
**Community Mobilization for Women
and Girls Who Self-Harm:
An Environmental Scan of Manitoba Service Providers**

Project Phase III

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in Conjunction with the Elizabeth Fry Society of Manitoba**

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The opinions expressed in this report are those of the authors, Catherine J. Fillmore and Colleen Anne Dell, and do not necessarily represent those of their affiliations or the Elizabeth Fry Society of Manitoba.

“This issue, or the lack of awareness and knowledge regarding treatment, prevention and awareness activities surrounding self-harm, needs to be urgently developed and implemented.”
(Survey #18)

DEDICATION

In Memory of Darcie Hall

Darcie first came to the Crossing Communities Studio in 2000, and without a moments hesitation, she courageously jumped right into making art. Darcie never missed a studio except for the times that she was too sick from pain and nausea. One of the first artworks that Darcie made was a small, stitched train cast in wax; and all around the train there were delicate, red threads sticking out of the wax. She said that when she stopped self-harming, she would remove the threads. Darcie has passed on now, and the train with the threads is still here. She was kind, intelligent, and delightfully funny and taught us all that we have so much to learn about how to care for each other.

We miss you Darcie.

With love, Edith and all of the girls and women in the Crossing Communities Art Project

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REPORT SUMMARY

Self-harm among women and girls is a serious health concern in Canada (Fillmore and Dell 2001; Presse and Hart 1999; Arbour 1996; CAEFS 1995; Weekes and Morrison 1992). In 2000, the Elizabeth Fry Society of Manitoba initiated an *exploratory study* of women in correctional institutions and in the community who had a history of self-harm. Considerable understanding and insight was gained from this research regarding the women's perceptions of self-harm, their needs, the risk factors, and the programs (supports and services) provided by community agencies and correctional institutions to address self-harm. Greater awareness was also attained in these areas regarding staff perceptions of self-harm and the centrality of culture in Aboriginal healing programs, supports and services. The full report, *Prairie Women, Violence and Self-Harm* (PWVSH) accessed at: <http://www.pwhce.ca/pdf/self-harm.pdf>. Some of the major findings of this study included the following:

- There was a strong relationship between childhood and adult experiences of violence and involvement in self-harm;
- The onset of self-harm occurred primarily in adolescence;
- There was a lack of awareness of existing resources for self-harm in the community and in correctional institutions;
- Specific programs and clear guidelines and policies on self-harm were generally lacking in both community and correctional settings;
- There was a critical need for Aboriginal programs, supports and services designed and delivered by Aboriginal women.

Informed by the women's narratives, staff perceptions, and a review of the interdisciplinary literature, a definition of self-harm evolved in the research as follows: ***Any behaviour, be it physical, emotional, social or spiritual, that a woman commits with the intention to cause herself harm. It is a way of coping and surviving emotional pain and distress which is rooted in traumatic childhood and adult experiences of abuse and violence. It is a meaningful action which fulfils a variety of functions for women in their struggle for survival.*** A corresponding Holistic Model of Self-Harm was also constructed. It demonstrated the wide range of conduct that involved the body in the expression of emotional pain and distress. This ranged from inflicting external forms of harm, e.g., slashing the skin, to less visible, internal forms of harm, e.g., substance abuse. There were six main categories of self-harm classified in this model. In hierarchical order, these were: (1) physical self-injury; (2) self-destructive behaviours; (3) destructive relationships; (4) expressions of suicide; (5) body enhancement, and (6) self-injury related to psychiatric disorders. The nature of women's self-harm was clearly multi-dimensional and complex. Many of the women had become disenfranchised through poverty, sexism, a history of colonization, racism and discrimination, and it was within this context that some women turned to self-harm. ***This understanding led to a view of self-harm as a necessary though unhealthy way of coping with distressing and oppressive conditions in women's lives.*** This perspective on self-harm became the foundation of the subsequent two phases of the self-harm project.

In 2002, the Elizabeth Fry Society developed a *second phase* of the self-harm project. The focus of this project was to increase awareness of self-harm as an important health issue among criminalized women through a systematic dissemination of the research findings from the 2001 report, *Prairie Women, Violence and Self-Harm* as well as to strategically disseminate this new knowledge. The major target populations were foremost the women participants of the study, women (in the community and correctional institutions) who self-harm, service providers, major decision makers in the fields of health and justice, and educators in the school and university systems.

In 2003, the Elizabeth Fry Society established *phase three* of the self-harm project. Both the findings of the 2001 PWVSH study and the team's knowledge translation activities signalled the need to gain a greater understanding of the perspective of community service providers on women's and adolescent girls' self-harm. In this phase, the research team worked in active collaboration with the Winnipeg Intersectoral Committee on Self-Harm, which was established during the second phase of the project, to develop an environmental scan of Manitoba community and institutional service providers who work with women and girls who self-harm.

The purpose of this current environmental scan is to examine the knowledge, experiences and practices of service providers on several dimensions of self-harm: social portraits of women and girls who self-harm; definitions, perceptions and awareness of self-harm; prevalence of self-harm; risk factors; responses to self-harm; and recommendations. The major research goals are to build a knowledge-base of the perceptions and awareness of self-harm across a broad spectrum of community and institutional service providers in Manitoba, to construct a database of existing resources, to identify guidelines for programs and policies, to investigate specific research questions and relationships that emerged from the 2001 PWVSH research, and to share this information in a Manitoba community forum and to plan the next steps for action in developing guidelines for self-harm programs and policies.

Survey Respondents— the Service Providers

The client population of the service providers was based on three main groups. The largest client group was composed of women and girls, followed closely by women clientele, and then a client group of adolescent girls only. Nearly half of the agencies provided services specific to Aboriginal women and/or adolescent girls. The majority of the service providers occupied managerial and supervisory positions, and roughly one-third of them were in front-line staff positions. Most of the respondents had been in their current position for several years. The average length of employment for supervisors was close to ten years, and for both managers and front-line staff, it was just over seven years. The respondents had considerable work experience in their field, with supervisors averaging just over 16 years of experience, and front-line staff and managers averaging around 12 and 14 years, respectively.

Social Portrait of Women and Girls Who Self-Harm

The service providers' social portrait of their *adult women* clientele who self-harm reflected to a large degree the women in the 2001 PWVSH study. The majority of the women clients were in their early and middle adult years. They had relatively low levels of educational attainment, although nearly a fifth of them had obtained some level of post-secondary education. Thirty-nine percent of the women had completed junior high, and twenty-six percent of them had finished high school. Nearly half of the women were Aboriginal and about a third were Caucasian. The women had high rates of unemployment and underemployment. More than two-thirds of the women were unemployed, and only sixteen percent of them were able to secure full-time work. Only a third of the women were married or living common-law. A third of the women were single, while another third were separated, divorced or widowed. It is important to note that over three-quarters of the women had dependent children to support. Two-thirds of the women were Canadian citizens. Among the agencies that worked with adult women, approximately half of their clientele had a history of criminalization. Like the 2001 PWVSH study, this portrait underlined the material deprivations of poverty and the women's difficulties in accessing stable employment to support themselves and their children.

The service providers reported that their women clients had experienced significant levels of abuse and violence in their lives both during their childhood and as adults. They had a history of child abuse from family members as well as from strangers. In their adult years, they experienced considerable partner violence. Of special significance is the finding that abuse by a former partner was the most common type of abuse experienced by the women. This was supported in the 2001 PWVSH study, which also found a strong relationship between partner abuse and violence and self-harm. The service providers also reported that their women clientele were perpetrators of physical aggression or violence throughout their childhood and adult lives. The most common context for its expression was within the family. This was another finding that was strongly supported in the 2001 PWVSH study. Finally, for a large majority of women, a pattern of physical aggression or violence originated in their adolescence.

The 2001 PWVSH study did not address *adolescent girls* specifically, but the findings suggested that the onset of self-harm was typically in adolescence. For the current environmental scan, the service providers described several traits of their adolescent client population. Approximately half of the adolescent girls were between 12 and 14 years old, and half were between 15 and 17. With respect to schooling, forty-six percent of the adolescent girls were attending junior high, and a third of them were attending high school. Of special note is that a sizable percentage (18%) of the girls were not attending school. Approximately a third of the girls worked, although these were mostly in part-time jobs. A large percentage (63%) of the adolescent girls were Aboriginal, and about a quarter of them were identified as Caucasian. Slightly more than two-thirds of the girls were Canadian citizens. Among the agencies that reported working with adolescent girls, two-fifths of their clientele had a history of criminalization.

A striking feature of the service providers' social portrait of the adolescent girls was the high level of family disruption and trauma in their lives. Only thirty-six percent of the girls lived with their families, while the rest lived in foster families, residential facilities or group homes. A small percentage (8%) of the girls lived on the streets or with their friends. Another significant feature was the high degree of family abuse and violence experienced by the adolescent girls, even greater than that reported for the adult clientele. Like the women clientele, the adolescent girls also experienced considerable abuse and violence both from strangers and in their dating relationships. Finally, in keeping with the findings for the women clientele, the service providers reported that the adolescent girls had also displayed physical aggression, and that it was primarily against other family members.

Definitions, Perceptions and Awareness of Self-Harm

Nearly half of the service providers reported that their agency had formulated a *definition* of self-harm. These definitions shared three main themes: (1) self-harm involves a broad range of behaviours; (2) it is a coping or survival response to deep emotional pain; and (3) it is an intentional act without conscious suicidal intent. This perception of self-harm is highly consistent with the findings of the 2001 PWVSH study.

The service providers generally were in strong agreement with all the *types of self-harm* listed in the survey. These were identical to those listed in the 2001 PWVSH study, and this finding corroborated the view that self-harm involves a diverse range of behaviours. There was also a similar ranking in terms of the importance of each type of self-harm, with physical self-injuries, sexual risk-taking and substance abuse ranked at the top. It is important to point out that the service providers identified a few new forms of self-harm—for example, gambling and gang affiliation.

All the service providers agreed with the view of self-harm as a coping strategy to deal with emotional pain and distress. They also supported all the *coping functions* of self-harm that were listed in the survey, which were consistent with those in the 2001 PWVSH study. There were, however, some significant new findings. The service providers in the present study showed much greater awareness of self-harm as a response to an abusive partner, as a form of cleansing or releasing of emotional pain, and as a means of regaining power or control over one's self.

More than sixty percent of the service providers reported that their agency did *not* have a *policy* on self-harm. The lack of a clear policy on self-harm was a consistent finding with the 2001 PWVSH research. For the service providers who reported a policy on self-harm in the present study, a fairly common response in community settings was a harm-reduction and protection planning model. In institutional settings, some service providers described their use of "behaviour chain analysis," a practice that involved charting incidents and possible triggers as well as close monitoring or constant observation following an incident of self-harm. Some service providers reported the protocol of a specific suicide risk assessment tool and an intervention strategy, while others emphasized that incidents of self-harm needed to be treated differently than suicidal

behaviour. The responses of service providers, working in crisis or urgent care centres, differed in some respects by emphasizing the importance of client involvement—for example, the women treating their own wounds; and they also indicated a concern with “copycat” behaviour. Specific to the adolescent age group, service providers noted that contacting guardians and assisting with making agency referrals were a common part of their policy responses. A third of the service providers who did not have a direct policy on self-harm identified alternative health care policies that fell under various types of legislation, such as the Mental Health Act and Child Protection Act, as well as emergency department protocol. An important finding that emerged was the recognized need for an integrated and systemic approach to self-harm policies.

The findings from the 2001 PWVSH study suggested that clients for the most part can make a clear distinction between self-harm and *suicidal behaviours*. Based on their professional experiences and opinions, the service providers in the present study also indicated that most clients were able to make a distinction between self-harm and suicidal intentions. This view, however, was not shared by all service providers. While the majority of service providers felt that their clients were able to make a clear distinction, they also expressed some doubt for a small number of their clients. Furthermore, some of the service providers’ responses indicated that they wanted a clearer understanding of the relationship and differences between self-harm and suicide. This is an area of unquestionable concern to service providers, and one that requires further study and careful examination.

In the 2001 PWVSH study, the correctional staff identified *peer influence* as a risk factor for women’s involvement in self-harm in a residential setting. For the service providers in this environmental scan, however, there was considerable uncertainty about the role of peer influence for women and adolescent girls. Seventy-five percent of the service providers for adolescent girls and forty-four percent of the service providers for women expressed uncertainty regarding the role of peer influence on self-harm. Similar percentages of service providers felt that peer influence was a factor in women’s and adolescent girls’ self-harm—22% and 17% respectively. The open-ended responses by the service providers provided greater insight into this relationship, suggesting that adolescent peers who self-harm were a contributing factor to girls’ involvement in self-harming behaviours. This is another area that requires further investigation.

Prevalence of Self-Harm

The service providers found it difficult to estimate the prevalence of self-harm among their adult and adolescent female clientele. Two-thirds of the service providers, for example, were unable to provide any information on the extent of self-harm and on any changes in the rates of self-harm for their clientele over the past two years. For those respondents who identified an increase in self-harm among women and adolescent girls in community agencies and correctional institutions, certain similarities were found both in the forms of self-harm (physical self-injurious behaviours, alcohol and drug abuse, and destructive relationships) and in the reasons for the increase in self-harm (family problems, past abuse, greater service provider awareness, and an increased comfort in

disclosure). A number of factors appeared to influence the prevalence rates and should be considered in reviewing these findings. These factors related to the reasons for low reporting rates (e.g., respondents' fear of a punitive response) as well as for high reporting rates (e.g., increased awareness of self-harm among service providers). There are other factors that should also be taken into account, such as variations in the definition of self-harm (from specific to general) and a lack of systematic data collection.

More specifically, fourteen percent of the *community service providers* identified an increase in self-harm among their *women clients* for four types of self-harm: physical self-injurious behaviours (slashing, burning), alcohol and drug abuse, sexual risk taking, and involvement in destructive relationships. Some of the major reasons reported for this increase were related to family and marital problems, abuse issues and a greater openness of service providers in addressing self-harm.

For *correctional institutions*, twenty-one percent of the service providers reported an increase in *women's* self-harm, notably for three types of self-harm: physical self-injurious behaviours, alcohol and drug use, and tattooing. Gambling, a type of self-harm not identified in the 2001 PWVSH study for incarcerated women, was also reported. The main reasons identified for this increase in self-harm were associated with a greater awareness among correctional staff about self-harm as a coping response and a greater willingness among the women themselves to talk about their self-harming behaviours to staff.

With respect to *adolescent girls*, twenty-one percent of the *community service providers* identified an increase in self-harm—a higher percentage than that reported for the women clientele. They reported that the most common increases in self-harm were for physical self-injurious behaviours and destructive relationships. Consistent with the findings for the women clientele, the service providers identified family and relationship problems as the major reasons for the increase in self-harm among adolescent girls. In addition, they identified two other important factors: loss of cultural identity for Aboriginal girls and the influence of peers who self-harm. The service providers related this increase in self-harm to greater agency awareness and reporting of self-harm and to greater client disclosure.

For *correctional institutions*, twenty-two percent of the service providers identified an increase in *adolescent girls'* self-harm—a similar increase to that reported for women. The respondents reported increases mainly for physical self-injurious behaviors, drug and alcohol abuse, and destructive peer relationships. The major reasons that the respondents identified for this increase were family abuse, placement breakdowns, loss of family connection and cultural identity issues for Aboriginal girls.

Risk Factors for Self-Harm

The painful experiences of marginalization and disenfranchisement that the women and adolescent girls endured in their daily lives strongly shaped their ability to cope. For many of the women and girls, these conditions increased their emotional pain and distress

and therefore the propensity to self-harm. The service providers identified eight major areas that they felt placed *women* at risk of self-harm in the *community*. These included the following: experiences of abuse and violence, family disruption, social isolation, unhealthy personal relationships, poor levels of health, and social structural factors, primarily those related to subsistence living and consequent discrimination and marginalization. These findings are consistent with the risk factors reported for women in the 2001 PWVSH research. The service providers in this environmental scan, however, described these risk factors in much greater detail and also identified additional areas of risk. They detailed, for example, the devastating impact of residential schools and the history of colonization as factors that increased Aboriginal women's risk of self-harm. In addition, the respondents identified negative relationships with government agencies as a risk factor. Finally, the service providers emphasized community disorganization and lack of resources as important factors contributing to women's self-harm in the community.

