Harm-minimisation for self-harm

your guide to today's mental health issues

Traditionally, the main principle for treating self-harm has concentrated on prevention or cessation, but has the time come to focus instead on harm-minimisation techniques?

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In my work for harm-ed I'm informed not just by my academic grounding in the issue, but also by my years of personal experience of self-harm. Six years of frequent admissions to inpatient services instilled in me a passion for improving services and a specific commitment to the harm-minimisation approach. In this article, I focus on the NICE guidelines for longer term management of self-harm (2011) and their conclusions on the issue of harm-minimisation; drawing also on wider research and theory, and the accounts that we commonly hear during training.

Many people working in health and social care have already heard of harm-minimisation – the term has been around since the 1980s (Newcombe, 1987); and as an alternative to zero-tolerance approaches, its principles have been in evidence since at least the 1920s (Rolleston, 1926). The approach has its strongest history in the field of substance misuse, where, despite initial controversy, needle exchanges and drug awareness programmes are now accepted as mainstream practice.

Not so for self-harm, where prevention or cessation remains the dominant principle upon which interventions are based and where harm-reduction techniques – such as imparting basic anatomical knowledge to people who self-harm – are still regarded as marginal practices, surrounded by controversy, obscured by anxiety, and heavily resisted at organisational and managerial levels. But this may be about to change.

In consideration of harm-minimisation approaches to self-harm, the NICE guidelines observe: "The resistance to employing harm reduction techniques in this context (i.e. working with self-harm) had no evidential support – whilst there was significant evidence supporting harm-reduction techniques in other areas of healthcare."

NICE therefore makes the following recommendation to those working with people who self-harm: "Consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user and the wider multidisciplinary team."

In doing so, they add to the number of guidelines advising the use of harm-reduction strategies, including *Mainstreaming Gender and Women's Mental Health* (Department of Health, 2003); NICE guidelines for *The Short-term Physical and Psychological Management and Secondary Prevention of Self-Harm* (2004); the Royal College of Psychiatrists' *Better Services for People who Self-Harm: Quality standards* (2006) and the Department of Health Self-Harm Expert Reference Group guide for staff working in secure mental health units (Douglas & Marriot, 2012, draft).

They also add to the small but growing body of evidence in support of harm-minimisation for self-harm, including formal evidence (Holley *et al*, 2012; Pengelly *et al*, 2008) based on practice and research, and perhaps most importantly, first-hand evidence drawn from experience (Pembroke, 2000; Shaw & Shaw, 2006).

Coping strategies

Thought experiment: visualise a difficult day that leaves you feeling stressed out. Now identify what coping strategies you would usually draw on to make yourself feel better. Which of these are actively or potentially harmful to the self? Can you identify any other common coping strategies that involve actual or potential harm to the self?

It's a safe guess that most people will recognise how at least one of their coping strategies – smoking, drinking, comfort food etc. – is actively or potentially harmful to the self. Self-harm exists as part of a much wider spectrum of common and socially accepted behaviours that cause (often significant) harm to the self.

Guided by a body of research and literature extending back over decades (Favazza, 1987; Tantam & Huband, 2009) it is now widely accepted that self-harm is a coping strategy, rooted in difficult feelings and experiences, which functions by restoring calm, expressing distress, releasing tension, experiencing comfort and grounding a person in reality (Arnold, 1995; Hawton *et al*, 2003; MHF & Camelot

Foundation, 2006; Heslop & Macauley, 2009). We can reflect on our personal experiences to recognise how these functions are shared with most common coping strategies. However, self-harm is marked out, not just by the directness, immediacy and physicality of the harm caused – which sets it apart from smoking, or unhealthy eating, for example – but also by social attitudes that are, even according to the most conservative of measures, predominantly negative (NICE, 2011).

Thought experiment: visualise yourself at the end of that difficult day, about to use your coping strategy. Someone tries to prevent you from having your glass of wine, cigarette, walk with the dog etc. How do you feel? What do you do?

Feelings commonly reported by training participants include: distress, frustration, despair, anger and a loss of control; leading many people to respond by withdrawing, becoming aggressive, "doing it anyway" and "doing it even more".

Evidently, a primary emphasis on the prevention or cessation of an important coping strategy is unlikely to be the most helpful response. Ask a drugs worker or a teenage sexual health worker why they don't 'just say no' to their clients. You might anticipate answers like, 'it's unrealistic and patronising'; 'it would ruin the therapeutic relationship'; 'it increases risk by driving the problematic behaviour underground'; 'it undermines the potential for services to facilitate lasting change.' And so we are alerted to the distinct possibility that, when working with self-harm, a focus on prevention or cessation may be the exact opposite of helpful.

