability in rituals and things like that. So I think there is a lot of value in providing those opportunities.

Elders also emphasized the healing powers of having a cultural connection, which included working with Elders and participating in ceremonies:

P003: A lot of them believe that they're not worth anything, nobody accepts them for who they are, what they are... So, I bring them in here, I smudge them and they feel really good. Some of them will come here once a week just to smudge, that's all. They say, 'that'll be good enough for me for a week, I'm ok'. So they feel good about that, it pulls them through. As they come here and come and get their smudge kits and it's something that helps them in tough times, when they're having tough times...when I learned about this place and I came in here to work with these guys and I found that a lot of our relatives have lived in the city and don't know what it's like to be an Aboriginal person. They've never experienced living on a reserve. They've either lived in foster homes or their parents lived in the city. So they don't know. They come here and they learn and they sweat with us and they do the rest of the ceremonies, smudging, sharing circles, pipe ceremonies.

P011: And, so we come in as Elders and we give that, love, honour, and respect. Some of these guys have never been listened to... It takes a while for them before they can get it to come out in ceremony. You take 'em into a ceremony whether it be a spirit bath, sweat lodge, pipe ceremony, smudge and circle, they all of a sudden belong. They're part of... it's a minor miracle to see them smile.

Many participants discussed the calming effect that seemed to occur after engaging in culturally-based activities such as working directly with an Elder or participating in ceremonies:

P009: I would agree with that, that access to, whether it's Elders on site or being able to participate in ceremony regularly, being able to just go to the sweat lodge and you know experience that. I can think of a few individuals that it seems to have calmed them down and provide them with more clarity.

P001: From a correctional perspective and I, too, have seen some of the people...that have just calmed in the presence of an Elder in ways that they don't in front of other people, whether it's a relationship or what, there has been for the most part such a deep respect in the presence of Elders and that's been magical sometimes, you know when they are really uncalmable. So, I don't know exactly what happens, I don't purport to know exactly what happens but I know it works for them and that they identify with it.

The spirituality that can be found with Aboriginal cultures can foster hope in offenders, a much needed emotion that is often lacking:

P013: I think that finding a base of spirituality is huge and I mean that goes for anything, right. Having something to believe in always gives people hope and when you have hope you're more willing to start looking at those negative things. I think that's where culture and spirituality comes in. I don't think it's the driving force for them stopping or reducing [self-injury] but I think it gives them that sense of hope and gives them something to believe in which then, of course, increases their motivation to make changes for themselves.

P010: I think cultural and spiritual practices can be one of those resources that help to develop resiliency. And I think resiliency is one of the key antidotes to suicide and to self-harm. And I think that, again it taps into that really deep core of a person that, you know, they're spiritual and cultural self. And that's not something that is evident to a lot of people, something that you can measure or see necessarily. But I think it's a huge part in really developing that inner strength and that it can be a really, really powerful outlet to heal and to let go of the trauma that has occurred and to help them move in a positive direction from the horrible things that they've encountered.

The medicine wheel, which is a prominent teaching tool in Aboriginal cultures, can provide a helpful framework for treating the whole person, rather than assessing issues in isolation. The importance of a holistic approach was noted earlier in this report:

P003: We look at the medicine wheel, we look at the circle and it's got four quadrants: mind, body, spirit, and emotions. We can't deal with just self-harming without dealing with the other parts... We have to deal with the whole person. So it's the problem we've had in the past is, we put spirituality in a church, we put emotional in the psych ward, we put physical in the gymnasium, we put mental in the school. In our way, we got a long house, they all come together and it's all used in the same way. Mind, body, spirit, and emotions.

P008: I think the challenge lies in that, from a spiritual standpoint there's more, I would say there's more, not sure how to say, not understanding what they're doing but there's an understanding that they're lacking something in their life. They're lacking that connection to Mother Earth, right. Especially, I say, if they cut themselves...So coming from that standpoint it's not a necessarily a challenge, it's more of a, there's more work to do to have that reconnection between their spirit and to their body and their mind.

Many of the lessons and approaches used with, and by, Aboriginal people can be transferred to non-Aboriginal people. In addition to using a holistic approach to treat the entire

person, Elders also mention key teachings such as respect, kindness, sacredness, patience, and tolerance that could be applied to anyone.

P007: You know, a lot of people when they talk about culture they mention culture in general, people think about seeing a person in a powwow outfit and chanting and dancing. This is not what our culture is all about. It's about walking a kind way, respectful way, being humble, being patient, being tolerant. That's why I believe in the holistic ways.

One mental health professional specifically highlighted the applicability of the Aboriginal based interventions for non-Aboriginal offenders:

P004: I think there's another piece to it and I think it's something that we could look at, is people, some of the non-Aboriginal people, who are not a good fit for the mainstream program and the mainstream way we think about interventions, they have benefited from the way that the Aboriginal programs work and the way that the Elder works with people and the way they learn. [The Elder] does it differently and for some of our guys who are not a good fit for our mainstream programs and, you met some this morning, [offender name] has attended several streams and was very anti his culture when I first met him... So, I think that there's something not just in the cultural connection, but in the way learning is approached and skill development is done. It is very different and it works for Aboriginal people but I think it works for non-Aboriginal people as well. I think we need to kind of look at that when we're talking about programs and consider what is it that's done differently and why is it effective for some people?