The service providers identified six main risk factors for *women in institutions*. It is important to point out that the respondents focused primarily on correctional institutions. These were separation from the family, stressful conditions of the institutional environment, negative staff relations, difficult peer relationships, segregation and mental health issues. Three of the central risk factors that the service providers identified were directly related to the emotional distress experienced by women placed in detention, notably the pains of imprisonment. These factors were concerns and fears of losing their children, the trauma of segregation, and negative relationships with institutional staff. While the correctional staff in the 2001 PWVSH study did not report negative staff relations, the women in that study did identify this as a risk factor for self-harm. In both studies, the service providers placed great emphasis on the conditions of the institutional environment and its role in increasing women's emotional pain and distress and thus their tendency to self-harm.

In the 2001 PWVSH study, many of the women identified adolescence as the period for the onset of self-harm. The service providers in the present study identified six major risk factors for *adolescent girls* in the *community*. These were experiences of abuse and violence, family disruption and trauma, social isolation and lack of healthy peer relationships, weak ties and involvement in youth community activities and lack of access to resources, poor personal health factors, and social structural factors, mainly related to family poverty and transient living conditions. Although adolescent girls and women in the community shared certain risk factors, particularly experiences of abuse and violence, for adolescent girls there was an even greater concern with sexual exploitation by family members and/or strangers and involvement in the sex trade. Other similarities included lack of community resources, social isolation, and personal health factors such as alcohol and drug abuse. Overall, the service providers identified a multiplicity of risk factors and emphasized the confounding effects of poverty, abuse, poor mental health, developmental disabilities, and negative peer influences, including bullying, which leave youth vulnerable to self-harming behaviours.

The experiences of *adolescent girls* in *institutions*, in particular, detention in a correctional facility, introduced a number of risk factors that increased their likelihood of self-harm. The service providers in this environmental scan identified six main risk factors: separation from family, negative relations with institutional staff, poor peer relationships (negative peer influence and bullying), family histories of childhood abuse and neglect and the experience of loss within the family, mental health issues (depression and substance abuse) and identity issues. The respondents recognized how the lack of a trusting relationship with staff left adolescent girls without an outlet to deal with their complex histories of abuse and loss, their feelings of isolation and their mental health needs. They also suggested that bullying played a greater role for adolescents than for women and that it had a demoralizing influence on adolescent girls, which can lead to self-harm. It is noteworthy that these coincide to a large extent with the institutional risk factors for women, with certain exceptions—for example, the issues of self-esteem and identity, which are critical to healthy adolescent development.

Responses to Self-Harm

The service providers reported that their *women* clients most frequently were involved in the following four types of self-harm: physical self-injury (cutting and slashing), self-destructive behaviours (alcohol and drug abuse—both illegal and prescription/over the counter), destructive relationships (family violence) and expressions of suicide (suicidal thoughts and attempts). For the 2001 PWVSH and the present study, the service providers' responses were fairly consistent regarding certain guiding principles of care for women who self-harm. They identified, for example, empowerment, cultural sensitivity, and compassionate and committed staff who provide follow-up and continuity of care. A common theme underlying the responses of the service providers in both studies was the provision of on-going, coordinated and empathetic support. Some of the main guiding principles and courses of action that defined the responses of the service providers to women's self-harm included:

- Offer choices and information about the consequences of self-harm to empower women;
- Provide feedback and support to women as they progress through the stages of their healing;
- Provide support, advocacy, and access to appropriate community resources (shelters, alternative housing transportation) and make referrals to them (medical appointments, community mental health worker, an Elder);
- Ensure that there is contact with workers associated with a specific culture.

The three most common types of self-harm identified by the service providers for *adolescent girls* were physical self-injury (slashing, cutting), self-destructive behaviours (eating disorders, sexual risk-taking and substance abuse) and destructive relationships (childhood-based trauma and victimization). The major theme underlying the service providers' responses to self-harm among adolescent girls was the provision of care within an environment of acceptance and compassion, although they also emphasized the importance of an integrated approach based on a range of community supports and

services. Some of the main guiding principles and courses of action that defined the service providers' responses to the care of adolescent girls' self-harm included:

- Encourage active participation in care to foster a feeling of empowerment, e.g., involving client in caring for wounds;
- Use a broad range of community supports and services, e.g., from referral to the appropriate agency, such as the Mental Health Association, to spiritual guidance by an Elder;
- Provide educational opportunities in comfortable settings (small groups or on an individual basis);
- Assess the client's needs within a broader social context and ensure appropriate integration of services.

In the 2001 PWVSH report, the community workers and correctional staff identified one of the most helpful responses to self-harm as having Aboriginal programs and healing approaches. In this environmental scan, a large majority of the service providers reported that they had a cultural component in their programs (supports or services) for **Aboriginal women** (77%) **and girls** (63%). These encompassed a broad range of cultural teachings, traditional ceremonies and healing approaches. The service providers described some of these for their **women** clients as follows:

- Traditional Aboriginal Spirituality using the Medicine Wheel as a teaching tool in programming;
- Programs on developing healthy relationships, including a focus on working with survivors of residential schools;
- Cultural awareness workshops, on-site sweat lodges, full-moon ceremonies, Sun Dances;
- Sharing circles with an Elder, sweats, ceremonies, awareness of history and culture;
- Availability of Elders for traditional counselling.

For **Aboriginal girls**, the service providers reported similar kinds of programming. They identified, however, some important differences. The respondents described the need for much greater inclusion of Aboriginal staff in programming and for increasing the numbers of Aboriginal foster parents. In addition, the service providers emphasized the challenge of ensuring that children claim their Aboriginal identity in a positive way. It is also important to point out that many service providers were active in referring their clients (both women and adolescent girls) to culturally-specific programs.

Recommendations

The service providers identified five main areas of recommendations for working with **women** who self-harm. These were (1) to raise community awareness about self-harm (e.g., the complex nature of self-harm as a coping mechanism); (2) to increase educational opportunities about self-harm (e.g., self-harm and suicidal intentions); (3) to provide more training on self-harm for service providers (e.g., more education and organizational workshops); (4) to increase resources for women who self-harm—from

specialized programs to follow-up supports and services (e.g., need for more outreach services, follow-up, mentoring opportunities and advocacy); and (5) to address the broader social structural factors underlying women's self-harm (e.g., systemic issues of poverty, safe housing, adequate nutrition, education, child-care and employment). These were highly consistent with the recommendations proposed by the service providers in the 2001 PWVSH study. It is important to point out that while an Aboriginal approach to healing was not addressed in the recommendations, it was strongly advocated in many other sections of the environmental scan.

The service providers identified five main areas of recommendations for working with *adolescent girls* who self-harm. While these were broadly similar to those reported for women, the recommendations were oriented specifically toward the needs of adolescents. Under the first recommendation of raising community awareness, for example, the service providers pointed out the importance of distinguishing self-harm as a health issue and not just teenage rebellion. For the second recommendation of increasing educational opportunities for youth, they emphasized the importance of including parents in educational workshops. With respect to the third recommendation of providing more training for service providers, the respondents noted the need for including a wide spectrum of adolescent settings, such as foster and group homes, in order to introduce earlier interventions to troubled girls at risk of self-harm. Regarding the fourth recommendation of increasing resources, the respondents emphasized the need to include more supports and services oriented specifically toward adolescents. Under the fifth recommendation of addressing the broader social structural factors, the service providers emphasized the need for more adequate housing and shelters for youth and more counselling services for children and adolescents. Overall, the recommendations for adolescent girls were distinct from those reported for women in some important respects. There was a greater emphasis on addressing troubled family relationships, on recognizing the vulnerability of youth to sexual exploitation and the heightened risk of self-harm, and on dealing with issues of identity and self-esteem.

Next steps

In summary, this environmental scan of service providers emphasized the need for specific steps to be taken to address the issue of self-harm. The following statements outlined the need for action in certain areas:

- It is necessary to standardize definitions of self-harm and to implement systematic methods of data collection in order to assess the prevalence and types of self-harm in various settings;
- While there are studies on women's perceptions of self-harm, there is a need for qualitative research on the perceptions of youth and self-harm;
- Service providers require greater opportunities to learn about the agency or institution's policy guidelines or common practices; where these are not formulated, a forum is necessary to identify and develop policies and practices;
- Further research is necessary to explore the relationship and differences between self-harm and suicide;

- There is a lack of evaluative research on treatment and healing approaches, programs, supports and services for women and adolescent girls who self-harm; careful monitoring and evaluation of intervention strategies are essential to improve the quality of care;
- Service providers require opportunities to learn about the existing resources on self-harm, especially on the available effective or promising treatment and healing approaches;
- Public education campaigns are necessary to improve both public and professional understanding of self-harm;
- There is a persistent lack of adequate health care services for Aboriginal women, which requires immediate attention in developing culturally-specific healing approaches, programs, supports and services for self-harm; these interventions need to be designed, developed, implemented and evaluated by Aboriginal women.

The immediate next step in this research is to address the two remaining outlined goals of the project. First, the findings of this environmental scan will be shared in a Manitoba community forum, and the next steps for action will be planned with respect to developing guidelines for programs and policies. Specifically, the purpose of this forum will be to discuss the environmental scan in light of its new findings and its comparability with the 2001 PWVSH study. Drafts of the guidelines for programs and policies on self-harm will also be prepared and discussed. This community forum will be held in conjunction with the Crossing Communities Art Project and will involve the survey respondents, the Winnipeg Intersectoral Committee on Self-Harm, women who have the lived experiences of self-harming, the research team, and other key community agencies and individuals. This event is expected to take place in winter, 2005.

Second, a research project that emerged from the 2001 research study and the current environmental scan will commence in the summer of 2005. It will also be discussed at the winter 2005 community forum. Specifically, with funding from the Canadian Institutes of Health Research, Institute of Aboriginal Peoples' Health, a three year project will be undertaken to examine the role of self-identity in the healing journeys of Aboriginal women who have a history of criminalization and who are identified as drug users. The research will commence with an understanding of women's drug use as a form of self-harm. This project is a collaborative effort of Carleton University, the National Native Addictions Partnership Foundation, the Canadian Centre on Substance Abuse, the Elizabeth Fry Society of Manitoba and the University of Winnipeg. The goal of the study is to contribute original knowledge to the treatment field that can assist in improving the quality of health for Aboriginal women in Canada.

SECTION I

OVERVIEW OF THE THREE PHASES OF THE SELF-HARM PROJCTET

Self-harm among women and girls is a serious health concern in Canada (Fillmore and Dell 2001; Presse and Hart 1999; Arbour 1996; CAEFS 1995; Weekes and Morrison 1992). The Elizabeth Fry Society of Manitoba, in its work with criminalized women and girls, recognized an increase in the number of women who self-harmed as a way of coping with emotional pain and distress. The need for further research to gain a greater understanding of self-harm among women was evident, and this led to two related research initiatives and one knowledge translation strategy¹.

In 2000, the Elizabeth Fry Society initiated an *exploratory study* of women in the community and in correctional agencies who had a history of self-harm. This project was made possible by a grant from the Prairie Women's Health Centre of Excellence. The study focused on the women's perceptions of self-harm and their needs, the risk factors, and the programs (supports and services) provided by community agencies and correctional institutions to address self-harm. Specific attention was also paid to staff perceptions of self-harm in relation to the programming needs of Aboriginal women. The full report, *Prairie Women, Violence and Self-Harm* (PWVSH), can be accessed at: <http://www.pwhce.ca/pdf/self-harm.pdf>. Some of the major findings of this study included:

- The women perceived a broad range of behaviours as self-harm; these extended beyond the traditional focus on direct, physical injuries to the body and encompassed such behaviours as illicit drug use, alcohol abuse and sexual risk-taking;
- The onset of self-harm occurred primarily in adolescence;
- There was a strong relationship between childhood and adult experiences of violence and involvement in self-harm;
- There was a lack of awareness of existing resources for self-harm in the community and in correctional institutions;
- Specific programs and clear guidelines and policies on self-harm were generally lacking in both community and correctional settings;
- There was a need for Aboriginal programs, supports, and services designed and delivered by Aboriginal women.

¹ Knowledge translation is defined by the Canadian Institutes of Health Research as “the exchange, synthesis and ethically-sound application of knowledge-within a complex system of interactions among researchers and users-to accelerate the capture of the benefits of research for Canadians through improved health, more effective services and products, and a strengthened health care system” (CIHR 2004).

In 2002, the Elizabeth Fry Society received funding from the National Crime Prevention Strategy to develop a *second phase* of the self-harm project. The focus of this project was to increase awareness of self-harm as an important health issue among criminalized women through a systematic dissemination of the research findings from the report, *Prairie Women, Violence and Self-Harm* (2001) as well as to strategically apply this new knowledge. The major target populations were firstly the women themselves who participated in the study, service providers, major decision-makers in the fields of health and justice, and educators in the school and university systems.

Through the collaborative efforts of the research team, the research findings were translated in a variety of ways. These included the development of a national resolution on self-harm with the Canadian Association of Elizabeth Fry Societies; the distribution of more than 3,500 plain language summaries of the research report to community agencies and correctional facilities; presentations to the offices of the Minister of Justice and Minister of Health in Ottawa, the provincial Department of Justice in Manitoba, and the Canadian Human Rights Commission on federally sentenced women; meetings with prison representatives from provincial correctional facilities (Portage Correctional Centre, Manitoba Remand Centre, Manitoba Juvenile Detention Centre) and federal corrections (Correctional Service Canada); public lectures and presentations with community service providers and at academic conferences; preparation of publications for academic journals and community newsletters; participation in relevant community events through Elizabeth Fry Society partnerships, such as the Crossing Communities Art Project²; and on-line access to the report.

A critical development toward the end of the second phase of the project was the establishment of a broad, community-based partnership among Winnipeg agencies and organizations. The Winnipeg Intersectoral Committee on Self-Harm was convened in 2002. It was composed of a diverse membership of service providers and professionals in the Winnipeg community who expressed a deep interest and concern for the health and well-being of women and girls who self-harm. The Intersectoral Committee played an active and invaluable role in the present research project, which is described in more detail in the methodology section of this report.

In 2003, the Elizabeth Fry Society received a second grant from the National Crime Prevention Strategy to establish *phase three* of the self-harm project, "*Community Mobilization for Women and Girls Who Self-Harm: An Environmental Scan of Manitoba Service Providers.*" This phase of the project emerged from the findings of the first study of *Prairie Women, Violence and Self-Harm (2001)* and from the team's knowledge translation activities. Both signalled the need for gaining a greater understanding of the perspectives of service providers: their perceptions of self-harm, the risk factors, awareness of resources, and their programs (supports and services) and policies on self-

² The Crossing Communities Art Project is a non-profit charitable organization dedicated to using the arts to empower criminalized women and girls and those at risk of criminalization (Regier 2005:1). Through its art mentorship projects, women and girls who self-harm are offered an alternative means of coping (2005:8).

harm. In the third phase of the self-harm project, the Winnipeg Intersectoral Committee worked in close and active collaboration with the research team to develop an environmental scan of Manitoba service providers.

SECTION II

BACKGROUND

I. ELIZABETH FRY SOCIETY OF MANITOBA

The Elizabeth Fry Society (EFS) of Manitoba is one of twenty-four, community-based agencies across Canada whose mandate is to assist criminalized women and girls. The agency network, under the Canadian Association of Elizabeth Fry Societies (CAEFS), is founded on the pioneering work of Elizabeth Fry who worked to educate prison officials and the public about the adverse conditions for women at the Newgate Prison in London, England in 1812. In the early 1950s, the Manitoba branch of the Elizabeth Fry Societies was established, continuing Elizabeth Fry's legacy by promoting community education and awareness about women in the criminal justice system and by offering programs, services and supports to Manitoba women. Nearly a half a century later, the EFS of Manitoba continues to advocate on behalf of women and girls who have been or may be at risk of criminalization. The EFS of Manitoba actively partners with other community agencies and organizations in order to ensure that women and girls receive substantive equality in program delivery and services. It has spearheaded several, community-initiated projects over the past few years, including the self-harm research to the benefit of their clients.

II. RESEARCH TEAM

Members of the initial self-harm research team who contributed to the third phase of the project included Debbie Blunderfield³, Cathy Fillmore and Colleen Anne Dell. There were also two new additions to the team, University of Winnipeg students, Nailini Sookoo and Jori Thorvardson.

³ Debbie Blunderfield completed her tenure as the Executive Director of the Elizabeth Fry Society in March, 2005.