Table 1 below lists, in the left-hand column, helpful responses to self-harm as identified in research (Royal College of Psychiatrists, 2006; Arnold, 1995; Newham Asian Women's Project, 2007). In the right-hand column are examples of common practices informed by a preventative approach to self-harm.

Let's examine the alternative. I work in a training partnership that defines harm-minimisation as "an alternative to preventative approaches which aim primarily to prevent people from self-harming. Harm-minimisation approaches accept that someone may need to self-harm at a given point, and focus instead on supporting that person to reduce the risk and the damage inherent in their self-harm." (harm-ed, 2010).

Take the example of self-cutting: in the left-hand column of table 2 are listed some of the risks, and in the right, steps that may be taken to reduce those risks.

To see these strategies in practice we can look to a number of organisations that have worked using this approach for years, including:

- St George's Hospital in South Staffordshire NHS Trust
- The Crisis Recovery Unit at Maudsley Hospital, London
- Royal Edinburgh Hospital
- Calderstones NHS Trust
- Guild Lodge in Lancashire Care NHS trust
- 42nd Street, which supports the emotional wellbeing of children and young people in Manchester
- Scottish mental health charity Penumbra
- The Leeds Survivor Led Crisis Centre.

Table 1: Preventative and zero-tolerance approaches

Helpful responses to self-harm	Preventative approaches to self-harm
Positive, non-judgmental attitudes	Punitive responses eg. insufficient anaesthetic; withdrawal of leave
Choice and involvement	Detention and restraint
Optimistic and hopeful approaches	Exclusion from treatment on the grounds of continued self-harm
Compassion, comfort, caring	The withdrawal of care and comfort following an incident of self-harm
The opportunity to talk/express feelings	'No self-harm' contracts or promises
Individualised care	Collective restrictions
Provision of information	Withholding information

Table 2: Possible risks and harm-minimisation measures

Possible risks	Harm-minimisation measures
Severing arteries, nerves or tendons	Basic anatomical information about bodily structures, access to medical attention etc.
Risk of infection	Using clean implements, keeping wounds clean, access to first aid and medical care etc.
Scarring	Wound care, issues surrounding site of cutting, access to specialist services etc.
For more information about practical strategies for reducing harm see Dace (1998) and National Self Harm Network (2000), which can be downloaded from www.harm-ed.co.uk.	

We can also look to prominent individuals such as psychologist Sam Warner, psychiatrist Pat Barker, and nurse consultant Suzie Marriott, alongside many anonymous frontline workers whose practice has been informed by harm-minimisation principles, often without the backing of their organisation.

Conclusion

"The resistance to employing harm reduction techniques in this context had no evidential support" (NICE, 2011). However, I'm guessing that there will be significant resistance among this readership, and that this resistance is based in some very real experiential evidence. This goes a long way to explaining why prevention or cessation of self-harm is the goal of many services, and why the NICE (2004 & 2011) guidelines themselves use cessation as the golden rule in measuring the effectiveness of interventions. But in addition to that there are other significant challenges, including high levels of anxiety around suicide and severe injury, alongside fears of transgressing codes of conduct and 'duty of care', and subsequent criminal or civil proceedings. These anxieties are heightened in a context of lack of organisational policy and guidelines or of back-up from management and colleagues.

However, informed by the excellent work of staff at St George's in South Staffordshire – including the late (and much missed) Chris Holley – the Royal College of Nursing's Learning Zone (2009) resources go some way to addressing and allaying these concerns, setting out basic principles for how harm-minimisation might be employed in practice:

- Every person who self-harms is unique, therefore assessment, care-planning and care must be individualised
- The capacity to engage in harm-minimisation might vary. The level of risk must be reviewed regularly and the care plan should be altered accordingly for an agreed period of time
- The boundaries of self-harm must be negotiated fully and documented
- The care plan must be detailed. It should describe what nurses need to do in a given situation
- The care plan should have been agreed between the patient, nursing staff and the whole multidisciplinary team (this may include the legal department)
- The care plan must include strategies for nursing staff and the patient when the person is no longer feeling safe and not able to manage their self-harming safely
- This approach must be thoroughly based on the agreed organisational risk assessment and documentation must be fully consistent with regulations.

Despite this, and the growing body of evidence and guidance in support of a harm-minimisation approach, real and justified concerns remain. But, as the NICE 2011 guidelines make clear, these concerns should not obstruct a readiness to learn from the example of other health services, especially substance misuse services.

Rather, with adequate support and supervision, those concerns can help to inform a thoughtful, individualised response to self-harm, one which fits more closely with the core principles of a helpful response as identified by people who self-harm, and the people who care for them. Service users, activists and committed professionals have worked for years to move this approach from marginal to mainstream. With the backing of the NICE guidelines, and with a body of evidence behind it, now is the time.

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