Working paper submitted for 'Ethnographies of diagnostic work' 17-18 April, Lancaster University, UK.

Please do not quote without the authors' permission.

'The one's that say they'll do it never do, it's the one's you don't expect that string themselves up': Prison Officers' diagnosis of potential suicide and their strategies for continual crisis management

Personal Journal 18/1/95

Nothing like beginning with the day from hell - decided to observe Reception having decided to chart the progress of 'a prisoner' as he travels through the prison, noting any event which may produce interesting aspects of literacy events and practices.

The first one out of the police car (Bell, Fleetwood) looks about ten and so fazed that any idea of talking to him goes right out the window - shell-shocked - returned I think due to breach of bail.

He is followed by the Liverpool van of 10 prisoners - six new numbers - the first (Turner a left-hander who writes with considerable concentration)I notice the weals on the back of his neck - he has attempted to hang himself the evening before -
Each one seems to illustrate aspects of society's casualties - limps, scars, acne, inarticulate speech, gangliness, cold, thin, hungry, non-payment of fines. I know that I am seeing them at their worst having just come of the streets, the courts, other jails but it is an eye-opener and a salutary lesson in the realities of research.

When this diary entry was made I had already been working with people in prison for a number of years. I have continued to work with them up until the present time. Back in 1995, diagnostic work was not of any particular interest except as a practice I observed such as part of the process described above or under the guise of reflexivity when I sought to assess my own position within the prison and the research. Diagnosis is still not my primary concern but as I consider the extent and depth to which I have become familiar with the system and the people who operate within it, it becomes apparent that it runs like a thread through many prison activities and practices. It seems reasonable to turn the ethnographic lens towards this new topic and in particular, to look at diagnosis that pertains to self-harm and suicide.
In this paper I intend to cover four areas - two rather briefly and two in more depth. I want to begin by briefly unpacking the notion of ethnography, its benefits and pitfalls and what it can contribute to studies on diagnosis.
Secondly I want to outline the theoretical and disciplinary position I take, in order to make clear my interest in various aspects of self-harm, suicide and the attendant diagnostic work that goes on around it.
Thirdly I want to use ethnographic narrative to chart some significant points in prison activities and practices that involve issues around the diagnosis of self-harm and suicide.
Finally, I want to map some of these issues onto the themes of the seminar.

But first some background

Suicide is a terrible thing - as much for those who are left behind as for the person who 'succeeds' in killing themselves. For such an act to be performed in prison seems to add additional layers of distress, guilt, accountability and interrogation as to how and why such a thing should happen. Recent reports suggest that people who are imprisoned are considerably more likely to attempt suicide than those in the community, with the most vulnerable groups being women and young men.
Given that the prison population of both these groups has risen considerably, the Prison Service is understandably at pains to ensure that suicide is kept to a minimum. Additionally, there is a developing culture among some young

prisoners around 'pseudo hanging', noted by the psychiatrist in Feltham where *we saw [epidemics of self-harm] and 25 hanging attempts in a single week'..* Some young men gaining credibility as being able to tie 'emergency release' mechanisms for others to use. New protocols around suicide and self-harm have recently been put in place, moving from a suicide prevention strategy that stressed the monitoring of prisoners and their relocation to a 'safe' cell or medical Unit, to ACT (Assessment, Context and Teamwork) - a pro-active, team approach which is intended to involve the whole prison community which has now been rolled out in both the Scottish and English prison systems. Each of these two prevention systems is supported by pro-forma bureaucracy and the use of generic indicators to assess whether someone is at risk. Even so 366 self-inflicted deaths in custody have occurred since 2002. However, my experience, having observed everyday prison life for some time, noting the fragility of some of the population and recognising the stresses of the job of looking after them, leads me to believe that it is only the diagnostic capabilities of operational staff that prevents the rates from being considerably higher.