III. MEMBERS OF THE WINNIPEG INTERSECTORAL COMMITTEE ON SELF-HARM

As a community-initiated, participatory research project, members of the research team worked in close collaboration with the Winnipeg Intersectoral Committee on Self-Harm. Members of this committee represented a broad spectrum of community service providers in health, justice and social services. The following agencies and organizations were included:

- Canadian Mental Health Association
- Eastman Region Probation Services
- Department of Health & Community Services
- Manitoba Women's Advisory Council
- Misericordia Hospital
- New Directions
- Probation Services
- Winnipeg Remand Centre
- Crossing Communities Art Project
- Department of Child & Family Services
- IKWE-WIDDJIITWIN INC.
- Ma Mawi Wi Chi Itata Centre
- Native Women's Transition Centre
- Ndaawin
- Special Needs Program, Manitoba Family Services and Housing
- Wolseley Family Place

It is important to recognize that the contributions of project team members extended beyond their professional roles in the workplace to include the knowledge and experiences acquired from their participation in local communities as well as from their personal roles—whether as social activists or as mothers. Each member was deeply committed to the research outcomes that would improve the health and well-being of women and girls who self-harm, both in the short and long-term.

SECTION III

DEFINITION OF SELF-HARM

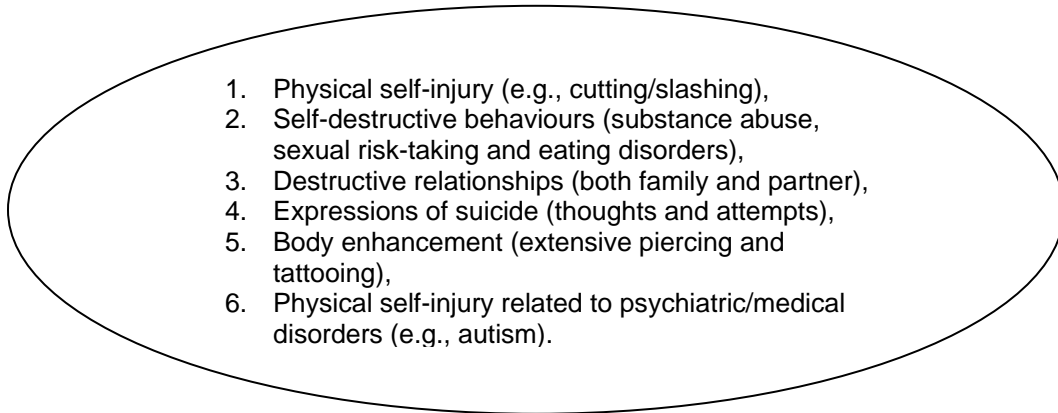
It is important to have a comprehensive understanding of the definition of self-harm, as it is the foundation for all three phases of the self-harm project. In the first phase of the research project, both a deductive and inductive approach was adopted in order to understand the complex nature of self-harm. It was deductive in that the starting point for the definition of self-harm was derived from an inter-disciplinary review of the literature. This traditional definition focused on direct, physical, and highly visible acts such as slashing, burning, and head banging and was termed *self-injury*.

The traditional definition with its focus on physical injuries or self-mutilation, however, proved limiting in a number of respects. It did not reflect the women's experiences and understandings or the range of behaviours that they identified as self-harming. It is noteworthy that the staff perceptions and accounts of self-harm in this first phase of the project also strongly supported the women's stories. Moreover, the traditional definition was inconsistent with some of the more current sociological, psychological, and mental health literature (Burstow 1992; Babiker and Arnold 1997). The research shifted therefore to an inductive approach by focusing on the women's own stories as the starting point for defining self-harm. Beginning with the women's definitions, experiences and understandings is an important contribution to the research literature, as most studies on self-harm have focused solely on the researchers' own theoretical positions (Liebling et al. 1997). A more meaningful definition of *self-harm* replaced the traditional definition of self-injury. The definition of self-harm that developed at this stage in the study was:

Any behaviour, be it physical, emotional, or social, that a woman commits with the intention to cause herself harm.

Based on this definition and the analysis of the data, a Holistic Model of Self-Harm was constructed (see Figure 1). This model is enclosed within a circle to represent the interconnected nature of women's self-harm and to demonstrate the wide range of conduct that involves the body in the expression of emotional pain and distress. The women identified several forms of self-harm including external, physical forms of harm such as slashing the skin and less visible, internal forms of harm such as substance abuse, sexual risk-taking and eating disorders. There are six main categories of self-harm classified in this model: (1) physical self-injury, (2) self-destructive behaviours, (3) destructive relationships, (4) expressions of suicide, (5) body enhancement, and (6) self-injury related to psychiatric disorders. These categories are subdivided further to include all the forms of self-harm identified by the women. In the model, the categories are hierarchically ranked with the most common forms of self-harm placed at the top. This typology and ranking of self-harm is corroborated in other studies (Babiker and Arnold 1997).

Figure 1: Holistic Model of Self-Harm

- 
1. Physical self-injury (e.g., cutting/slashing),
 2. Self-destructive behaviours (substance abuse, sexual risk-taking and eating disorders),
 3. Destructive relationships (both family and partner),
 4. Expressions of suicide (thoughts and attempts),
 5. Body enhancement (extensive piercing and tattooing),
 6. Physical self-injury related to psychiatric/medical disorders (e.g., autism).

The final change in the definition was the incorporation of the women's perspectives of the origins and functions of self-harm. A significant antecedent or origin of women's self-harm identified in this study was the experience of abuse and violence. This is corroborated by the literature which identifies a strong link between childhood abuse and self-harm (Mazelis 2003; Smith et al. 1998; Babiker and Arnold 1997; Shaw and DuBois 1991; Van der Kolk et al. 1991; Green 1987). The incorporation of the origins of self-harm in the final definition fills an important gap in the research literature that frequently overlooks the interconnected nature of self-harm and the link to both childhood and adult life experiences of abuse and violence (Livingston 1996; Ross et al. 1979). While childhood abuse and self-harm has strong empirical support, few researchers have included a focus on traumatic adult experiences of violence and self-harm (Greenspan and Samuel 1987). Most importantly, this definition expresses how self-harm serves as a coping response for women, and how it enables them to survive deep emotional pain and distress. The final definition of self-harm is:

Any behaviour, be it physical, emotional, social or spiritual, that a woman commits with the intention to cause herself harm. It is a way of coping and surviving emotional pain and distress which is rooted in traumatic childhood and adult experiences of abuse and violence. It is a meaningful action which fulfils a variety of functions⁴ for women in their struggle for survival.

⁴ These functions include: a need for attention and nurturing; a form of punishment and self-blame; a way of dealing with isolation and loneliness; a means of distracting and deflecting emotional pain; a response to an abusive partner; a cleansing and release of emotional pain; an attempt to regain a sense of reality and the feeling of being alive; a communication or message signifying painful life experiences; and an opportunity to feel a sense of power and control.

This definition and the Holistic Model of Self-Harm provided a solid framework for the analysis of self-harm throughout the three phases of the self-harm project. It is foremost a woman-centered approach that begins with the women's standpoints and locates their individual life experiences within the context of the broader socio-economic and political structures in order to understand their use of self-harm as a coping mechanism. Many of the women have become disenfranchised through poverty, sexism, a history of colonization, racism and discrimination. It is within this context that women turn to self-harm as a coping mechanism to survive their emotional pain and distress. Self-harm therefore is viewed as a means of survival rather than as an intention to end one's life. While it is an unhealthy coping mechanism, it is one that some women find necessary to deal with the pain and oppression in their lives (Burstow 1992). This view is also supported in the research of Currie (2001) and others (Neron 2000; Ship and Norton 2001; Mill 1997) who identified, for example, that women's "drug and alcohol use is a method of coping with specific crises or personal problems" (Currie 2001:12).

SECTION IV

RESEARCH PURPOSE & GOALS

I. PURPOSE

The current project, *Community Mobilization for Women and Girls Who Self-Harm: An Environmental Scan of Manitoba Service Providers*, emerged from the initial 2001 research, *Prairie Women, Violence and Self-Harm* (PWVSH), which identified the need to generate new knowledge on self-harm from the perspectives of service providers. In the earlier study, information was collected from a limited number of correctional and community service providers. A much larger sample was required to conduct a more detailed investigation. For this study the research focus shifted therefore from the perspectives of women and girls who self-harm to the perceptions and understanding of service providers. Very broadly, we wanted to document the knowledge, experiences, and practices of service providers who work with women and girls who self-harm.

Using a community-initiated, participatory approach to research and partnership, the purpose of this environmental scan is to examine the knowledge of service providers on several dimensions of self-harm: a social portrait of women and girls who self-harm; definitions, perceptions and awareness of self-harm; prevalence of self-harm among agency clientele; risk factors for self-harm; and service provider responses to self-harm. A service provider is defined as a Manitoba community organization, agency or institution (correctional or non-correctional) that provides services for women and/or girls who self-harm. Where applicable, the findings of the environmental scan are compared with those from the 2001 PWVSH report, highlighting similarities as well as differences. The aim of the environmental scan is to provide an integrated body of information that builds upon the existing knowledge-base contributed by phases one and two of the self-harm project.

II. GOALS

The five main goals of the environmental scan of Manitoba service providers are:

1. to build a knowledge-base of the perceptions and awareness of self-harm among a broad cross-section of community and institutional service providers in Winnipeg and in the rural regions of Manitoba and to compare these findings with the earlier study, *Prairie Women, Violence and Self-Harm* (2001);

2. to construct a database of existing resources (programs, supports and services) for women and girls who self-harm;
3. to identify guidelines for programs and policies based on the knowledge and experience of service providers involved in the care of women and girls who self-harm;
4. to investigate specific research questions and relationships that arose from the initial (2001) research (for example, adult experiences of violence and self-harm; self-harm and suicide; the influence of peers on involvement in self-harm; and specific programming, services, and supports for Aboriginal women and girls who self-harm);
5. to share the findings of the environmental scan in a Manitoba community forum and plan the next steps for action with respect to developing program and policy guidelines.

SECTION V

SERVICE PROVIDER RESPONSES TO SELF-HARM⁵: THE CURRENT LITERATURE ON PROGRAMS, PRACTICES AND POLICIES

The health treatment literature in general is criticized for its inadequate consideration of women's health needs and the lack of gender-specific models of treatment (Cormier, Dell and Poole 2003). Specific to the self-harming behaviour of substance abuse, for example, research shows that there is "greater stigma...attached to women's substance abuse problems; ...greater resistance on the part of family and friends; [and]...more negative consequences attached to treatment entry" (Roberts et al. 1999:36). As a result of the growing prevalence and awareness of self-harm (House et al. 1999), especially among adolescent girls (Clarke 2004; Hawton et al. 2002), greater attention has been paid to developing policy guidelines in Canada (e.g., Correctional Service Canada) and in other countries, such as the United Kingdom. One study in the U.K. reported that despite guidelines issued by governmental bodies (Department of Health and Social Security) and medical authorities (the Royal College of Physicians), only about half of hospitals actually have guidelines in place for the care of patients who self-harm; many hospital workers directly involved with patients who self-harm are not aware of the guidelines; and less than a quarter of the hospitals have a designated specialist team for making assessments (Thomas Coram Research Unit 1998:1-3). The lack of consistent policy-guidelines across service sectors was also a notable concern in the 2001 study, *Prairie Women, Violence and Self-Harm* (PWVSH).

Self-harm is a serious health problem, and while there are a variety of treatments available, there is little evidence of their effectiveness (Sinclair and Green 2005). Current studies on self-harm emphasize the lack of research on evaluating treatments and healing models for women and adolescent girls and suggest the need for further empirical-based research. A recent systematic review of the literature, for example, on the effectiveness of psychosocial and pharmacological treatments in reducing self-harm concluded that there was not sufficient evidence to make strong recommendations for the most effective forms of treatment (Hawton et al. 2002). It is fairly well established in the literature, however, that "it is crucial that a woman direct her own healing process, and not be stigmatized, punished or retraumatized for her choices" (Mazelis 2003:3). Other studies have pointed out that secondary services have limited impact on young people (Sinclair and Green 2005). For instance, the experience of a hospital admission to emergency can be traumatic for adolescents, as they often have difficulties in connecting with unfamiliar staff rather than "trusted and known general practitioners or counselors"; one youth, for example, spoke of how a counselor just wanted to go through "cognitive

⁵ It is important to point out that the lack of consistency in definitions of self-harm made it somewhat difficult to make direct comparisons with other studies; this is a common methodological problem for research on self-harm.

whatever (therapy); she spent an hour going through all this rubbish; and I just wanted to talk and she just wanted to go through her theories” (2005:5).

While limited, the following studies identify the helpful/promising responses (programs, practices and policies) and the more general guiding principles for the care and treatment of women and girls who self-harm. Since there is considerable overlap in the literature among these areas, they are discussed below under the two main headings listed: helpful/promising responses (programs, practices and policies) and guiding principles for care and treatment. As emphasized in the research literature, there is also a need to recognize the specific health and treatment needs of Aboriginal women and girls. This is discussed below in a third section on helpful/promising responses to Aboriginal women and girls who self-harm.

I. HELPFUL/PROMISING SELF-HARM PROGRAMS, PRACTICES AND POLICIES FOR WOMEN AND ADOLESCENT GIRLS

- Standardizing definitions of self-harm for more effective monitoring and evaluation of intervention strategies; more broadly, implementing a multi-disciplinary approach that focuses on underlying problems; and establishing a broad base of support, e.g., peer support programs (McHugh and Towl 1996:5);
- Implementing staff training about self-harm as part of initial professional training and in an ongoing in-service context that includes detailed information on the complex nature of self-harm, its relationship and differences to suicidal intentions; understanding the definition and functional nature of self-harm and its origins; opportunities for staff to discuss their feelings and concerns about self-harm; recognizing the need for staff to establish teams to identify their own needs for support, back-up and supervision; and providing information and research about helpful and unhelpful responses based on the perspectives of service users (Babiker and Arnold 1997:98-99);
- Requiring a psycho-social assessment before being discharged—one conducted by staff with specialized training on self-harm; putting procedures in place for referrals between professionals, such as general practitioners and psychiatric professionals, for out-patient and follow-up care; and stipulating that patients under 16 years are to be admitted as in-patients (Thomas Coram Research Unit 1998:3);
- Developing therapeutic programs that contextualize the client as a trauma survivor to identify the self-harming behaviour as a “coping mechanism for the after-effects of trauma survival” (Mazelis 2003:3);
- Avoiding the use of punitive responses in the attempt to control self-harm—for example, using physical restraint chairs, the granting and withholding of privileges, placement in segregation and strip cells (in secure environments) and

requiring clients to enter into contracts (Fillmore and Dell 2002); any responses that are “intrusive, dehumanizing and infantilizing” will only add to the client’s emotional distress and lead to further retraumatization and disempowerment (Mazelis 2003; Babiker and Arnold 1997:95); coercive interventions in general lead to an increased need to use existing coping skills which may involve self-harming behaviours (Mazelis 2003);

- Ensuring a judicious use of medications; based on a review of reports on the use of drug treatments for people who self-harm, Tantam and Whittaker reported that there was no evidence that drugs have any direct effect on the tendency to self-harm (cited in Babiker and Arnold 1997:92); other studies suggest that they may in fact produce untoward outcomes; for example, service users felt that the medications did not help them to address the root causes of their distress and added to their feelings of “unreality, confusion and inability to cope” and thereby led to more self-harming behaviours (1997:91);
- Using therapeutic programs that treat self-harm as a sign of emotional distress rather than as an issue of security (Fillmore 2005; Heney 1990); Correctional Service Canada, for example, which has reported a shift in its approach from one of security to treatment, employs dialectical behavioural therapy (DBT) as a primary intervention tool to reduce self-harm (Sly and Taylor 2003);
- Developing programs that train incarcerated women as peer counselors (Heney 1990);
- Encouraging existing primary relationships with professionals, such as general practitioners or school counselors, rather than dealing with professionals of secondary services, such as in hospital emergency departments; increasing accessibility of treatment for alcohol abuse problems; recognizing and treating depression; and organizing public education campaigns to improve public and professional understanding of mental illness and the available effective treatments (Sinclair and Green 2005:8);
- Implementing problem-solving therapy, long-term psychological therapy and assertive outreach (Hawton et al. 2002:2); a competent therapist with strong interpersonal skills (e.g., ability to forge a therapeutic alliance with the client) is associated with an increase in positive treatment outcomes (Link et al. 1997; Hester 1995; Najavits and Weiss 1994);
- Providing quick, accessible and comprehensive services in making after-care arrangements and which include a mechanism for engaging clients who generally do not attend routine clinic appointments; increasing access for general practitioners to obtain training, information, and guidelines for assessment and management of self-harm patients in primary care (House et al. 1999:141);

- Providing opportunities for service providers to learn about their agency's self-harm policy, guidelines or common practices; identifying and developing policy guidelines where there are no existing policies or guidelines in place (Babiker and Arnold 1997:100).

