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Harm reduction as a strategy for supporting people who self-harm on mental health wards: the views and experiences of practitioners

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1 **1. Introduction**

2 Harm reduction or minimisation is a term used to describe policies, programmes or
3 interventions that aim to reduce the health-related harms of behaviour (European Monitoring
4 Centre for Drugs and Drug Addiction, 2010). The defining feature of this approach is its
5 focus on reducing the adverse effects of a behaviour, rather than prevention or cessation of
6 the behaviour itself. Examples of harm reduction interventions include the prescription of
7 methadone maintenance to people dependent on opioids, or the promotion of strategies to
8 reduce the risk of HIV transmission during unprotected sex (European Monitoring Centre for
9 Drugs and Drug Addiction, 2010; Parsons et al., 2005). Harm reduction is well established
10 within sexual health, alcohol and substance misuse services, and has been shown to
11 improve the physical health and wellbeing of service users (Midford et al, 2014; Rekart,
12 2006; Wheeler et al, 2010). Harm reduction for self-harm can be described as “*accepting the*
13 *need to self-harm as a valid method of survival until survival is possible by other*
14 *means...and is about facing the reality of maximising safety in the event of self-harm*”
15 (Pembroke, 2009, p. 6). There is no established model of harm reduction as applied to self-
16 harm, but practices can include advising people how to self-harm safely, how to clean their
17 wounds, and supplying them with safer means to self-harm such as clean blades. This is a
18 controversial approach which raises a number of legal and ethical challenges for
19 practitioners (Gutridge, 2010; Edwards and Hewitt, 2011), yet it is advocated by some
20 people who self-harm, who find that being prevented from doing so, causes them more
21 distress, can lead to an escalation in their self-harming behaviour, is stigmatising and is
22 detrimental to their relationship with professionals (Duperouzel and Fish, 2008; Lindgren et
23 al., 2011; Pembroke, 1994; Shaw, 2012). Recent guidance from the UK’s National Institute
24 for Health and Care Excellence (NICE) recommends ‘*tentative approaches to harm*
25 *reduction for some people who self-harm*’ in the community (NICE, 2011, p. 259). There is
26 evidence that a variety of approaches have been adopted within both community and
27 inpatient mental health services, yet there has been very little research into this practice.
28 Birch et al., (2011) examined rates before and after implementation of a harm reduction

1 programme within a female forensic service and reported a reduction in incidents of self-
2 harm, however the study was conducted within a single service, with a small sample, and
3 with no control group. Fish et al., (2012) surveyed views of harm reduction amongst
4 practitioners in a forensic learning disability service and found 85% were in favour of the
5 introduction of a harm reduction policy for self-harm, and when developing a trust handbook,
6 Pengelly et al., (2008) sought written feedback from a psychiatrist and psychotherapist,
7 alongside representatives from the Nursing and Midwifery Council and Royal College of
8 Psychiatrists. The authors concluded that harm reduction for self-harm was a professionally
9 defensible position. Studies exploring staff attitudes towards self-harm in general have found
10 that clinicians have a mixture of both positive and negative feelings towards those who self-
11 harm, but that mental health practitioners are more accepting of self-harm than those in
12 general health services (Saunders et al., 2012). It is possible that, when carefully applied
13 and under the right circumstances, mental health practitioners may be supportive of harm
14 reduction as a strategy for the management of self-harm. Yet, to the best of our knowledge,
15 the views of practitioners about harm reduction (particularly nurses and nursing assistants
16 who provide the majority of care to people who self-harm in mental health settings) have not
17 been rigorously investigated. We therefore set out to explore nursing practitioners'
18 perspectives and experiences of harm reduction practices for self-harm on mental health
19 wards.