The ethnographic stance - its strengths and possible weaknesses

I see myself as someone who IS an ethnographer - not someone who 'does' ethnography or who 'uses ethnographic methods (Bloome & Green 1997). I only work in prisons and have employed a variety of means by which to gain an understanding of this unusual and unpredictable world including case studies, focused conversations, correspondence, drawings, photography, poetry, observation, and participation including serving meals, drinking coffee, sharing chocolate and eating sweets. I have worked with adult and youthful offenders, long and short term in a variety of settings in Europe and North America. I spend considerable amounts of time doing what appears to be 'hanging around' and am often know as 'that woman'. Those with whom I have undertaken most work are young male offenders under the age of 21. I have gained sustained access to individual prisons for a number of years or for short durations of time. Some prisoners have been involved with my work for more than 15 years while others have taken a more transitory role. My main focus of interest is in communicative practice and how it can impact on mental health and well-being. I am interested in strategies for survival refuting the claims by de Certeau (<<>>) that the underdog can only aspire to tactics while the powerful retain the strategies.

I see ethnography as the only appropriate method if one is to truly gain a deep understanding of the nuances of institutional life. Prison has a culture of suspicion, mistrust and paranoia which runs through it regardless of the position one might hold. As Clemmer pointed out in his seminal text The Prison Community (1941) the idea is to 'build rapport' and 'break down mistrust'. This is not possible without sustained engagement.

My concern is that in a climate of 'fast research' ethnography is itself becoming a victim of speed. As I have noted elsewhere (200?) the current approach seems to be one of 'blitzkrieg' ethnography with researchers parachuting in and then leaving with data or adopting an 'amphetamine' model with the speed and whizz of short term field work. While such an approach might draw on the ethnographic toolkit, it concerns me that there is an expectation that trust and rapport can be built up in a single interview, that an

orchestrated focus group can produce uncontrived data or that to merely state that we are 'doing ethnography' is sufficient proof that we are.
The process of diagnosis is a sensitive business with a general assumption that there is a possibility for both positive and negative outcomes - it is a time of indecision - of 'expecting the worst or the best' and therefore needs a delicate approach. Ethnography done properly has the potential to open up the value of diagnosis through proper attention to the importance of everyday interaction and communicative practice - which leads me to the second point that I want to touch on.

Disciplinary Position - and why I'm interested in self-harm and diagnosis
My work is an amalgam of trans/multi/inter-disciplinary work and theory. It draws on grand theories of postcolonial migration ((Bhabha1994) and symbolic power (Bourdieu 1991) as a way of suggesting that the prison occupies a third space between the institutional and the social. While it is not situated within geography, it draws on concepts of limen ((Turner 1969), pause (Tuan 1977), 'non-places' (Auge 1995) and exclusion (Sibley 1995) to describe the space and place within which diagnosis takes place. Nor is it situated within criminology but it builds on concepts of prison as total institution (Goffman 1961)(Cressey 1961), as community (Clemmer 1940), and as hierarchical ((Sykes 1958) as a way of recognising that competing discourses of institutional and everyday life.
It locates itself firmly within a model of situated communicative practice (New Literacy Studies; Barton et al 2000) which has a focus on the contextualised nature of various text. However, while diagnosis of self-harm and suicide in prison draws on the relationship between dominant and vernacular forms of language and autonomous and ideological instantiations of literacy, my interest is in expanding the notion of text to include the visual ((Wilson 1999), the sensory (Wilson, 1998), and the spatial (Wilson 2004). I want to suggest that inscription on prison space and communicative practice within it can be made through a variety of technologies including the artefact and the body. It can most certainly aid diagnosis when it includes the bodily scars of self-mutilation, the weal marks of attempted suicide or the ephemeral text of an un-washed and un-cared about body. It is these textual nuances that have most meaning for diagnostic work around self-harm and suicide in the prison setting.

Ethnographies of diagnosis
There are two continua to take into account when talking about suicide in prison and the diagnostic process. One refers to the points between self-harm and suicide. The other refers to those between 'hands on' diagnosis and bureaucratic risk assessment. Both involve prevention through intervention as the aim of both the prison and the staff is to prevent death in custody and to avoid blame. Each operates from the same premise - not to move further along the continuum than is humanly possible. The psychological and practical move from self-harm to suicide (still seen by many staff as a natural progression) - is not one that anyone (other possibly than serious perpetrators) wants to make. Equally, but for different reasons, the move from practical intervention to bureaucracy is also something to be avoided.