II. GUIDING PRINCIPLES FOR THE CARE AND TREATMENT OF WOMEN AND GIRLS WHO SELF-HARM

- Employing feminist therapies that recognize the connections between women's experiences of marginalization and disenfranchisement (poverty, abuse, sexism, history of colonialism and racism) and how these relate to women's criminalization (Kendal 1991) and self-harm (Fillmore and Dell 1991);
- Promoting qualities for effective staff-patient relationships: acceptance, understanding, compassion and respect (Babiker and Arnold 1997:88);
- Using an approach that recognizes and respects self-harm as a coping mechanism to survive emotional pain and distress; accepting the clients' self-harm and eventually turning toward other safer means of coping through a process of supportive exploration (Babiker and Arnold 1997:95); in contrast, avoiding punitive responses to women's self-harm such as trivializing its seriousness, making disparaging and disrespectful comments and ignoring the issue, as these only exacerbate feelings of emotional pain, distress and isolation (Elliott and Morris 1987);
- Encouraging integrated services for people with multiple vulnerabilities (Mazelis 2003:4) and providing a holistic approach to care because "...an individual is much more complex than just their substance use or self-harm" (Don 2005);
- Focusing on the root causes of the self-harm, including child physical and sexual abuse, to promote healing through counselling, group work and therapies that facilitate exploration, expression, relaxation, self-esteem and a more positive relationship with the body, such as music and dance therapies (Babiker and Arnold 1997:91);
- Increasing women's and adolescent girls' access to art mentorship projects both in the community and in correctional institutions; research indicates that art projects benefit women and youth and offer opportunities for creative expression that can act as an alternative means of communication or coping mechanism for those who self-harm (Regier 2005);
- Recognizing that there may be negative consequences for women with addictions when they access treatment; the addictions literature found that mothers with substance use problems face devastating barriers to treatment (Boyd 2004; Greaves et al. 2002); for example, in a Vancouver study, Stein, Burden and Nyamathi (2002) found that mothers who were able to access treatment for

substance abuse reported higher levels of current custody problems (35%) and loss of custody in the past (35%); Roberts and Ogborne also identified several negative consequences and barriers to treatment including “job loss, anger from spouse, loss of friends”, and lack of child-care support (1999:92);

- Addressing the broader social problems that contribute to high levels of emotional distress such as poverty, housing, isolation, childcare, domestic violence, harassment and/or abuse (Babiker and Arnold 1997:91).

III. HELPFUL/PROMISING RESPONSES FOR ABORIGINAL WOMEN AND GIRLS WHO SELF-HARM

Research on the health needs of Aboriginal women in Canada has been neglected and requires greater attention (Currie 2001). On almost every socio-economic and health indicator, Aboriginal women fare poorly in comparison to non-Aboriginal women in Canada (Beavon and Cooke 2003:61; White et al. 2003: xxiv). The high rates of violence and abuse in some Aboriginal communities have reached epidemic proportions, most commonly afflicting women and children; the mortality rate for Aboriginal women due to violence, for example is three times that of non-Aboriginal women (Health Canada 1999). Colonialism is the foundation that produces the many forms of discrimination and disadvantage that Aboriginal women experience in their lives (Monture-Angus 2002). The residential school system, for example, has had profound transgenerational effects which are manifested in the overrepresentation of Aboriginal women in the criminal justice system and in self-destructive behaviours (Cote 2002:176-77). With respect to Aboriginal girls in Canada, Jiwani (1999) aptly states that “state level violence through child apprehension and transfer to foster homes allows the state to continue its practices of colonization” (no page-web document). Within prison, the experiences of incarceration for Aboriginal women have led to increases in self-harming behaviours, especially when placed in segregation (Shaw 2000; Adelberg and the Native Women’s Association of Canada 1993; Faith 1993). A *Survey of Federally Sentenced Aboriginal Women in the Community* (1990) by Sugar and Fox indicates that these self-destructive behaviours continue upon release from prison. Aboriginal girls in detention are also particularly prone to self-harm (Justice for Girls 2005).

The silencing of Aboriginal women’s voices has meant cultural isolation by excluding Aboriginal traditions and cultures in prison programs and services (Monture-Angus 2002). The violation of women’s human rights resulted in CAEFS (Canadian Association of the Elizabeth Fry Societies) and the Native Women’s Association of Canada filing a complaint with the Canadian Human Rights Commission about the discriminatory treatment of women in prison. Among the issues dealing with prison release, the CAEFS complaint articulated that there are insufficient community-based options for women, particularly for Aboriginal women (CAEFS 2003). These reports demonstrate that considerable work needs to be done to address Aboriginal women’s health needs and more appropriate alternatives to incarceration. The following research

provides some recommendations and guidelines for attending to the specific health needs of Aboriginal women and girls who self-harm.

- Recognizing that colonialism has created a climate of distrust that will obstruct traditional programming and services in the Canadian correctional system; this recognition includes an awareness that colonialism is also gendered and that tribal identities, for example, should be taken into account in providing cultural programs and services (Monture-Angus 2002);
- Providing services in ways that empower clients, especially for Aboriginal women and members of minority groups, who have a history of colonization and oppression; subjecting clients to compulsory treatments can be counter-productive and might exacerbate the self-harming behaviours (Babiker and Arnold 1997:98);
- Increasing the participation of Aboriginal workers in the design, operation and evaluation of Aboriginal programs, services and supports in correctional institutions (Monture-Angus 2002);
- Developing a separate security and assessment system for Aboriginal (and other visible minority) women (Hannah-Moffat and Shaw 2001); this relates to the concern of the over-classification of Aboriginal women in prison which has increased their cultural isolation and propensity to self-harm (Arbour 1996; CAEFS 2003);
- Establishing shelters and safe homes for abused women and children in Aboriginal communities and in urban centres which are controlled and managed by Aboriginal women who can provide culturally appropriate services (Aboriginal Justice Inquiry of Manitoba 1991: 11(Ch.13); both childhood and adult experiences of violence and abuse are related to self-harm (Fillmore and Dell 2001);
- Increasing resources and the availability of community-based, alcohol treatment programs for Aboriginal women that are culturally appropriate and designed and implemented by Aboriginal people (Aboriginal Justice Inquiry of Manitoba 1991:18 (Ch 13);
- Developing alternatives to incarceration appropriate to Aboriginal cultures for Aboriginal women (Aboriginal Justice Inquiry of Manitoba 1991:21 (Ch 13);
- Providing criminalized Aboriginal women and girls with opportunities “to experience their strengths and values and integrate these strengths into their families and communities” through art mentorship projects and art programs as an alternative to incarceration; research demonstrates that art projects are effective in reducing violence in prison, in developing skills, in coping with the stress of incarceration, in promoting healing from trauma and in facilitating safer communities (Regier 2005:1).

SECTION VI

METHODOLOGY

For this study, an environmental scan of service providers and self-harm, a community-initiated, participatory approach to research was employed. These terms are used to describe the values of respect, diversity, and shared-decision making power among all members contributing to the project and to emphasize that the project is grounded within the service provider community. A number of research approaches informed the research methodology for the project: a woman-centered perspective (Dell 2005; DeVault 1996; Cook and Fonnnow 1990; Gelsthorpe 1990), community-based participatory research (U.S. Department of Health and Human Services 2001; O’Fallon, Tyson and Dearry 2001) and indigenous knowledge methodologies (McNaughton and Rock 2003; Martial et al. 2003). A community-initiated, participatory approach to research is critical in generating meaningful returns to the community and in promoting social change. Most importantly, it is action-oriented in order to improve the health and well-being of women and girls in their communities.

A survey was selected for this study, as it was the most appropriate method to collect data on a large population of service providers. Respondents were selected for the study by using a purposive or non-probability sampling technique. Several community directories were accessed for appropriate contacts including *A Community Resource Guide for Manitobans*, *Service for Victims of Crime Directory* and *Justice Directory of Services*. In addition, the Winnipeg Intersectoral Committee on Self-Harm and members of the research team provided key contact information and resources to develop the sampling framework.

The survey was constructed around many of the same themes as the interview schedule for the 2001 *Prairie Women, Violence and Self-Harm* study (PWVSH). This was important for the purpose of comparison as well as for broadening the scope of the research to include service providers. The areas of comparison focused on the social portrait of women and girls who self-harm, definitions, perceptions and awareness of self-harm, the frequency and extent of self-harm, risk factors, agency responses to self-harm and recommendations. The present study also investigated specific research questions and relationships that arose from the 2001 PWVSH research: adult experiences of violence and self-harm, suicide and self-harm, peer influences, and specific responses (programming, services and supports) for Aboriginal women and girls who self-harm. There was active collaboration among members of the research team and the Intersectoral Committee in creating items for the survey instrument and in pre-testing a number of drafts of the survey. Collaborative participation during this stage of the research process was invaluable and greatly enhanced the validity of the survey instrument.

Specific sampling criteria were established to select a service provider (i.e., community organization, agency or institution—correctional or non-correctional) for inclusion in the

study. The agency had to provide services for women and/or girls in one or more of the following categories: health (physical and mental), justice, social service, Aboriginal and/or culturally-specific services, abuse/intimate partner violence and addictions/substance abuse. The environmental scan was distributed through postal mail and included a letter of explanation, an ethical consent form, and a self-addressed, stamped, return envelope. In total, the environmental scan survey was sent to 178 Manitoba community agencies that provide services to women and/or adolescent girls. One hundred and thirty-three agencies were generated from the directories, and forty-five additional agencies were suggested by the research team and the Intersectoral Committee.

For this study, a large purposive sample was necessary because little is known about service providers who work with women and girls who self-harm. For about half of the 133 agencies, it was not clear from the available information whether they dealt specifically with women and girls who self-harm, and this likely contributed in large part to the lower response rate. Another reason for the low response rate may have been the timing of the mail-out survey during the summer vacation months (late June and early July, 2003). A total of forty-three surveys were returned and completed for a response rate of twenty-four percent. Another twenty-three surveys (13%) were returned with an acknowledgement that the nature of the survey was not applicable to their agency. The data for the service providers were not broken down into specific categories, such as Aboriginal and non-Aboriginal agencies, due to the limited sample size and the concern for ensuring anonymity in reporting the findings. Attention to cultural differences, however, was made whenever possible in the analysis of the findings.

The method of data analysis in this survey-based study was a combination of both quantitative (i.e., counting) and qualitative (i.e., content analysis) techniques. Since each type of research has certain assets and limitations, this study is strengthened by a combination of both quantitative and qualitative data. The insights and expertise of the Winnipeg Intersectoral Committee on Self-Harm informed all stages of the research process, and their participation in a community forum will be especially important in developing guidelines for programs and policies and in designing an action plan (see Section VII).

I. RESPONDENTS

The environmental scan was addressed to the Directors of the sample of service providers with the request that either they or a designate, whoever was the most knowledgeable about the area of women and girl's self-harm, complete the survey. The majority of the respondents were in managerial (55%) and supervisory (14%) positions, and nearly a third of them were front-line staff (31%). Most of the respondents had been in their current employment position for several years. The average length of employment for supervisors was 8.9 years, and for both managers and front-line staff it was just over 7 years (see Table 1).

Table 1

Position	Average service provider length in position (years)
Supervisor	8.9
Manager	7.3
Front-Line Staff	7.2

Further, the respondents had considerable work experience in their field, with supervisors averaging just over 16 years of experience and front-line staff and managers averaging between 12 and 14 years, respectively (see Table 2).

Table 2

Position	Average service provider length in field (years)
Supervisor	16.2
Manager	14.3
Front-Line Staff	12.0

In reviewing the findings in the following section, it is important to emphasize that the responses are based exclusively on the *perspectives* and *experiences* of the service providers.

SECTION VII

FINDINGS

The findings of the environmental scan of service providers are described in five main sections: (I) background information on service provider roles, services and mandates, and client populations; (II) definitions, perceptions and awareness of self-harm; (III) estimates of the frequency and extent of self-harm; (IV) identification of risk factors contributing to self-harm; and (V) responses to self-harm. The findings are reported for both women and girls who self-harm and, where applicable, these are described in the context of the community and in an institutional setting.

I. BACKGROUND INFORMATION ON SERVICE PROVIDER ROLES, SERVICES AND MANDATES & CLIENT POPULATIONS

Service provider roles, services and mandates

The majority of the service providers identified their primary function as a general community service provider (57%). This was followed by the more specific functions of therapy and counselling (17%), residential treatment (14%) and medical care (10%). Only 2% of the service providers identified advocacy as their primary role⁶. The three main services offered by the agencies to the women and adolescent girls centered on the issues of abuse and violence (21%), corrections and justice (19%) and social services (19%). This was followed by services for mental health (17%), alcohol and drug abuse (14%) and general health (10%).

A common theme underlying the service providers' mandates or mission statements was the offering of services that contributed to the well-being of clients and their communities. The majority of the mandates and missions endorsed an approach that emphasized personal empowerment and healing, the need for advocacy and public education, and community involvement at all stages of healing (e.g., crisis and long-term). Service providers for Aboriginal communities stressed healing from "colonization, residential schooling, institutional care and intergenerational abuse" (Survey #31).

A range of background information was collected on the service providers' client populations of women and adolescent girls who self-harm.

⁶ Numbers may not total 100 due to rounding.

Service provider client populations

The client population of the agencies was comprised mainly of adult women (18 agencies or 42%), and only five agencies (12%) were specifically related to adolescent girls. However, twenty of the forty-three agencies (47%) served both adult women and adolescent girls. Twenty-one of the forty-three agencies provided services specifically to Aboriginal women and adolescent girls; of these agencies, eight (38%) provided services to Aboriginal women, and three agencies (14%) provided services solely to adolescent girls. Ten agencies (48%) provided services to both Aboriginal women and adolescent girls.

More than three-quarters (76%) of the service providers surveyed worked with adult women clientele who had a history of criminalization, and seventy-two percent of them served criminalized adolescent girls. With respect to the women clientele, over half (54%) had a history of criminalization, while forty-one percent of the adolescent girls shared this history.

Social portrait of service provider clients who self-harm—Women

The majority (58%) of the adult women clients who self-harm were between 18 and 39 years of age. Twenty-six percent of the women were between 40 and 64 years, and sixteen percent were over 65 years. Thirty-nine percent of the women had completed junior high, while twenty-six percent had completed high school. Nineteen percent of the women clientele had some post-secondary education. A high percentage of the women (68%) were unemployed. Only sixteen percent of the women had obtained full-time employment, and sixteen percent had part-time jobs. A large percentage of the women were Aboriginal (47%), and about a third of the women were Caucasian⁷. Two-thirds of the women were Canadian citizens; eighteen percent had landed status, while sixteen percent of the women had new immigrant status. With respect to their current marital status, only about a third of the women were married or living common-law. A third of the women were single, while another one-third of the women were separated, divorced or widowed. It is important to note that more than three-quarters of the women had dependent children. This portrait reflects to a large degree the women in the 2001 *Prairie Women, Violence and Self-Harm* (PWVSH) study whose lives were marked by the material deprivations of poverty and lack of access to stable employment to support themselves and their children (see Table 3)

⁷ The service providers were asked to identify the three most prevalent race/ethnic backgrounds of their women clientele. It was not possible from the open-ended nature of the question to further specify within the Aboriginal category (i.e., First Nations, Inuit and Métis).

Table 3

Social portrait of service provider clients who self-harm—Women (age 18 and over)^{8 9}

Age	
18-39	58%
40-64	26%
65+	16%
Education	
Elementary (grade 6 and below)	16%
Junior High (grades 7-9)	39%
High school (grades 11-12)	26%
Post secondary ¹⁰ (some years and completed)	19%
Employment status	
Unemployed (includes social assistance)	68%
Employed – full time	16%
Employed – part-time	16%
Race/ethnic background	
Aboriginal	47%
Caucasian	33%
Other	20%
Immigrant status	
Canadian citizen	66%
Landed status	18%
New immigrant (not landed status)	16%
Marital status	
Married/common law	34%
Single	34%
Separated/divorced	22%
Widowed	10%
Dependent children	
Yes	76%
No	24%

The service providers reported that their clients had experienced considerable abuse and violence in their lives—a finding strongly corroborated in the 2001 PWVSH study. Eighty-one percent of the women had experienced family violence as a child or adolescent, with approximately a quarter of them having experienced emotional, physical, and sexual abuse and neglect. Eighty-one percent of the women also had experienced abuse by a stranger during their childhood or adolescence. The most common type of stranger abuse was sexual abuse (34%). Of special importance is the

⁸ Numbers may not total 100 due to rounding.

