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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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).

**Table 1: Preventative and zero-tolerance approaches**

<table>
<thead>
<tr>
<th>Helpful responses to self-harm</th>
<th>Preventative approaches to self-harm</th>
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<tbody>
<tr>
<td>Positive, non-judgmental attitudes</td>
<td>Punitive responses eg. insufficient anaesthetic; withdrawal of leave</td>
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<tr>
<td>Choice and involvement</td>
<td>Detention and restraint</td>
</tr>
<tr>
<td>Optimistic and hopeful approaches</td>
<td>Exclusion from treatment on the grounds of continued self-harm</td>
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<tr>
<td>Compassion, comfort, caring</td>
<td>The withdrawal of care and comfort following an incident of self-harm</td>
</tr>
<tr>
<td>The opportunity to talk/express feelings</td>
<td>’No self-harm’ contracts or promises</td>
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<tr>
<td>Individualised care</td>
<td>Collective restrictions</td>
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<tr>
<td>Provision of information</td>
<td>Withholding information</td>
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**Table 2: Possible risks and harm-minimisation measures**

<table>
<thead>
<tr>
<th>Possible risks</th>
<th>Harm-minimisation measures</th>
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<tbody>
<tr>
<td>Severing arteries, nerves or tendons</td>
<td>Basic anatomical information about bodily structures, access to medical attention etc.</td>
</tr>
<tr>
<td>Risk of infection</td>
<td>Using clean implements, keeping wounds clean, access to first aid and medical care etc.</td>
</tr>
<tr>
<td>Scarring</td>
<td>Wound care, issues surrounding site of cutting, access to specialist services etc.</td>
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</tbody>
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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.