Prison staff are already overwhelmed with paperwork which is seen - regardless of to what it pertains - as irksome and a barrier to 'hands-on' work with prisoners.
Diagnosis of self-harm and suicide within prisons takes place at many levels and different stages. At the meta level procedures and protocols are in place to prevent a potential 'death in custody'. At the mesa level each establishment has its teams of professional who have a code of practice to adhere to. At the micro level staff use their jail craft experience and expertise to diagnose potential 'at -risk' prisoners. I want to outline three specific points of intervention - the Reception process, the Induction process and the Residential Units.
At the reception stage - referred to in the diary entry above - Prison Service Order 0500 includes a number of mandatory actions relating to:

- identification of prisoners at risk of suicide/self-harm
- cell sharing risk assessments
- identification of prisoners subject to public protection measures
- recording of information relating to new prisoners, and its dissemination around the prison and to other agencies
- supply of items for prisoners' immediate personal needs

While the first is obvious, the other four are also related to prison self-harm. Prisoners not only kill each other (as in the case of Zahid Mubarek) but can incite one another to engage in pseudo hangings; prisoners on public protection may require segregation from the rest of the population; new prisoner are particularly vulnerable and therefore more likely to self-harm; the supply of items may well include a razor.

While the PSO is no doubt in the mind of staff as they receive prisoners into the jail, their diagnosis is much more likely to rest on the word of the driver of the prison van who may have additional information, the visual texts that present themselves such as 'weals' on the neck, the general 'habitus' of the offender and the spoken text around questions such as 'you alright lad?' 'no history of self-harm then?' or 'you ain't gonna hurt yourself then are you?'

Once in the jail, prisoners move to an Induction wing. At the bureaucratic level, a dossier may be opened and behaviour and attitude monitored by other professionals such as health care staff, prison doctor or visiting psychiatrist. Diagnosis takes place in relation to risk of suicide and self-harm. At this point a prisoner may move along both continua - higher risk of self-harm and higher level involvement with bureaucracy - and be moved to the medical unit or in more severe cases towards being Sectioned. But in most cases, prisoners remain within the parameters of 'informal' assessment and diagnosis by regular prison staff. Colin, for example - a long-term contributor to my work - and a prolific offender well know to the prison - tries to hang himself on a weekly basis for around the first month of his imprisonment. Over time, prison staff have diagnosed that in addition to fulfilling bureaucratic requirements, his changes in attitude, reflected in his bodily texts of 'not busy = depressed' or 'busy = less depressed' means that - in his words - 'keeping me busy' is the best intervention. Often this means that he remarks prison space by a move

to a month long stay in the hospital wing, or even the Segregation block as he also tends to be confrontational even to staff there to support him. He also responds particularly well to dealing with the marks of others - ie cleaning duties which often involve the removal of graffiti, blood or excrement of other prisoners.
Most prisoners however move in to the main body of the jail where they write themselves onto the prison landscape in various ways. Diagnosis for those already identified as 'potential' self-harmers or 'potential risk of suicide' remains fixed in bureaucracy, which itself continues to be re-assessed with case conferences, medical reports etc. The general population, however, rely on the observational expertise of staff and indeed other prisoners. Some diagnosis is forced upon staff with conventional texts - anonymous notes being sent by prisoners as a 'cry for help' (the blue face in the mirror) - when the alarm bell of 'at risk' shifts responsibility to other professionals in other fields such as the medical team.
In other cases, a diagnosis of vulnerability is countered by a policy of 'leaving well alone' and often quite effective. In my experience, the wish of a prisoner to offer to hand in her razor at times of stress was diagnosed by staff as a reason for praise rather than a diagnosis of required intervention, and seen as a move away from her usual self-harm practices. A recent contributor to my work - a self-harming anorexic - told me that his strategy for getting through prison time was to spend his time 'thinking'. The staff had christened him 'the gnome' as he spent most of his time writing himself into the prison world by sitting facing away from the door on his bed. However - and unbeknown to him - continued to make diagnoses re his progress and mental well-being by monitoring whether he came out for meals and noting how much food was left on his tray.