⁹ Respondents may choose more than one category.

¹⁰ Vocational training, college and university.

finding that abuse by a former partner was the most common type of abuse experienced by the women. This was supported in the 2001 PWVSH study, which also found a strong relationship between partner abuse and self-harm. More than ninety percent of the service providers reported that their women clients had experienced partner abuse, with the most common forms being emotional (28%) and physical (27%) abuse. Of special concern is the high percentage of women (84%) that the service providers identified as currently being in abusive partner relationships. Once again, the most common forms of abuse were emotional (29%) followed by physical (27%) abuse.

The service providers reported that the women clientele themselves were also perpetrators of physical aggression or violence—another finding that is strongly supported in the 2001 PWVSH study. They stated that over three-quarters (78%) of the women had displayed physical aggression or violence as an adult. The most common pattern for women was the expression of physical aggression or violence within the context of the family. Thirty-nine percent of the women’s physical aggression was directed toward a marital partner, while thirty percent of their aggression involved other members of the family. Twenty-seven percent of the women’s violence was peer-related, and only four percent was randomly directed toward strangers. These patterns of women’s violence are consistent with current research that identifies criminal violence as most likely to occur between friends or acquaintances rather than against strangers (Comack 2002:250). While there has been an increase in charges involving women in partner violence, there are important differences in their use of violence, tactics and degree of harm inflicted; Comack reported, for example, that “female partners of men accused used violence in only 23% of the cases” as compared to “male partners of women accused who used violence in 65% of the cases” (2002:246).

For seventy percent of the women clientele, a pattern of physical aggression or violence originated in their adolescence. Again, the family was the most common context in which the violence occurred. Twenty-five percent of the physical aggression expressed in adolescence was directed toward a parent, and twenty-seven percent of the aggression was directed toward a sibling. A slightly higher percentage (29%) of the physical aggression or violence was peer-related. It is noteworthy that nineteen percent of the aggression or violence was specific to a dating partner. It is also important to point out that there were no incidents reported of women being physically aggressive or violent in their adolescence toward a stranger (see Table 4).

Table 4

Portrait of violence of service provider clients who self-harm—Women^{11 12}

Background family violence as a child/adolescent	
Yes	81%
No	2%
Unknown	17%
Types of violence	
Emotional	26%
Physical	25%
Sexual	24%
Neglect	25%
Background abuse by a stranger	
Yes	81%
No	17%
Unknown	2%
Types of violence	
Emotional	22%
Physical	22%
Sexual	34%
Exploitation	24%
Background partner abuse/violence (spousal/dating) (past)	
Yes	93%
No	5%
Unknown	3%
Types of violence	
Emotional	28%
Physical	27%
Sexual	24%
Neglect	20%
Background partner abuse/violence (spousal/dating) (current)	
Yes	84%
No	13%
Unknown	3%
Types of violence	
Emotional	29%
Physical	27%
Sexual	24%
Neglect	20%
Pattern physical aggression/violence by the client (as adult)	
Yes	78%
No	20%
Unknown	3%
Types of violence	
Marital partner	39%
Other members of the family	30%
Peers	27%
Random/stranger	4%
Pattern physical aggression/violence by the client (as adolescent)	
Yes	70%
No	26%
Unknown	5%
Types of violence	
Peer	29%
Sibling	27%
Parent	25%
Dating partner	19%
Random/stranger	0%

¹¹ Numbers may not total 100 due to rounding.

¹² Respondents may choose more than one category.

Social portrait of service provider clients who self-harm—Adolescent girls

Our initial study, *Prairie Women, Violence and Self-Harm* (2001), did not address adolescent girls specifically, but the findings suggested that the onset of self-harm was typically in adolescence. In the current study, the service providers described several traits of their adolescent client population. They reported that more than half (54%) of the adolescent girls were between 15 and 17 years old, and forty-six percent were between 12 and 14. With respect to schooling, forty-six percent of the adolescent girls were attending junior high, and a third of them were attending high school. It is important to note that eighteen percent of the adolescent girls were not attending school. Regarding employment, thirty-one percent of the adolescent girls worked, but mostly (27%) in part-time jobs. The service providers identified a large percentage (63%) of their adolescent clients as Aboriginal, and about a quarter of them as Caucasian. A little over two-thirds (68%) of the adolescent girls were Canadian citizens, with the remainder having either landed (15%) or new immigrant status (19%) (See Table 5).

A striking feature of the service providers' social portrait of the adolescent girls was the high level of family disruption and trauma. Only thirty-six percent of the adolescent girls lived with their families. Twenty-eight per cent of the girls lived in a youth residential facility, while another twenty-eight percent of them lived either in a foster family or in a group home. Eight percent of the adolescent girls lived on the streets or with their friends (see Table 5).

Another noteworthy feature of the service providers' social portrait was the high degree of abuse and violence among adolescent girls, which was even greater than that reported for the women clientele. More than ninety percent of the adolescent girls had experienced family violence as a child (up to 12 years), which included emotional (25%), physical (25%) and sexual abuse (25%), and neglect (26%). As an adolescent (12 to 17 years), an even greater percentage (95%) had experienced family violence. This similarly included emotional (25%), physical (26%), and sexual abuse (25%), and neglect (25%). More than ninety percent of the adolescent girls had also experienced abuse by a stranger. Here, the most common forms of violence were sexual abuse (32%) and sexual exploitation (29%). In addition, the adolescent girls had experienced considerable abuse and violence in their past dating relationships (80%) as well as in their current relationships (75%). The service providers described a persistent and pervasive pattern of violence in the lives of the adolescent girls—a strong antecedent of self-harm identified in the 2001 PWVSH study.

Like the women clientele, the service providers reported that the adolescent girls often had been perpetrators of physical aggression or violence as a child (62%). Again, the most common context for the girls' physical aggression was in the family, with sixty percent of the aggression directed against parents and siblings. Forty-one percent of their physical aggression and violence, however, was directed toward peers. The service providers also reported that eighty-three percent of the girls were involved in physical

aggression or violence during the period of adolescence. Forty-eight percent of their violence was directed against parents or siblings, while thirty percent was directed toward peers. It is important to point out that twenty-two percent of the adolescent girls' violence was directed toward a dating partner. Overall, adolescence, as compared to adulthood, reflected a period of greater involvement in physical aggression and violence. In keeping with the women clientele, the experiences of abuse and violence among adolescent girls commonly occurred within the context of the family. Like the women clientele, the service providers also reported that the physical aggression or violence perpetrated by adolescent girls did not involve random acts of violence against a stranger (see Table 6).

Table 5

Social portrait of service provider clients who self-harm—Adolescent girls (under age 18)

13 14	
Age	
15-17	54%
12-14	46%
Education	
Attending Junior High (grades 7-9)	46%
Attending High school (grades 10-12)	33%
Attending Post secondary	3%
Not attending school	18%
Employment status	
Unemployed	69%
Employed – full time	4%
Employed – part-time	27%
Race/ethnic background	
Aboriginal	63%
Caucasian	26%
Other	12%
Immigrant status	
Canadian citizen	68%
Landed status	15%
New immigrant (not landed status)	19%
Family background	
Lives with family	36%
Youth residential facility	28%
Foster family/group home	28%
Street/friends	8%

¹³ Numbers may not total 100 due to rounding.

¹⁴ Respondents may choose more than one category.

Table 6

Portrait of violence of service provider clients who self-harm—Adolescent girls¹⁵

Background family violence as a child (up to age 12)	
Yes	91%
No	5%
Unknown	5%
Types of violence	
Emotional	25%
Physical	25%
Sexual	25%
Neglect	26%
Background family violence as a child (12-17 years)	
Yes	95%
No	0%
Unknown	5%
Types of violence	
Emotional	25%
Physical	26%
Sexual	25%
Neglect	25%
Background abuse by a stranger	
Yes	91%
No	5%
Unknown	5%
Types of violence	
Emotional	20%
Physical	20%
Sexual	32%
Exploitation	29%
Background partner abuse/violence (spousal/dating) (past)	
Yes	80%
No	15%
Unknown	5%
Types of violence	
Emotional	26%
Physical	28%
Sexual	26%
Neglect	20%

¹⁵ Note that respondents may choose more than one category.

Table 6 Continued

Background partner abuse/violence (spousal/dating) (current)	
Yes	75%
No	20%
Unknown	5%
Types of violence	
Emotional	30%
Physical	28%
Sexual	22%
Neglect	20%
Pattern physical aggression/violence by the client (up to 12)	
Yes	62%
No	33%
Unknown	6%
Types of violence	
Peer	41%
Sibling	30%
Parent	30%
Random/stranger	0%
Pattern physical aggression/violence by the client (12-17)	
Yes	83%
No	11%
Unknown	6%
Types of violence	
Peer	30%
Parent	24%
Sibling	24%
Dating partner	22%
Random/stranger	0%

II. DEFINITIONS, PERCEPTIONS AND AWARENESS OF SELF-HARM AMONG SERVICE PROVIDERS

The service providers offered information on several dimensions of self-harm for women and adolescent girls both in the community and in correctional institutions. This included their perceptions of self-harm in relation to the definitions, types and functions of self-harm as a coping strategy; their perceptions of the relationship and differences between self-harm and suicidal behaviours; and their responses to self-harm with respect to programs, practices and policies.

Definition of self-harm

Almost half of the service providers (48%) reported that their agency had formulated a particular definition of self-harm, while about fifty percent of them did not have one; only two percent reported that they did not know whether they had a policy. In response to an open-ended question, the service providers' definitions of self-harm shared three main themes: (1) self-harm is a coping or survival response to deep emotional pain; (2) it is an intentional act without conscious suicidal intent; and (3) it involves a broad range of behaviours. One service provider, for example, defined self-harm as "self-destructive and self-injurious behaviour (and) as a way of coping in a maladaptive environment" (Survey #33). Another service provider commented that it was "any self-inflicted injury or intentional self-abusive behaviour" (Survey #37). This perception of self-harm is highly consistent with the findings of the 2001 PWVSH study.

Types of self-harm

The service providers generally were in strong agreement with all the types of self-harm listed in the survey—the same list used in the 2001 PWVSH study (see Table 7). All the service providers identified physical self-injury as a type of self-harm, and ninety-five percent of them identified substance abuse. All the service providers identified sexual risk-taking as a form of self-harm, while ninety percent identified other risk-taking behaviours, such as reckless driving. Eighty-two percent of the service providers identified eating disorders as a type of self-harm. Ninety percent of them identified destructive partner relationships within the family as a form of self-harm. Of special note was the finding that almost all (98%) of the service providers agreed that self-harm included highly legal methods to inflict harm, but it was without suicidal intent. The least agreement was for body enhancement where sixty-one percent of the service providers identified it as a form of self-harm. These findings corroborated those of the 2001 PWVSH study, in particular that self-harm involved a diverse range of behaviours. There was also a similar ranking in terms of the importance of each type of self-harm with physical self-injuries, sexual risk-taking and substance abuse ranked as the leading

three forms. It is important to point out that the service providers identified some new forms of self-harm, such as gambling and gang affiliation. Other addictions, such as tobacco, however were not reported in either study, and its omission is surprising given the importance of tobacco addiction among women and adolescent girls in the research literature (Greaves 1996).

Table 7

Types of self-harm	Agree	Disagree	Do Not Know
Physical self-injury <i>"That is where you cut yourself up and burn yourself. Anything to hurt yourself".</i>	100%	0%	0%
Substance abuse (all forms of legal and illegal drugs and alcohol) <i>"To me...my drug habit...to me that's my way of injuring myself".</i>	95%	5%	0%
Sexual risk taking <i>"And I'm not even, I don't like myself at the moment, that's why I'm doing it (prostitution), you know. If I like myself, I sure as hell won't be doing it. That's the way I see myself, eh".</i>	100%	0%	0%
Other risk taking <i>"I would drive at tremendous speeds down the highway, you know, a bush highway that had animals. And I would drive 160 km per hour, at 170 km per hour".</i>	90%	2%	8%
Eating disorders <i>"I would go weeks with just drinking water to the point that I would be walking across a room, and I would pass out".</i>	82%	9%	9%
Destructive PARTNER relationships <i>"You're tired of having somebody else hurt you, so you're going to hurt your own self, you know".</i>	90%	7%	3%
Destructive FAMILY relationships <i>"I used to do it with a butter knife. And just to make her (mother) feel sorry, make her stop drinking, or stop hitting me.</i>	82%	10%	8%
Highly lethal methods without suicidal intent (e.g., overdose on pills) <i>"Because I was alone, I just decided to take pills. Or OD on coke. Or drink too much, like drink a lot of hard stuff, and make yourself so sick that you have to go to the hospital. But I wasn't trying to kill myself. I just wanted to ease the pain".</i>	98%	2%	0%

Body enhancement (e.g., extensive tattooing, piercings) <i>“And I want to get my (prison) number (tattooed) across my heart. It’s how you feel and care about something. How to be lonely, how to hurt, how to everything”</i>	61%	30%	9%
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Self-harm as a coping strategy and its functions

All of the forty-three service providers agreed with the perspective of self-harm as a coping strategy to deal with emotional pain and distress. One respondent stated, “Participants may view self-harm behaviours as a way to cope with the pressure and stresses of daily living. Women who move from one abusive relationship to the next see themselves as searching for a loving relationship” (Survey #11). The service providers also supported all the coping functions that were listed in the survey—again the same list used in the 2001 PWVSH study. In rank order of importance, the service providers specified nine leading coping functions of self-harm (see Table 8).

Table 8

Main coping functions of self-harm identified by service providers¹⁶ (N=43)	
Distracting/deflecting emotional pain	41
Release/cleansing of emotional pain	39
Self-punishment/self-blame	39
Sense of control/power over self	38
Need for nurturing/attention	37
Expression/message of painful life experiences (fear)	37
Dealing with isolation/loneliness	33
Opportunity to feel/bring back to reality	32
Response to abusive partner	28

In keeping with the 2001 PWVSH study, the service providers’ responses substantiated the finding that self-harm is a coping response to emotional pain and distress. There were some differences, however, in terms of the emphasis placed on certain functions of self-harm. In this study, they viewed self-harm to a greater extent as a response to an abusive partner, as a means of releasing or cleansing oneself of emotional pain, and as a form of regaining control or power over one’s self.

¹⁶ Note that respondents were asked to identify all that apply.

Self-harm policy

The majority (62%) of the service providers reported that their agency or organization did *not* have a policy on self-harm in contrast to just over a third (36%) who had a policy. Only a very small percentage (2%) of the service providers did not know whether a policy existed at their agency. The lack of a clear policy on self-harm was a consistent finding with the 2001 PWVSH research.

Overall, there was little consistency among the service providers' self-harm policies. However, regardless of the agency or institutional setting, a number of the service providers stated that their policies on self-harm were based on a harm-reduction and protection planning model. This policy was described by one respondent as “a protocol for counselors to identify, explore behaviour, assess ability to stop and a willingness to contract” (Survey #1), and by another respondent as “a harm-reduction, non-punitive response that requires the client’s consent to follow a treatment plan” (Survey #34).

In an institutional setting, a few service providers reported a policy of completing a “behaviour chain analysis” to chart incidents and possible triggers (Survey #35) and close or constant observation (Survey #10) following an incident of self-harm. Some service providers indicated the need to implement a suicide assessment and intervention strategy, while others emphasized that incidents of self-harm needed to be treated differently than suicidal behaviour. These inconsistencies in approach reflect the justifiable concerns and difficulties in distinguishing between self-harm and suicidal intentions.

The responses of service providers working in crisis or urgent care centres differed in some respects by emphasizing the importance of client involvement—for example, active participation in treating their wounds. One service provider commented, “Self-harm is to be treated separately from suicidal ideation—clients clean all wounds; (give) no inordinate attention” (Survey #37). They also indicated a concern with “copycat” behaviour and the need to minimize peer clustering to reduce modeling self-harming behaviours. Specific to the adolescent age group, service providers noted that contacting guardians and assisting with agency referrals were a common part of their policy responses.