Discussion

There were two, interrelated themes that were evident in all of the interviews and focus groups: (1) the recommendation that you treat the whole person, not just the NSSI; and (2) the importance of establishing positive therapeutic relationships with offenders in the treatment of NSSI. These findings are consistent with the clinical research on *therapeutic alliance*, which is the collaborative and affective bond between therapist and patient and has consistently been shown to be related to therapeutic outcomes (Martin, Garske, & Davis, 2000). Marshall and Serran (2004) conducted a literature review on the effects of a therapeutic alliance on offender motivation and treatment participation. They highlighted the significance of a supportive and trusting environment and the importance of this environment in turn allowing staff to establish the positive relationships with the offenders that can promote change. In a meta-analysis including more than 2,000 studies with individuals from the community, Orlinsky, Grave, and Parks (1994) found that factors such as therapist empathy, understanding, validation, and affirmation were directly related to positive client change. Together, these factors describe the foundation of a good therapeutic alliance.

Previous research on NSSI in federal offenders found that one of the ways offenders avoid self-injuring is via appropriate release of emotion, such as seeking emotional support or help from someone (Power & Beaudette, in press a; Power & Usher, 2010a; Power et al., 2012). The current research highlighting staff impressions that establishing a good working relationship in which the offender trusts the staff member enough to reveal his or her NSSI is consistent with this finding. When offenders feel there is someone to whom they can openly and safely disclose their self-injurious desires, they may be able to avoid engaging in the behaviour. Many of the staff who participated in the study had experience working with both men and women offenders, and their advice on the importance of developing a positive working relationship applied to their work with both genders.

While some participants in the study did mention using skills they learned in training, most staff did not feel that training on a specific intervention model was required. Instead, most people emphasized the importance of good clinical care. This approach is a universal skill that can be used in any type of treatment setting with individuals who are facing a myriad of psychological issues.

The general importance of forging a positive therapeutic relationship does not discount

the value of specific treatment models such as DBT (Linehan, 1993) for offenders who engage in NSSI. Rather, it suggests that while this type of treatment may not be appropriate for all cases, the foundation of any treatment approach remains a quality relationship between the mental health professional and the offender. Effective application of DBT itself requires a positive therapeutic alliance in addition to its specific treatment approaches. Indeed, the one time a specific treatment approach was mentioned, it was a skills-based approach (e.g., teaching offenders coping skills that they can use instead of NSSI) which is consistent with the approaches used in DBT and other cognitive-behavioural programs. Some of the skills taught by DBT include skills that can be used for self-soothing practices (e.g. take a warm bath, get a massage) and distraction (e.g., snapping a rubber band, holding an ice cube; McKay, Wood, & Brantley, 2010). McMinn and colleagues (2009) conducted a study to determine whether individuals with BPD would benefit equally from DBT or general psychiatric management (i.e., psychodynamically-derived therapy and symptom-targeted medications). They reported no statistically significant differences between the two outcomes groups. Overall, a significant reduction in suicide attempts and NSSI behaviours were observed for both approaches. These findings demonstrate that in some cases, good clinical practice can be just as effective as specialized care in the treatment of NSSI and suicide attempts.

Most staff demonstrated a good understanding of NSSI as a coping mechanism, as this was found to be the most common reason why offenders self-injure (Power & Beaudette, in press a; Power & Usher, 2010a; Power et al., 2012) and did not speak disparagingly about offenders who engaged in these behaviours. Rather, staff discussed the underlying issues with great sympathy and understanding, which attests to their confidence in helping offenders who struggle with NSSI. Despite research suggesting that SIB is a stressful event to deal with as a mental health professional and that staff may even experience vicarious traumatization through working with individuals who self-injure (Gamble et al., 1994), few participants in our study reported this type of work to be particularly stressful. Their positive attitudes are not surprising in the context of past research that suggests that improving attitudes and understanding of SIB and psychological distress can increase the confidence and self-efficacy of front-line staff (McAllister et al., 2009). This attitude is consistent with previous research that found a relationship between perceived feeling of efficacy in working with offenders and job satisfaction among health care practitioners in correctional settings (Garland & McCarty, 2009).

Not all staff who participated in the interviews and focus group exhibited an in-depth understanding of NSSI. Indeed, a few participants identified responses from some staff members that could be detrimental to the offenders (e.g., negativity, punitive consequences) or observed that they ignore the issue altogether, which is in itself problematic. It is important to remember that the study participants were not randomly selected and that those who did participate were more likely to be staff members who were the most confident in dealing with this issue. Although not all staff exhibit these positive attitudes, all of them can benefit from the knowledge and experiences of those who did participate.