Finally - and ironically - as an aside - the second most likely point at which a prisoner may attempt suicide or serious self-harm is as they reach the end of their sentence - especially if they have been serving a long time. For staff intent on keeping the current population alive, little attention seems to be paid to this aspect of potential tragedy or to any form of diagnosis. Comments 'after the event' such as 'and he was getting out next week'; 'he seemed to be looking forward to leaving' or 'she seemed such a strong person' indicate that the need for closer observation and more stringent diagnosis of vulnerability.

Concluding thoughts and reference to the themes of the seminar
In terms of collaboration - diagnosis around self-harm and suicide lends weight to my argument that prison works on a system of compromise and operates within a third space where conventional norms are disrupted and reconfigured. Rather than maintaining the division between the keepers and the kept the identification of potential self-harmers and the diagnosis of what intervention should take place often works on a system of team work, with appointed prisoner Listeners playing an equally active role. Equally in the event of a suicide - certainly in those with which I have been involved - the whole prison or whole Unit is united in finding ways to deal with the grief and aftermath. In terms of diagnosing an appropriate course of cathartic action, in one instance, the cell in which the suicide had taken place was designated a

shrine which both the women and the staff could access and which was blessed by the prison pastor.

In terms of Human to Human engagement, diagnosis is often hindered by conflicting views as to what self-harm might be or the fact that for most self-harmers suicide is not considered an option. A common staff response of 'it's only a cry for help' 'it's manipulation' or 'it's attention seeking' does nothing to assist a correct diagnosis or an appropriate course of action. The conflict of perceptions between self-harm as release; self-harm as NOT a pathway to suicide; self-harm as one step on the road to suicide makes diagnosis difficult and can in fact exacerbate situations.

With regard to the engagement of human to matter, the prison often relies on 'the language of ligature-free cells' as a means of being able to avoid making further diagnoses of risk of suicide. Placement in such a cell however, re-marks someone as vulnerable - which is itself often a contributing factor to self-harm and may lead to further feelings of worthlessness. The indignity of rip-proof clothing, the wearing of special garments, the confinement to 'safe' cells only serve to brand people in certain ways and offer the prison a chance to 'de-diagnose', leaving the environment to do the job of intervening.

Concerning 'translations' - again there is the potential for certain actions and therefore proper diagnoses to be 'lost in trasnslation'. Just as self-harm doe not necessarily equal a propensity for suicide, 'old' self-harm marks do not necessarily mean current self-harm and the fact that someone might say proudly that they have 'only' cut themselves four times in one week should be diagnosed as a positive rather than a negative act.

Finaly, in terms of relations. We have already established that diagnosis can be a whole prison affair. However, self-harm and indeed suicide is a private affair. It is therefore often undiagnosable, remaining invisible until such times as it enters the public domain. While most prison staff make every effort to understand and make appropriate diagnosis as to levels of risk, nevertheless it needs to be remembered that the self-harmers are the experts and staff the novices.

To conclude then

In day to day prison life - vernacular diagnoses - ie informal, self-diagnosis, non-official diagnosis, and strategies such as 'getting a grip', talking to the priest, (occasionally) talking to other prisoners, talking to a specific officer often take precedence over formal, organised more bureaucratic forms of assessment. However, for these to have any real effect, the prison needs to operate on a system of open-ness and trust. General communicative understanding needs to be done before something so personal/fundamental can be discussed. Additionally, the language of the body - as well as the language of bureaucracy, protocols and procedures needs to be brought into the equation. Vernacular diagnoses, however, are in direct contrast to 'dominant' diagnoses which are either set out in a rubric in terms of attitude/risk assessments etc or related to the protocols to be used after the event of a death in custody.

Overall, the axes of 'self-harm to suicide' and 'hands-on to bureaucracy' relies on understanding the nuances of daily life and a wide reading of language forms. Where people are placed on these axes is often dependent on a variety of subtle indicators including bodily texts and visual cues. In a culture of blame however, individual successful diagnoses of potential suicide and

self-harm and the prevention of further damage to any number of prisoners is overshadowed by the perceived collaborative neglect of the system of a whole when someone dies in custody