A third of the service providers who did *not* have a direct policy on self-harm identified alternative health care policies that dealt with self-harm. A further fifty percent of the service providers did not identify any alternative health care policies, while seventeen percent reported that they did not know of alternative policies. The alternative health care policies fell primarily under the authority of various forms of legislation, such as the Mental Health Act and Child Protection Act, emergency department protocol, critical incident clinic policies and divisional suicide policy. An important finding that emerged from the analysis was the recognition of the need for an “integrated, family/systemic” approach; from this perspective, self-harm is not treated as a “stand-alone problem” (Survey #40).

Self-harm as suicidal behaviour

Current research challenges the common assumption that self-harm and suicidal behaviour are interchangeable concepts and suggests that they have different intents, etiologies, bodily harms, frequency and methods (Paul et al. 2002; Wichman et al. 2002:2). Suicidal acts are more lethal and are oriented toward ending pain and suffering, while self-harm is viewed as a coping response to survive emotional pain and distress (Wichman et al. 2002; Fillmore and Dell, 2001; Livingston and Beck 1996; Burstow 1992). There are some competing studies, however, that report higher rates of suicide after deliberate self-harm (Department of Health 2004; Hawton et al. 2002), suggesting that further research is necessary to explore the relationship and differences between self-harm and suicide.

The findings from the 2001 PWVSH study suggested that clients generally could make a clear distinction between self-harm and suicidal behaviours. Based on their *professional experiences*, the service providers in the present study also indicated that most clients (73%) could make a distinction between self-harm and suicidal intentions. This is apparent in the following statements of the service providers:

- “Although the role of self-harm in each client’s life is unique/individualized, many clients who self-harm would not view themselves as having suicide ideations” (Survey #1);
- “I think that some can distinguish the behaviours—they don’t even think of killing themselves” (Survey #5);
- “Self-harm is mostly attention-getting, power and control, (while) suicide is depression and hopelessness” (Survey #13);
- “For the most part, many deny being suicidal when asked” (Survey #20);
- “For the most part, it seems that they do not connect suicide to what they are doing. Suicide to them seems to be another category” (Survey #27);
- “Often self-harm has been separated from suicidal thoughts, i.e., wanting to feel, not wanting to die” (Survey #31).

Fifteen percent of the service providers, however, did *not* agree that clients could make such a distinction. One respondent stated that “During lengthy periods of self-loathing, there is no distinction” (Survey #25). Twelve percent of the respondents did not know if there was a distinction between self-harm and suicide. Another respondent suggested that “Sometimes the differentiation is not so clear” (Survey #7). While the majority of the service providers felt that their clients were able to make a clear distinction, they also expressed some doubt for some of their clients. As one service provider reported, “We believe that it is a separate issue from suicide. It may eventually lead to suicide though” (Survey #18). One factor complicating this distinction for clients is the current labeling of self-harm as suicidal behaviour by agencies. A service provider pointed out, for example, that “Usually they (clients) even call it ‘acting suicidal.’ In many cases the clients have been to other systems that do not differentiate” (Survey #37).

Based on their own *professional opinions*, a higher percentage of service providers (81%) agreed that there was a distinction between self-harm and suicide. The service providers articulated this view in the following statements:

- “Most women want the pain to stop; (they) have different ways of coping and do not wish to end their lives” (Survey # 5);
- “Self-harm is not seen by the client as ending it, whereas suicidal behaviours are. Self-harm is seen as acting out/attention getting/a need for help. Being suicidal is more desperate—depression—they have tried to cope but they are less able to and (there is) a downward spiral” (Survey #13);
- “Suicidal behaviours may have more of an intention to die vs. self-harming may be more focused on managing emotional pain” (Survey #14);
- “The vast majority of clients do not want to die; they just have extreme difficulty coping with living” (Survey #22);
- “The thoughts behind suicide and self-harm are different as is the intention; in my experience though, self-harm can increase and lead to accidental suicide” (Survey #31).

In their professional opinion, twelve percent of the service providers did *not* feel that there was a clear distinction between self-harm and suicide. One respondent reported that “Sometimes, yes and no. It depends on the meaning attributed to it by the client” (Survey #6). Another respondent stated that “For some clients, self-harm is extremely different than suicidal behaviours; for others, these behaviours may be along the spectrum of behaviour/action of suicidality” (Survey #1). Seven percent of the service providers reported that they did not know if there was such a distinction. As one respondent noted, “It’s hard to distinguish that in someone other than yourself. The person has to be honest” (Survey #5). Some of the service providers’ responses also indicated that they wanted a clearer understanding of the relationship between self-harm and suicide. As a respondent pointed out, “Yes (there is a distinction), but I do believe that it is important to see how they both can be connected at times” (Survey #27). This is an area of unquestionable concern to service providers, and one that requires further study and careful examination.

III. SERVICE PROVIDER PERCEPTIONS OF THE PREVALENCE OF SELF-HARM IN COMMUNITY & CORRECTIONAL INSTITUTION SETTINGS¹⁷

The service providers found it difficult to estimate the prevalence of self-harm among their clients over the past two years. In part, this can be explained by the shame and stigma associated with self-harm and the reluctance of women and girls to seek help in the community (Don 2005:17; Mazelis 2003; Babiker and Arnold 1997:36). In correctional institutions, the reluctance to seek help is compounded by the women's fear of a punitive response, such as segregation, or of being assigned a higher risk assessment score and security rating for engaging in self-harm (CAEFS 2003; Martel 1999; Faith 1993). In addition, variations in defining self-harm and the lack of a systematic data collection method to record incidents of self-harm are important factors that contribute to the difficulties in determining its frequency (Hawton et al. 2002). For youth, in particular, research is practically non-existent on their own definitions and perceptions of self-harm (Hawton et al. 2002). With these limitations in mind, some observations can be made based on the information reported by the service providers. Overall, there were some strong similarities in the forms of self-harm (physical, alcohol and drug abuse, and destructive relationships) and in the reasons for the increases in self-harm among women and adolescent girls in these settings (family problems, past abuse, greater service provider awareness and increased comfort in disclosure).

Community & correctional institution settings— Women

A sizable percentage of the service providers (66%) were unable to provide information on the prevalence of self-harm among their women clientele in the community over the past two years. Slightly more than a third of the service providers, however, did feel that they could comment. That is, twenty-one percent of the service providers reported that the prevalence of self-harm stayed the same, while fourteen percent identified an increase in women's self-harm in the community. The increases occurred largely for four types of self-harm: physical self-harm (slashing, burning), alcohol and drug abuse, sexual risk-taking and involvement in destructive relationships. The primary reasons reported for the increase in self-harming behaviors among women were related to family and marital problems and dealing with past abuse issues. One respondent's explanation for the increase in women's self-harm was that "the systems have become more restrictive and less available to women and their families; for example, if respite is taken away or daycare cannot be found when it is needed, the family is more stressed" (Survey #11). Another respondent felt that the increase in women's self-harm might be related to a greater openness of service providers to talk about it; for example, "We are better prepared and more open so women are more open to tell us about it" (Survey #24). None of the community service providers reported a decrease in self-harm among their women clientele.

¹⁷ This section on the prevalence of self-harm in institutional settings is specific to correctional facilities.

Like the community setting, fifty-seven percent of the correctional institution service providers were unable to provide information on the prevalence of self-harm among their women clientele over the past two years. However, twenty-one percent of the service providers reported an increase in women's self-harm, notably for the physical forms of self-harm such as alcohol and drug abuse, and tattooing. Gambling, a type of self-harm not previously identified in the 2001 PWVSH study for incarcerated women, was also reported. These respondents related the increase in self-harm to a greater staff awareness about self-harm as well as to a greater willingness and openness of the women to talk about their self-harm. One respondent stated that "Caregivers more often ask specifically about self-harm" (Survey #13). While fourteen percent of the service providers reported no change in the prevalence of self-harm, seven percent reported a decrease in women's self-harm in correctional institutions. One respondent noted that "The reason for a decrease—more resources available, more socially acceptable to talk about it" (Survey #13).

Community & correctional institution settings— Adolescent girls

A large percentage (63%) of the service providers were unable to estimate the prevalence of self-harm for adolescent girls in the community. For those who were able to provide some information, twenty-one percent reported an increase in self-harm among adolescent girls in the community. The two most common increases were for physical injuries (slashing, burning and punching walls) and destructive relationships (affiliation with violent gangs). In contrast to the women clientele, the service providers described increases for adolescent girls in high-risk behaviours (driving recklessly and joy riding), sexual exploitation in the sex trade, and piercings and tattoos. Like the women clientele, the service providers identified family and relationship problems as the major reasons for the increase in self-harm among adolescent girls in the community; more specifically, these included childhood abuse, lack of family connection and placement breakdowns. In addition, the respondents identified two other contributory factors: loss of cultural identity for Aboriginal girls and the influence of peers who self-harm. It is important to note that the service providers also felt that the increases in self-harm were related to greater agency awareness and reporting of self-harm as well as to greater client disclosure. One service provider stated, "There has been an increase in disclosure; can't say there's an increase in incidence" (Survey #21). Only five percent of the service providers reported a decrease in self-harm for adolescent girls in the community, while eleven percent reported no change.

Like the findings for women in correctional institutions, the majority (67%) of service providers did not know whether there had been an increase in the self-harm of adolescent girls in correctional facilities. Twenty-two percent of the respondents reported an increase in adolescent girls' self-harm in correctional facilities. Consistent with women in correctional institutions, the service providers reported increases for physical self-harm and drug and alcohol abuse. In addition, the respondents noted an increase in destructive relationships (with peers) among adolescent girls in detention. They also provided

similar reasons for the increase in self-harm among adolescent girls in detention. The reasons were primarily related to unresolved past trauma such as family abuse, placement breakdowns, loss of family connection and cultural identity for Aboriginal girls. One respondent felt, however, that adolescent girls were “becoming more overtly violent toward others and themselves; they want more control and release of frustration and pain; they need a way to ask for help” (Survey #13). A small percentage (11%) of the service providers identified a decrease in self-harm among adolescent girls in detention, while none of them reported that it had stayed the same.

Peer influences and Self-Harm Among Women and Adolescent Girls

Research suggests that peer influence (in terms of a modeling effect) is a factor in women and youth’s self-harm, especially in correctional institutions (Heney 1990). Studies in the community also identify the importance of peers or friends who self-harm as a contributing factor to adolescents’ self-harm (Hawton et al. 2002). In a British study of adolescent girls and boys, for example, Clarke (2004) reported that recent exposure to self-harm by peers (or family) was associated with greater involvement in self-harm.

In the 2001 PWVSH study, the correctional staff identified peer influence as one of the risk factors for women’s involvement in self-harm. For the service providers in the present study, however, there was considerable uncertainty about the role of peer influence for women. A sizable percentage (44%) of the service providers were uncertain about the role of peer influence as a contributory factor in women’s self-harm in a residential setting. One respondent, for example, stated that it was more of a “suspicion” (Survey #32). Twenty-two percent of the service providers, however, considered peer influence a factor in women’s self-harm.

Regarding adolescent girls in a residential setting, there was also a great deal of uncertainty expressed by the service providers about peer influence and self-harm. A large majority (75%) of the respondents were unsure about the role of peers, while seventeen percent felt that peer influence was a contributory factor in adolescent girls’ self-harm. As one respondent stated “I suspect there is, but I don’t know” (Survey #32). The open-ended questions provided some insight into the role of peer influence. One service provider noted that “In any peer grouping there is the possibility of a potential for copycat effects of any behaviours; (it’s) dependent upon the needs met by self-harm, the responses from others to self-harm, and the consequences of self-harm; copycat effects are possible” (Survey #1). Other respondents observed that the close living quarters could lead to “copycat effects,” and that peer influences would be greater on adolescents rather than on adults. In comparison to women, a smaller percentage of service providers (8%) indicated that peer influence had no effect on increasing adolescent girls’ involvement in self-harm.

IV. SERVICE PROVIDER PERCEPTIONS OF THE RISK FACTORS FOR SELF-HARM AMONG WOMEN AND ADOLESCENT GIRLS

While the adolescent girls and women clientele shared some of the same background experiences that contributed to their involvement in self-harm (family violence and abuse), environmental and broader social structural factors also played significant roles. In this section of the environmental scan, the service providers identified the factors that they believed placed women and adolescent girls at risk of self-harm in both community and institutional settings. It is important to point out, however, that the respondents focused primarily on correctional institutions.

Community risk factors—Women

The research on community risk factors emphasizes the relationship between women's experiences of marginalization and self-harm. Women's levels of stress and emotional pain and thereby the propensity to self-harm are increased by living in impoverished conditions (poor housing, homelessness, unemployment, low educational attainment and low-status work), by experiences of racism and racial discrimination and by sexism (most clearly evident in cases of intimate partner abuse and violence) (Babiker and Arnold 1997; Livingston and Beck 1996:47). Women who are struggling to cope with their emotional pain and distress without family or community supports, are at even greater risk of self-harm (Babiker and Arnold 1997:52).

In response to an open-ended question, the service providers identified eight major areas that they felt placed women at greater risk of self-harm in the community. These findings were consistent with the risk factors reported by the service providers in the 2001 PWVSH research, although in the present study they are described in much greater detail. In general, the service providers identified the following risk factors: experiences of abuse and violence, family disruption, social isolation, unhealthy personal relationships, poor levels of health, and social structural factors related to subsistence living and consequent discrimination and marginalization. More specifically, one respondent described the risk factors as "parental neglect and residential schools; victimization (physical, sexual); community isolation; partner abuse; community patterns of substance abuse and apathy; poverty and lack of adequate housing; a large number of children; the reserve system; and lack of education and employment" (Survey #13). Another respondent wrote "History of abuse; usually long-term physical or sexual abuse; past sexual abuse is almost always present" (Survey #3). The service providers in the present study emphasized additional areas of risk. Most importantly, the service providers recognized the devastating impact of residential schools and the history of colonization as factors that increased Aboriginal women's risk of self-harm. The service providers also identified institutional relationships as risk factors, for instance, negative experiences with government agencies. Finally, the respondents emphasized community

disorganization and lack of resources as factors that contribute to women's self-harm. These findings are summarized in Table 9.

Table 9

Community risk factors for self-harm— Women
<p>Experiences of abuse and violence</p> <ul style="list-style-type: none"> - History of childhood abuse in the family, especially long-term physical or sexual abuse and neglect - History of abuse in residential schools - Past partner abuse - Ongoing partner abuse - Abuse and violence working in the sex trade
<p>Family disruption</p> <ul style="list-style-type: none"> - Stress, conflict and instability in relationships - Loss of parent or child (breakdown/loss in family) - Parenting difficulties - Forced secrets
<p>Social isolation</p> <ul style="list-style-type: none"> - Loneliness - Lack of personal support network
<p>Community disorganization and lack of resources</p> <ul style="list-style-type: none"> - High rates of community violence - Remoteness of community
<p>Personal relationships</p> <ul style="list-style-type: none"> - History of unhealthy relationships with partners - Unsuccessful and dysfunctional relationships with peers - Feeling judged by others
<p>Personal health factors</p> <ul style="list-style-type: none"> - Mental health conditions, e.g., depression, low self-esteem - Alcoholism and drug addictions - Unwanted pregnancy
<p>Government agency relationships</p> <ul style="list-style-type: none"> - Negative relationships with government agencies, e.g., agencies related to child & family services, welfare and the criminal justice system
<p>Social structural factors</p> <ul style="list-style-type: none"> - Poor school success - Lack of adequate housing - Unemployment - Poverty - Lack of education - Experiences of systemic discrimination and feelings of marginalization

Institutional risk factors—Women

The research on self-harm in correctional institutions focuses on the sources of women’s emotional distress resulting from the experience of incarceration which increase the likelihood of self-harm. Some of the major factors that contribute to the “pains of imprisonment” identified in the literature are separation and fear of losing children, negative relations with staff, the use of segregation, and rigid and arbitrary rule enforcement (Boritch 2000:318). These factors have been attributed to the increase in women’s self-harm in prison, especially the experience of segregation (Faith 1993; Martel 1999).