20 **2. Methods**

21 This study comprised a survey of attitudes towards harm reduction amongst inpatient mental
22 health practitioners using the Self-harm Antipathy Scale (SHAS; Patterson et al., 2007;
23 Phase I), followed by qualitative interviews with a subsample of 18 participants to explore
24 their views of this approach (Phase II). The SHAS includes two questions related to harm
25 reduction practices, namely whether self-harm should be stopped, and whether individuals
26 should be given the freedom to choose whether or not they self-harm. Agreements with
27 these statements indicate a more positive attitude (low antipathy) towards self-harm.

1 For Phase I, the sample were all nursing staff working on 31 acute psychiatric wards
2 in 15 NHS hospitals in the South East of England, recruited as part of the Safewards
3 Randomised Controlled Trial (see Bowers et al., 2015 for the inclusion criteria). Safewards is
4 a complex intervention designed to reduce conflict and containment on acute mental health
5 wards (www.safewards.net). For Phase II, an intensity sampling strategy was used in which
6 practitioners were randomly selected from those within both the top (range = 111-139; n=8),
7 and bottom (range= 36-52; n=10), 10th percentile of SHAS scores collected during Phase I
8 from the control arm of the Safewards trial. Qualitative studies, such as Phase II, do not
9 intend to capture views that are representative of a sample (e.g. Phase I), but instead aim to
10 further our understanding about a belief or behaviour. An intensity sampling strategy selects
11 cases that are likely to manifest 'intense' or rich examples of the topic of interest. The
12 sample does not, however contain extreme, or deviant cases (Patton, 1990). We adopted an
13 intensity sampling strategy for Phase II because it enabled us to select information-rich,
14 contrasting examples, most likely to provide significant insights into practitioner's perceptions
15 of harm reduction. Quotes from high and low scoring participants are denoted 'hi' and 'lo'
16 respectively in the text.

17 The SHAS is a 30 item self-report questionnaire consisting of statements about
18 people who self-harm. Participants must indicate agreement or disagreement with each
19 statement on a seven point Likert scale ('strongly agree' to 'strongly disagree'). Patterson et
20 al. (2007) used three sources of data to construct the SHAS, and to establish its validity;
21 published literature on attitudes towards suicidal behaviour (Domino et al. 1982, Platt &
22 Salter 1987, Pallikkathayil & Morgan 1988, Watts & Morgan 1994); focus groups with
23 practitioners; and in-depth phenomenological interviews with people who self-harm and
24 practitioners about their experiences of care (Patterson 2003). Factor analysis conducted by
25 the original authors revealed six subscales; (i) competence appraisal; (ii) care futility; (iii)
26 client intent manipulation; (iv) acceptance and understanding; (v) rights and responsibilities;
27 (vi) needs function. The items included in this study comprise the 'rights and responsibilities'

1 subscale. The SHAS has shown high internal consistency (Cronbach's $\alpha = 0.89$; Patterson
2 et al., 2007).

3 Survey data were collected during the two month pre-implementation phase of the
4 Safewards trial. Questionnaires were marked with a code unique to staff member, and were
5 distributed to participants along with a blank envelope. Questionnaires were either returned
6 direct to the researchers or via a sealed box on each ward. Data were entered onto
7 computer using Snap survey optical mark recognition software (Mercator Research Group,
8 2003) and copied to STATA version 11 for analysis (StataCorp, 2009). To ensure accuracy
9 all electronic data were checked against the original questionnaires. A missing data and
10 sensitivity analysis was conducted according to guidelines set out by Hair et al., 2006 (see
11 James, 2015 for a description of this analysis).

12 Semi-structured interviews were conducted with 18 participants over a 9 month
13 period at the end of the Safewards trial. Eligible practitioners were listed in a random order
14 and the first ten from each group invited to participate. Three participants declined; one due
15 to personal reasons, one because they no longer worked on the ward, and one did not give
16 a reason. Where practitioners declined to participate, the next person on the list was
17 approached. Interviews followed a topic guide to ensure all interviews were similar in their
18 structure and content which enabled comparison between transcripts. Interviews were
19 conducted in a meeting room on the ward or within the hospital, and were recorded using a
20 digital voice recorder.