For most participants, working with a team was fundamental to helping offenders who self-injured. Importantly, staff seemed to understand their strengths and weaknesses, as well as how to capitalize on the strengths of other professionals. This understanding is key to successfully working with offenders who engage in SIB while maintaining staff well-being, given that role ambiguity can cause increased burnout in correctional staff (Hepburn & Albonetti, 1980; Hepburn & Knepper, 1993; Lindquist & Whitehead, 1986; Schaufeli & Peeters, 2000; Van Voorhis et al., 1991; Whitehead & Lindquist, 1986). Recognizing the unique contribution that others, such as Elders, could offer and using these complementary skills to help the offenders, was reported.

Some participants noted the importance of reframing what is considered a “success” or a reasonable goal, which may have decreased their feelings of failure and other negative emotions when working with offenders who repeatedly self-injure (Griffin et al., 2010). They recognize that for many offenders, the self injury had been ongoing for years and that there are considerable personal, mental health, and physical health issues that may need to be addressed before an offender can overcome NSSI. This finding does not suggest that staff are not working toward complete desistance from NSSI, but rather that they recognize that there are many steps and paths towards desistance. This more positive and realistic approach appears to be more motivating for the staff. As they witness progress, they are willing to work toward even greater success, however that may be defined.

The uniqueness of Aboriginal cultures was acknowledged by the participants. Many described the disconnectedness from their cultural traditions that is often found among Aboriginal people (Bracken et al., 2009). Participants did not seem to identify a difference in the type or reasons for self-injuring among Aboriginal offenders compared to non-Aboriginal

offenders. While the reasons for NSSI are often deep-seated and rooted in past experiences and trauma, which may be different for Aboriginal offenders, the proximate reason was perceived to be the same (e.g., as a method of coping). The use of cultural ceremonies (e.g., smudges, sweats) was discussed by many staff as an effective method of treatment. Interestingly, many participants described a “calming” effect that they noted in offenders that resulted from engaging in these ceremonies. Previous studies (Power & Beaudette, in press a; Power et al., 2012) found that after engaging in NSSI, offenders describe feeling a sense of relief. Participating in Aboriginal cultural activities may represent a healthy alternative to NSSI given the same relief may be achieved through these means. The ceremonies were also thought to help create a sense of self and identity with the Aboriginal culture, which is often missing. Traditional teachings, such as the medicine wheel and the red road, could also contribute to establishing this connection. Previous research also found that some people engaged in cultural activities as a method of distraction or relaxation (Power & Beaudette, in press a; Power & Usher, 2010a; Power et al., 2012). While these culturally-based activities were viewed as effective for Aboriginal offenders, some participants also speculated that similar approaches might be effective with non-Aboriginal offenders. Indeed, it was reported that some non-Aboriginal offenders choose to pursue an Aboriginal healing path and found that working with an Elder is effective for them. One participant in particular viewed cultural activities as a potential mechanism for making progress with offenders who did not find that mainstream programming was effective.

Conclusions

The approach viewed as most effective in working with Aboriginal offenders who engage in NSSI involved treating the whole person (not just the NSSI) and establishing positive therapeutic relationships with the offenders. Responding in a positive and direct way to an individual’s NSSI is an effective method of intervention. Aboriginal offenders have unique cultural and life experiences that influence their NSSI. Staff observed that culturally-based interventions, such as ceremonies and working with Elders, may be particularly helpful for this population. The approaches found in this study, however, are likely to also be helpful with non-Aboriginal offenders who engage in NSSI, particularly those who have not had success with mainstream treatment.

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Appendix A

Interview Protocol/Focus Group Guide

I'm going to ask you some questions about your history working with Aboriginal offenders and with offenders who engage in self-injurious behaviour. You are free to skip any questions you don't feel comfortable answering but we appreciate you sharing your experiences.

How long have you worked with Aboriginal offenders?

- Can you tell me about some of your experiences working with this group? (e.g., does it differ from working with other groups? Does it pose any special challenges?)
- Did you attend any training targeted for work with Aboriginal offenders?

Can you tell me about your experiences working with offenders who self-injure?

- What are some of the challenges you face working with this group?
- Did you receive any special training or instruction on how to work with offenders who self-injure?

Are there specific challenges in working with Aboriginal offenders who self-injure?

Why do you think offenders engage in self-injury?

- What has led you to believe that's the reason?

What types of approaches have you used to help or treat offenders who self-injure?

- Which ones were the most effective?
- What is it that makes an intervention effective?
- Was there any type of approach that you found ineffective or that you think made the situation worse?

Have you used an integrated approach to treat self-injury? (i.e., sought the help from physicians, nurses, mental health professionals, Elders, cultural/spiritual leaders, naturopathic medicine, etc?)

- If yes, have you found these approaches effective/helpful for the offender? How so?
- Is this a formalized treatment model in your institution?
- Would you recommend this approach to others who are working with Aboriginal offenders who self-injure?

Why do you think offenders desist from self-injury?

- For example: maturation, programming, better alternatives to coping, better support, closer supervision, better communication, participation in activities, learning about culture, etc.

Do you think culture or spirituality plays a role in desistance from self-injury?

- If yes, how do you think it affects the offenders?

➔ Have you noticed a change or a difference in offenders before/after they take part in cultural and spiritual activities?