The service providers identified six main risk factors that they felt contributed to women’s self-harm in correctional institutions (see Table 10). These were separation from family, stressful conditions of the institutional environment, negative staff relations, difficult peer relationships, segregation and mental health issues. Three of the central risk factors that the service providers described were directly related to the emotional distress experienced by women placed in detention, that is, the pains of imprisonment. These factors were concerns and fears of losing their children, the trauma of segregation and negative relationships with institutional staff. While the correctional staff in the 2001 PWVSH study did not report negative staff relations, the women in that study did identify this as a risk factor for self-harm. In both studies, the service providers placed great emphasis on the conditions of the institutional environment and its role in increasing women’s emotional pain and distress and thus their tendency to self-harm. One respondent, for example, stated that “the environment can be cold and sterile as opposed to emphatic and nurturing” (Survey # 18). Another respondent described the women’s feelings of distress and loneliness in prison in terms of “isolation, fear, emotional distress, lack of control, low self-esteem, outcast, victimization (and) frustration” (Survey # 32).

Table 10

Institutional risk factors for self-harm— Women
Separation from family - Pain of separation from children and fear of losing them to child & family services
Institutional environment - Separation from traditional community supports - Feelings of isolation & loneliness - Stresses of confinement/lack of nurturing supports - Lack of emotional outlets
Negative relations with staff - Coldness of environmental setting - Institutional abuse, e.g., segregation, disrespectful remarks (“put-downs”)
Relationships in the institution - Interacting with others who self-harm - Difficulty dealing with others

Segregation

- Emotional distress of confinement—fear, lack of control, frustration

Mental health issues

- Ongoing trauma and emotional distress from past experiences of abuse and violence
- Ongoing problems with substance abuse and adjustments to coming off alcohol or drugs

Community risk factors—Adolescent girls

In the 2001 PWVSH study, many of the women indicated that they began to self-harm in their adolescent years. As a result, adolescent girls became a new focus for this study. This is a particularly important population to study as recent research indicates that among adolescent girls, there has been an upsurge in mental illness and stress disorders as well as self-harming behaviours such as self-inflicted injuries, depression, eating disorders, and drug and alcohol dependence (Stigma and Teens cited in Coulman 2003)¹⁸. Some studies have reported that the prevalence of self-harm among adolescent girls is much greater than that for boys (Hawton et al. 2002; Babiker and Arnold 1997).

Studies on self-harm among adolescent girls and boys in the community have identified several risk factors for self-harm. These include traumatic life events such as the loss of a close relative, physical abuse, mental health issues (anxiety, depression and drug or alcohol abuse), boyfriend or girlfriend problems, low self-esteem, bullying and social isolation (Clarke 2004; Hawton et al. 2002). Clarke (2004) writes about the “sub-culture of self-harm” among adolescents and underlines the central linkages to physical and sexual abuse, emotional distress and poverty.

The service providers in the present study identified six major risk factors for adolescent girls in the community (see Table 11). These were consistent with the research literature and included the following: experiences of abuse and violence, family disruption and trauma, social isolation and lack of healthy peer relationships, weak ties and involvement in youth community activities and lack of access to resources, poor personal health factors, and social structural factors which were mainly related to family poverty and transient living conditions. More specifically, the service providers emphasized the role of “past trauma of abuse, neglect and grief” (Survey #1); “rejection from family or boyfriends” (Survey #14); “social isolation and an unsupportive network” (Survey #21); the influence of peers (Survey #38); mental health issues (Survey #33); a history of mental illness in the family (Survey #40); the social structural factors of “poverty, a crowded reserve system”; and the “lack of a future, educational and employment” (Survey #13). Most of the service providers identified a multiplicity of risk factors that contributed to self-harm among adolescent girls. They also emphasized the confounding effects of poverty, abuse, poor mental health, developmental disabilities and negative

¹⁸ This statement must be situated within the increasing medicalization of women and girl’s health in North America.

peer influences including bullying which leave youth vulnerable to self-harming behaviours. These are detailed by two service providers in the following statements:

- “Emotional disturbance, mental health problems, AWOL/living on street, comprehension problems (Fetal Alcohol Syndrome/Fetal Alcohol Effects), learning disabilities, gang affiliations, trauma (Post Traumatic Stress Disorder), the sex trade, addictions, poverty” (Survey #30);
- “Poor family relationships, child abuse, dating violence, bullying, unsupportive networks, conflict with systems, isolation and feeling unheard” (Survey #21).

Adolescent girls and women in the community shared certain risk factors, particularly the experiences of abuse and violence. For adolescent girls, however, there was an even greater concern regarding the vulnerability of youth to sexual exploitation (by strangers and family members) and to recruitment and involvement in the sex trade which increases their risk of self-harm. This is supported in a recent study by Schissel and Fedec who discovered that the trauma of the sex trade for children and adolescent girls in Regina and Saskatoon was manifested in self-harming behaviours, such as slashing and alcohol and drug abuse (cited in Bernard and Schissel 2002:176). Another shared risk factor that the service providers identified for both women and adolescent girls was the critical lack of community resources. One service-provider commented that “To-date, we have identified many gaps in services, especially relating to the lack of youth and children services and poor coordination amongst existing services” (Survey #25). In addition, social isolation and personal health factors, such as alcoholism and drug addiction and unwanted pregnancies, were central risk factors for both women and adolescent girls who self-harm.

Table 11

Community risk factors for self-harm—Adolescent girls

Experiences of abuse and violence

- History of childhood abuse—physical and sexual
- Parental neglect
- Dating violence
- Stranger violence
- Sexual exploitation and involvement in the sex trade

Family disruption

- Harsh, authoritarian parenting
- Loss of family member, e.g., death
- Limited support network in family

Social isolation

- Feelings of loneliness and lack of healthy peer supports
- Bullying
- Breakup with a boyfriend
- Loss, e.g., suicide of a friend
- Peers who self-harm

Lack of ties/resources in the community

- Little or no involvement in youth community activities
- Lack of resources on reserve

Personal health factors

- Unwanted pregnancies
- Developmental delays
- Fetal alcohol spectrum disorder
- Mental health conditions; alcohol and drug abuse

Social structural factors

- Poverty
- Unstable and transient living accommodations; homelessness
- Low educational attainment and lack of job opportunities

Institutional risk factors—Adolescent girls

There is little research on adolescent girls in detention and self-harm, although it is estimated that the incidence of self-harm among young offenders (held with adult prisoners) is five times greater than their counterparts in the general population (Livingston 1996:23). The prison experience for youth introduces a number of risk factors that increase the likelihood of self-harm. Bullying is a contributory factor, although to a lesser degree for young female than male young offenders (1996:25). The use of isolation or segregation is strongly related to self-harming behaviour, particularly for female young offenders; in one study, Ross et al. reported that seventy percent of all self-harming incidents occurred while their sample of female young offenders was in segregation or alone (cited in Livingston 1996:25). For young female offenders, depression, feelings of hopeless and a history of child sexual abuse are also contributory factors to self-harm (Livingston 1996).

The service providers in the environmental scan identified six main risk factors contributing to self-harm among adolescent girls in detention: separation from family, negative relations with institutional staff, poor peer relationships (negative peer influence and bullying), family histories of childhood abuse and neglect and the experience of loss within the family, mental health issues (depression and substance abuse) and identity issues (see Table 12). The service providers recognized how the lack of a trusting relationship with staff left the girls without an outlet to deal with their complex histories of abuse and loss, their feelings of isolation and their mental health needs. All these factors increased the likelihood of adolescent girls turning to self-harm as a way of coping with their emotional pain and distress in detention. As one service-provider stated, “Their experiences are marked by great despair and feelings of isolation, fear, emotional distress, lack of control, low self-esteem, (being) an outcast, victimization, and frustration” (Survey #32). Some service providers suggested that bullying played a greater role for adolescents than for women, and that it had a demoralizing influence on adolescent girls which can lead to self-harm. One respondent emphasized that girls “need

to fit in with the group” and how girls can be “bullied, harassed, and intimidated into performing self-harm” (Survey #1). It is noteworthy that many of the risk factors—family separation, past abuse and mental health issues—coincided with the institutional risk factors for adult women. An important exception, however, is the critical issue of self-esteem and identity, which are vital to healthy adolescent development.

Table 12

Institutional risk factors for self-harm—Adolescent girls
<p>Separation from family</p> <ul style="list-style-type: none"> - Separation from significant others/family
<p>Negative relationships with others</p> <ul style="list-style-type: none"> - Untrained staff - Lack of trust with staff
<p>Negative peer relationships</p> <ul style="list-style-type: none"> - Bullying/harassment/intimidation by other youth in detention - Influence of peers who self-harm
<p>Impact of past family abuse and trauma</p> <ul style="list-style-type: none"> - History of childhood abuse and neglect in the family - History of loss of a family member/friend
<p>Mental health issues</p> <ul style="list-style-type: none"> - Depression - History of self-harm and substance abuse
<p>Identity issues</p> <ul style="list-style-type: none"> - Low self-esteem

V. SERVICE PROVIDER RESPONSES TO WOMEN AND ADOLESCENT GIRLS WHO SELF-HARM

In this section of the environmental scan, the service providers were asked several open-ended questions with respect to their agency or institution's responses to women and adolescent girls who self-harm. They were asked in particular to describe their responses in relation to the most common types of self-harm in which their clients were involved. The questions focused on the types of programs, supports and services that were offered and on the integration of any cultural components. Finally, the service providers were asked to suggest recommendations regarding the role of service providers in meeting the needs of women and girls who self-harm. For the analysis, the community and institutional responses are addressed together for the discussion of the service providers' responses to self-harm.

Main responses to women's self-harm by community and institutional workers

The service providers identified four types of women's self-harm that they most commonly dealt with in their community agency or institution: physical or self-injurious forms (cutting and slashing), self-destructive behaviours (alcohol and drug abuse—both illegal and prescription/over the counter), destructive relationships (family violence), and expressions of suicide (suicidal thoughts and attempts).

The most common type of self-harm identified by the service providers was *physical self-injury*, such as cutting and slashing. The major responses to physical self-injuries were implementation of a safety plan and counseling, individual and group therapy, specialized programming to facilitate healthier coping alternatives and distress tolerance skills, dialectical behavioural therapy, sexual abuse counseling, medical support and access to an Elder. A central theme underlying the service providers' responses was the need for a multi-layered approach. One respondent wrote that the responses broadly encompassed "...personal and community safety, assertiveness skills building, wen-do yoga, artistic play, sharing strength and wisdom through story, song, painting, photography and drama" (Survey #41).

The second most frequent type of self-harm reported by the service providers was *self-destructive behaviours*, which included foremost alcohol and drug abuse—both illegal and prescription/over the counter. The main responses to alcohol and drug abuse included residential treatment for addictions and out-patient programming (e.g., Alcoholics Anonymous, Addictions Foundation of Manitoba, National Native Alcohol and Drug Abuse Program, Women Offender Substance Abuse Program) and the incorporation of Aboriginal spirituality in programming. Regarding other self-destructive behaviours (e.g., high-risk lifestyle, eating disorders and gambling), a major response was

access to a wide spectrum of counselling services. One service-provider stated, “We offer individual counselling as well as groups for women with preoccupation and eating disorders; in therapy we come from a feminist perspective, but use tools from various places like cognitive behavioral therapy” (Survey #26).

The third most common type of self-harm reported by the service providers was *destructive relationships*, such as family violence. Their responses primarily focused on the provision of family violence groups for women, men and children and on access to support through such agencies as Sage House, EVOLVE, women’s advocacy agencies and legal aid. The service providers also emphasized the need for educational programs, individual and group cultural programs, and sexual abuse counselling. One respondent wrote that women need “counselling support in finding resources when the situation falls apart, i.e., shelter, alternative housing, counselling regarding birth control, condoms, medical appointments, transportation, support for both partners in the relationship, and intensive work with the family” (Survey #11).

The fourth most frequent form of self-harm identified by the service providers was *expressions of suicide* (suicidal thoughts and attempts). The service providers identified an immediate crisis response, for instance, accessing the mobile crisis unit and emergency hospital services as well as making physician referrals. They also provided some insights with respect to the need for longer term care—for example, counselling for the “expression of feelings around isolation” (Survey #23) and the need for contact with community mental health services.

The main guiding principles and courses of action that defined the service providers’ responses to women’s self-harm are summarized as follows:

- Offer choices and information about the consequences of self-harm to empower women;
- Address abuse issues to facilitate the healing process;
- Provide feedback and support to women as they progress through the stages of their healing;
- Offer peer support programs;
- Work on self-esteem enhancement, e.g., body image and identity;
- Provide support, advocacy and access to appropriate community resources and make referrals to them, e.g., community mental health worker, an Elder;
- Offer individual and team approaches to counselling;
- Provide an integrated approach, e.g., a feminist perspective to counselling as well as other approaches such as cognitive behavioural therapy;
- Provide both crisis intervention (e.g., Mobile Crisis Unit, hospital) and long-term care;
- Offer educational programs to counsel clients on how to access community resources, e.g., shelter, alternative housing, medical appointments, transportation;
- Ensure that there is contact with workers associated with a specific culture;
- Offer grief counselling.

These findings are more specific and detailed than those from the 2001 PWVSH study, although there is consistency in both studies with respect to the identification of certain guiding principles for care: empowerment, cultural sensitivity, and compassionate and committed staff members who provide follow-up and continuity of care. A common theme underlying the responses of the service providers to self-harm in both studies was the provision of on-going, coordinated, and empathetic support.

Main responses to adolescent girls' self-harm by community and institutional workers

The service providers identified three of the most common forms of self-harm for adolescent girls that their agency or institution dealt with as physical self-injury (slashing, cutting), self-destructive behaviours (eating disorders, sexual risk-taking and substance abuse) and destructive relationships (childhood-based trauma and victimization). These are highly consistent with the most common types of self-harm identified for the women in this study, except for the inclusion of expressions of suicide.

One of the main responses that service providers reported for *physical self-injurious forms* of self-harm among adolescent girls was a harm-reduction approach. A respondent described several aspects of their agency's approach as follows:

Identification of self-harm; clarification of role of self-harm in client's life (why, when, how, where); control over initiating self-harm behaviour; ability to stop/reduce self-harm; (consult) others who are aware/confided in behaviour (identify supports); examine willingness to contract re: self-harm; examine need to implement suicide standards and assess procedures; examine need to notify guardians and action this if unaware of behaviour; examine clients; referral to additional supports/counselling; assist clients in finding/learning ways to have needs met and/or reduce harm (Survey #1).

Other service provider responses to physical self-injury among adolescent girls were hospitalization, consultation with a psychiatrist, crisis intervention and medical support, involvement of the client in applying bandages and cleaning wounds, and individual and/or group counselling. Recognizing the importance of contextualizing self-harm, one service-provider commented that "All types of self-harm are seen and treated within the broader social or family context the client is living in" (Survey #40).

With respect to *self-destructive behaviours* among adolescent girls, the service providers described several responses depending on the particular high-risk activities. Their responses focused largely on the adolescent girls' use of alcohol and drugs, sexual-risk taking and delinquency. Their responses to these forms of self-destructive behaviour included education on healthy relationships and sexuality programs, peer support, counselling and referrals to community programs (Sage House, Addictions Foundation of

Manitoba, Alcoholics Anonymous, Native Addictions Foundation, and Child and Family Services).

Regarding *destructive relationships*, the service providers primarily described their responses to adolescent girls who had experienced childhood-based trauma and victimization. Some of the most common responses that they reported were contact with family violence groups, community resources, Child and Family Services/AWASIS (Child & Family Services Agency of Northern Manitoba), physicians, probation officers and personal counselors.

A major theme underlying the service providers' responses to the self-harm of adolescent girls is the provision of care within an environment of acceptance and compassion. One service-provider, for example, stressed that "Overall, we work to connect with the young women through establishing a nurturing, caring, non-judgmental relationship. As the young women feel safe with staff, they disclose and work on many issues" (Survey #14). They also emphasized a reliance on community supports and services. The main guiding principles and courses of action that defined the service providers' responses to the self-harm of adolescent girls are summarized as follows:

- Encourage active participation in care to foster a feeling of empowerment, e.g., involving clients in caring for wounds;
- Use a broad range of community supports and services, e.g., referral to the appropriate agency, such as the Mental Health Association, or to an Elder for spiritual guidance;
- Advocate and support, e.g., accompanying clients to appointments, such as doctors and psychiatrists;
- Provide educational opportunities in comfortable settings, e.g., small groups or on an individual basis;
- Assess the clients' needs within a broader social context and ensure appropriate integration of services.