21 All interviews were transcribed verbatim and the transcripts anonymised. Interviews were
22 analysed using thematic analysis which aimed to provide a detailed account of themes
23 related to the research aims, rather than a representation of the entire dataset (Braun &
24 Clarke, 2006). For this study, a 'theme' constituted a pattern of meaning which was either
25 directly observable in the data (explicit content), or was seen to underlie the data (manifest
26 content; Joffe, 2011). Our study was driven by questions arising from mental health practice,
27 rather than theory. We therefore chose to use thematic analysis because it is a flexible

1 approach, which is not aligned with any particular theoretical perspective (Tashakkori &
2 Teddie, 2003). It is frequently used in applied health research, which most often operates
3 within realist, or pragmatic paradigms (Tashakkori & Teddie, 2003). For this study we
4 adopted a realist perspective, which focusses on the experiences of the individual, and
5 assumes that the motivations and experiences of staff are communicated in a
6 straightforward way during interviews (Braun & Clarke, 2006). Thematic analysis also offered
7 the optimal analytic approach to our data as it produces results which are in principle,
8 accessible to practitioners, service users and policy makers (Braun & Clarke, 2006).

9 Data analysis followed the six stage process outlined by Braun and Clarke (2006); All
10 interviews were repeatedly read by KJ, who developed the original coding framework, which
11 was then further developed through an iterative process involving regular meetings and
12 discussion with DS, to ensure the themes were coherent and internally consistent. Author
13 perspectives on harm reduction for self-harm were as follows: IS has lived experience of
14 self-harm and was in support of these practices, KJ and DS are researchers and were
15 neither in favour of nor against the approach. PM is a consultant psychiatrist who used to
16 run an adult psychiatric inpatient facility which explicitly used a harm reduction approach to
17 the management of self-harm.

18 Ethical approval for this study was obtained from the Dulwich Research Ethics
19 Committee (REF 11/LO/0798).

20 **3. Results**

21 Participant characteristics for Phase I and Phase II are outlined in Table 1.

22 **3.1 Phase I: Survey study**

23 Six hundred and thirty practitioners met the criteria for inclusion in Phase I, 544 (86.3%)
24 consented to participate, of which 395 completed questionnaires, giving a response rate of
25 62.7%. After removing cases with missing data, the final sample size was 387 (61.4%).
26 Cronbach's alpha was 0.87. The SHAS includes the following questions which capture

1 beliefs related to harm reduction for self-harm; (1) 'People should be allowed to self-harm in
2 a safe environment' and (2) 'An individual has a right to self-harm'. Responses to each
3 question were collapsed from a 7 point Likert scale (strongly agree to strongly disagree), into
4 three possible views; agree, disagree and undecided. A greater proportion of participants did
5 not believe that people should be allowed to self-harm in a safe environment than those who
6 did (46.1% n=175, vs 36.3% n=138 and 17.6% n=67 undecided), however more felt a
7 person had a right to self-harm than those who did not (45.7% n=173 vs 35.6% n=135 and
8 18.7% n=71 undecided).

9 **3.2 Phase II: Interview study**

10 On average, interviews lasted just under 45 minutes (range 26-72 minutes). Of the eighteen
11 practitioners interviewed for this study, four worked on one of two wards which were using
12 harm reduction practices to support people who self-harm at the time of data collection, nine
13 had some knowledge of harm reduction, but no direct experience of it, and five had never
14 heard of the approach. There were mixed views of harm reduction amongst participants,
15 although all who had adopted the approach felt it was beneficial. Practitioners' views and
16 experiences of harm reduction were captured in three themes:

- 17 1. Managing risk: perceptions of the risks associated with harm reduction for self-harm.
- 18 2. Roles and responsibilities: discussions around the role of the practitioner in
19 supporting people who self-harm, and whether they were responsible for preventing
20 people from harming themselves.
- 21 3. Implementing harm reduction for self-harm: accounts from practitioners who had
22 implemented harm reduction practices for people who self-harm by cutting on their
23 wards.