Cultural component in service provider programs/supports/services for Aboriginal women

In the 2001 PWVSH study, the community workers and correctional staff identified one of the most helpful responses to self-harm as having Aboriginal programs and healing approaches. A common theme that emerged from the work of Peterson et al. (2002) in alcohol and substance abuse treatment was the relationship between culture and substance use. For the Aboriginal women who participated in the study, they found that "the cultural basis for the programs had a positive resonance" (376). Similarly, the recent study by Dell and Graves (2005) of Aboriginal youth (12-25 years) in residential treatment for solvent abuse concluded that the major contributing factor to their healing journey was the cultural foundation of the program. In the current study, seventy-seven per cent of the service providers reported that they had a cultural component in their

programs (supports or services) for Aboriginal women. They described the cultural components of some of their programs as follows:

- “We have traditional Aboriginal Spirituality using the Medicine Wheel as a teaching tool in programs...”¹⁹;
- “We have a program on developing healthy relationships (with self and others) and with intergenerational survivors of residential schools”;
- “There is the presence of Aboriginal staff; staff complete a two-day cultural awareness workshop; (there is) a spiritual care staff member who is Aboriginal and is able to explore/apply traditional belief systems”;
- “We work both one-on-one with an Elder and a cultural worker (as well as) sharing circles”;
- “There are women’s teachings, on-site sweat lodges, full-moon ceremonies, Sun Dances, Warrior Dances; an Elder is available for traditional counselling”;
- “There is the Medicine Wheel Model and traditional methods, a sharing circle with an Elder, sweats, ceremonies, awareness of history and culture;
- “Regular services are provided by an Aboriginal Elder, counselling, and spiritual activities”.

It is important to note that many service providers were active in referring clients to culturally-specific programs, such as the Ma Ma Wi Chi Itata Centre (Survey #22). It is equally noteworthy that the service providers recognized the importance of individual preferences in deciding on a program selection. A service provider commented that “It depends on what the woman wants. They sometimes express their discomfort with traditional healing approaches. We follow their lead and refer to services that provide the cultural component if they want it” (Survey #11).

Cultural component in service provider programs/supports/services for Aboriginal adolescent girls

With respect to Aboriginal adolescent girls, sixty-three percent of the service providers reported that they had a cultural component in their programs (supports or services). A central theme underlying their responses was the need to provide Aboriginal girls with opportunities to learn about their cultural identity. The 2001 PWVSH study found that the relationship between self-identity, role expectations and the associated stigma of self-harm prevented women from seeking help. The substance abuse literature also identifies stigma and the resulting guilt and shame as barriers for women to access treatment, especially Aboriginal women (Currie 2001; Poole and Issac 2001). The service providers in the present study described some of their programs and activities as follows:

¹⁹ The survey numbers are not included to ensure respondent anonymity (i.e., to prevent comparisons between these quotations and other quotations in the report).

- “In the group component, Aboriginal staff have gone medicine picking; smudging is available; children offer tobacco for the ceremonies with a person gifted in this; staff take children to Aboriginal community events—Pow Wows. This aspect of programming is in the process of growing, especially on the part of non-Aboriginal staff. The biggest challenge is often to have children claim themselves as Aboriginal in a positive way. This of course is an ongoing process for them”²⁰;
- “We have some Aboriginal staff and foster parents (not enough). We have frequent cultural activities and events, traditional teachings, and we have an Elder on staff”;
- “We utilize the Medicine Wheel in our workshops and counselling to help explain parts of the self”.

Service provider recommendations for working with women who self-harm

The service providers identified five major areas of recommendations for working with women who self-harm. It is important to point out that while an Aboriginal approach to healing was not addressed in the recommendations, it was strongly advocated in many other sections of the environmental scan. Many of the recommendations in this study were consistent with those provided by the community and correctional workers in the 2001 PWVSH study. In the PWVSH study, however, there was greater exploration of both helpful and unhelpful responses, and as a result, there was more detail on approaches that the women felt were ineffective and/or traumatizing—for example, the use of restraints or segregation following an incident of self-harm. For the environmental scan, the recommendations were: (1) to raise community awareness about self-harm (e.g., the complex nature of self-harm as a coping mechanism); (2) to increase educational opportunities about self-harm for clients (e.g., self-harm and suicidal intentions); (3) to provide more training on self-harm for service providers (e.g., more education and organizational workshops); (4) to increase resources for women who self-harm, from specialized programs to follow-up supports and services (e.g., need for more outreach services, follow-up, mentoring opportunities and advocacy); and (5) to address the broader social structural factors underlying women’s self-harm (e.g., systematic issues of poverty, safe housing, adequate nutrition, education, child-care and employment). The service providers gave the following descriptions to highlight their proposed recommendations for women who self-harm (see Table 13).

²⁰ The survey numbers are not included to ensure respondent anonymity (i.e., to prevent comparisons between these quotations and other quotations in the report).

Table 13

Service provider recommendations for working with women who self-harm

- 1. To raise community awareness about self-harm**
 - “Raise awareness of the complexity of the issue, removing the stigma attached to self-harm that discourages communication and the increase in shame (for both community and institution)” (Survey #9);
 - “Prevention and awareness to general public, teachers, counselors, coaches” (Survey #18);
 - “To remove stigma and shame” (Survey #24);
 - “The transfer of knowledge; openness to discussions in grade school health curriculum” (Survey # 25);
 - “We need to normalize self-harm—educate people to see it as a coping mechanism” (Survey # 26).
- 2. To increase educational opportunities about self-harm for clients**
 - “Education/awareness of issue needed (empowerment)” (Survey #13);
 - “Need for outreach service/more intensive follow-up services” (Survey #31);
 - “Education/awareness for women and community on self-harm vs. suicidal tendencies” (Survey #39).
- 3. To provide more training on self-harm for service providers**
 - “More education for staff and offenders” (Survey #19);
 - “Needs to be more education given to people who work with self-harmers” (Survey #32);
 - “More education and organizational workshops to understand this issue” (Survey #39).
- 4. To increase resources for women who self-harm (from specialized programs to follow-up services and supports)**
 - “More active mental health/wellness; resources in community; nursing station nurses more active—addressing the issue with their patient; RCMP and justice system more active” (Survey #13);
 - “Mentors for women” (Survey #24);
 - “Emphasize programs which teach women how to be in charge of their lives and de-emphasize services which simply perpetuate enabling ‘victim’ behaviours” (Survey #29);
 - “Need for outreach services/more intensive follow-up service and advocacy programs, adequate housing, more collaboration with existing community services” (Survey #33);
 - “Ensure a variety of resources available to meet a range of needs—both institutional and community” (Survey #34);
 - “Increase efforts to ensure continuity of care into the community” (Survey #35);
 - “For the community (who self-harm) healing from the trauma of abuse through support from group programs and individual counselling” (Survey #41).
- 5. To address the broader structural factors underlying women’s self-harm**
 - “If we really want to address women’s health issues, we need to tackle the larger systemic issues that influence their health—poverty, safe housing, adequate nutrition, safe, nurturing child care, women’s treatment options, education, employment, etc.” (Survey #11).

While less frequently reported, the service providers also recommended easier access to resources (e.g., psychiatric services), increased funding for specialized programs

(supports and services), greater co-ordination of services (e.g., on a provincial level) and further research on self-harm.

Service provider recommendations for working with adolescent girls who self-harm

The service providers identified five major areas of recommendations for working with adolescent girls who self-harm. These were highly consistent with the recommendations identified for women and are categorized under the same general areas, although the activities relate specifically to adolescence. The five recommendations were: (1) to raise community awareness about self-harm among adolescents (e.g., view self-harm as a health issue and not just teenage rebellion); (2) to increase educational opportunities about self-harm for youth (e.g., involve parents in educational workshops); (3) to provide more training on self-harm for service providers (e.g., include a wide spectrum of adolescent settings); (4) to increase the resources for adolescent girls who self-harm—from specialized programs to follow-up supports and services (e.g., increase supports and services oriented specifically toward adolescents); and (5) to address the broader social structural factors underlying adolescent girls’ self-harm (e.g., provide more adequate housing and shelters for youth). The service providers presented the following descriptions to underline their proposed recommendations for adolescent girls who self-harm (see Table 14).

Table 14

Service provider recommendations for working with adolescent girls who self-harm

1. To raise community awareness about self-harm

- “Training for all staff and general public in the understanding and identification of self-harm, the available resources and supports; for self-harm to be identified as a health issue and not just teenage rebellion; to understand the complexity of this issue in our society” (Survey #1);
- “Education/awareness of the issues (empowerment; stress relief); problem-solving; communicating a need (Survey #13);
- “More education needs to be done within communities about self-harm” (Survey #27);
- “Invitation to those who self-harm to tell their story” (Survey #25).

2. To increase educational opportunities about self-harm for clients

- “Workshops for staff on strategies for working with girls who are at risk in the community” (Survey #5);
- “Education/awareness to clients, staff, and parents” (Survey #38).

3. To provide more training on self-harm for service providers

- “The majority of girls exhibiting self-harming behaviours are being seen/treated in child welfare settings such as foster homes or residential facilities. Specific training for the staff in these facilities in response to self-harm would allow for earlier intervention to a great number of troubled girls before the patterns of behaviour become deeply entrenched” (Survey #40);

<ul style="list-style-type: none"> • “Education of service providers, including guards, of self-harm as a coping behaviour; of the benefits it brings (i.e., the way it helps) and the difficulty of stopping” (Survey # 21); • “More education for staff and offenders” (Survey #19).
<p>4. To increase resources for adolescent girls who self-harm (from specialized programs to follow-up services and supports)</p> <ul style="list-style-type: none"> • “Increase the number of supports and services available for those who self-harm, including individual counselling, family therapy, and support therapy groups and skill development; implementation of a multifaceted therapeutic approach that is client focused and centered that embraces the complexity of the issue” (Survey #1); • Peer counselling in groups about the issue (including) nursing stations, mental health (workers), Child & Family Services, and group homes; victim-offender mediation” (Survey #13).
<p>5. To address the broader structural factors that impact adolescent girls’ decision to self-harm</p> <ul style="list-style-type: none"> • “A need for outreach services/more intensive follow-up services and advocacy programs, adequate housing, more collaboration with existing community services, and more counselling services for children and adolescents” (Survey #33).

The recommendations for adolescent girls, however, were distinct from those for women in some important respects. There was a greater emphasis on addressing troubled family relationships, on recognizing the vulnerability of youth to sexual exploitation and the heightened risk of self-harm, and on dealing with issues of identity and self-esteem. The service providers described these recommendations as follows:

- “Mother-daughter group counselling” (Survey #13);
- “One of our greatest dilemmas is that as the girls AWOL, they are often in grave danger. I don’t have a solution for that as the closed settings don’t seem effective....There is a service need in this area (sexually exploited children. We discharge youth from our program at age 18. They rarely qualify for intensive adult services or support and often do not have the skills they need to live safely” (Survey #30);
- “Creative positive programming, teaching self-love of body, mind, and spirit” (Survey #37).

SECTION VIII

CONCLUDING COMMENTS & NEXT STEPS

I. CONCLUDING COMMENTS

The last section of the environmental scan provided the service providers with an opportunity to offer any additional comments on the issue of self-harm. It produced some new reflections and questions for future research on self-harm. The respondents stressed, for example, the misunderstandings and stereotypes about self-harm in the community, the need to explore in greater depth the role and functions of self-harm as a coping response, and the need to recognize the complex needs of women and adolescent girls who self-harm and the necessity therefore of using a holistic approach. One service provider expressed these views in the following statement.

Traditionally, there has been a lack of understanding re: the role of self-harm in the lives of people. The stereotypes and misunderstandings must be removed so that we can help each client who struggles/uses/requests help with this behaviour. The purpose served by the behaviour must be examined within the context of the individual, the environment, and within our society. In addition to the psychotherapy and/or counselling that many clients could benefit from, by truly understanding the purpose of self-harm, we can better assist our clients in reducing harm, developing skills to deal with pain, triggers, etc., find alternative coping and communication mechanisms and increase a client's mindfulness of dangers/alternatives, etc. (Survey #1).

The service providers also emphasized the need for a coordinated strategy that cuts across all government levels in order to more effectively address self-harm. A service provider commented:

This issue, or the lack of awareness and knowledge regarding treatment, prevention, and awareness activities around self-harm needs to be urgently developed and implemented—a national and provincial strategy. (We need to) add regional co-ordinators in each province. Training of health care providers is a top priority; (We need a) best practices booklet that can be shared across the country, a national conference, and provincial workshops on this issue (Survey #18).

In addition, the service providers pointed out some of the weaknesses in the current delivery of programs and services, particularly for Aboriginal women. They raised the concern that the educational and health care systems were judgmental and dismissive of

the needs of Aboriginal women and held colonial attitudes that expressed a mono-cultural model of treatment and care. According to one service provider:

Recommendations are a challenging area. I believe this is a complex area and that each child/young woman needs to be understood in terms of her own family/community history and thus there is no 'pat' answer. As your questions reflect there are many dimensions to understand. More work needs to be done with educational and health systems, which are too often judgmental/dismissive towards young Aboriginal women and are too stuck in the colonial 'I know best' mentality. Always more training/support for those working closely with adolescents/adults to understand this area (Survey #14).

The service providers were able to identify some specific concerns related to programs (supports and services) in institutional settings. One service provider stated:

Institutional setting—develop criteria to define self-injury; identify the training needs of staff who work with female offenders (who self-injure), i.e., elements of harm reduction, protection-planning and empowerment; the resources required to support offenders—adequate psychological services; trained staff to work one-to-one and provide support (Survey #19).

Finally, a number of service providers pointed out the importance of careful assessment in determining the readiness of clients to begin to deal with the origins of their emotional pain and distress, such as physical or sexual abuse. As one service provider wrote, "The individual may not be ready to look at the bigger issues but may be ready to look at decreasing self-harm behaviours" (Survey #20). Another respondent stated, "A common theme of repeated victimization, especially sexual assault and domestic violence and self-harm, is evident with many women" (Survey #14).

In summary, the environmental scan of service providers indicated the need for further action in several areas of concern:

- It is necessary to standardize definitions of self-harm and to implement systematic methods of data collection in order to assess the prevalence and types of self-harm in various settings;
- While there are studies on women's perceptions of self-harm, there is a need for qualitative research on the perceptions of youth and self-harm;
- Service providers require greater opportunities to learn about the agency or institution's policy guidelines or common practices; where these are not formulated, a forum is necessary to identify and develop policies and practices;
- Further research is necessary to explore the relationship and differences between self-harm and suicide;

- There is a lack of evaluative research on treatment and healing approaches, programs, supports and services for women and adolescent girls who self-harm; careful monitoring and evaluation of intervention strategies are essential to improve the quality of care;
- Service providers require opportunities to learn about the existing resources on self-harm, especially on the available effective or promising treatment and healing approaches;
- Public education campaigns are necessary to improve both public and professional understanding of self-harm;
- There is a persistent lack of adequate health care services for Aboriginal women, which requires immediate attention in developing culturally-specific healing approaches, programs, supports and services for self-harm; these interventions need to be designed, developed, implemented and evaluated by Aboriginal women.

II. NEXT STEPS

The immediate next step in this research is to address the remaining two of the five outlined goals in this research (see section IV). First, the findings of this environmental scan will be shared in a Manitoba community forum, and the next steps for action will be planned with respect to developing guidelines for programs and policies. Specifically, the purpose of this forum will be to discuss the environmental scan in light of its new findings and its comparability with the 2001 PWVSH study. Drafts of the guidelines for programs and policies on self-harm will also be prepared and discussed. This community forum will be held in conjunction with the Crossing Communities Art Project and will involve the survey respondents, the Winnipeg Intersectoral Committee on Self-Harm, women who have the lived experiences of self-harming, the research team, and other key community agencies and individuals. This event is expected to take place in winter, 2005.

Second, a research project that emerged from the 2001 PWVSH study and this environmental scan will commence in the summer of 2005. It will also be discussed at the winter 2005 community forum. Specifically, with funding from the Canadian Institutes of Health Research, Institute of Aboriginal Peoples' Health, a three-year project will be undertaken to examine the role of self-identity in the healing journeys of Aboriginal women who have a history of criminalization and who are identified as drug users. The research will commence with an understanding of women's drug use as a form of self-harm. This project is a collaborative effort of Carleton University, the National Native Addictions Partnership Foundation, the Canadian Centre on Substance Abuse, the Elizabeth Fry Society of Manitoba and the University of Winnipeg. The goal of the study is to contribute original knowledge to the treatment field that can assist in improving the quality of health for Aboriginal women in Canada.

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