24 **3.2.1 Managing risk**

25 This theme describes participants' views about the risks associated with a harm reduction
26 approach to supporting people who self-harm. Most participants voiced concerns that harm

1 reduction practices would lead to an increase in the incidence and severity of self-harm and
2 put people at risk of serious harm or suicide:

3 *Hi8: "If it was allowed to spiral on and it was getting out of hand, I would be very*
4 *worried...Once you're done with your arms what's next? That's the scary thing"*

5 *Lo4: "So when they have it [a razor] and they think 'oh self-harm is free' I think they'll*
6 *self-harm more. They'll ask for knives, cans, razors, I think it would increase it"*

7 Whilst many practitioners found this difficult to contemplate, some recognised that people
8 who self-harm may not view their behaviour as high-risk:

9 *Lo2: "I think in my head I'm feeling this is high risk. At the same time when we see*
10 *people that self-harm, often they don't consider it as a high risk event. They consider*
11 *it as just something to relieve themselves. It makes them often feel better at that*
12 *moment in time"*

13 Although some participants recognised the potential benefits of harm reduction for self-harm,
14 they voiced concerns about how it would work in practice:

15 *Lo2: "I've heard about it and I think theoretically it's a good idea. I suppose the issue*
16 *is how tight their control is going to be and is someone going to have to be present at*
17 *the time when the act occurs...It would have to be pretty well controlled even if they*
18 *were about to do it without supervision."*

19 Many of those in favour of harm reduction believed practitioners would need to carefully
20 manage the risks involved by controlling the level of self-harm. However, participants were
21 unsure how to do this, or how people who self-harm, or their self-harming behaviours, would
22 be judged as low or high risk. Practitioners were worried that this would be very difficult to
23 predict:

24 *Hi8: "How do we measure the scale of self-harming that they're allowed to do?*
25 *Where do we stop, where do we draw the line?"*

1 Lo3: *“How do you assess who's going to be safely doing that and who isn't?...I think*
2 *it would require the teams together, and really discuss how they felt about that, and*
3 *whether they feel it's plausible and viable in this environment”*

4 Practitioners questioned whether this would be possible on a busy mental health ward, and
5 there were concerns that over-stretched staffing levels would not allow them to monitor
6 people carefully and support them in the event of a serious incident occurring:

7 Lo7: *“We feel stretched anyway, having 5 staff to 18 patients, who are extremely*
8 *unwell. So I think if you had a lot of people who are self-harming...then, two or three*
9 *cut too deeply, have you got enough staff to be able to deal with that?”*

10 Whilst a number of participants felt it would be possible for someone who self-harmed by
11 cutting to have a harm reduction care plan, there was agreement that ligatures or overdoses
12 were dangerous methods and so people using these methods should not be eligible for this
13 approach:

14 Lo2: *“That's the difficulty, is that there aren't that many safe ways of self-harming,*
15 *particularly if it's with reference to ligatures or taking overdoses.*

16 One practitioner commented that harm reduction may also put other service users at risk.
17 Despite these concerns, many believed that harm reduction, particularly when applied to
18 self-cutting, could help to reduce the risks associated with self-harm:

19 Hi4: *“If it's controlled, and it's a clean blade, and it's managed afterwards, and wound*
20 *care is put in...then you wouldn't get the incidents where people are finding – well,*
21 *anything. It could be from a pen, crunched up, or at Christmas time a bauble off the*
22 *tree. It could be a cup, a plastic cup. Then you think to yourself, “Well, why can't they*
23 *have had...?”*

24 Lo3: *“With some people, that desire is so intense that by taking away their stuff, you*
25 *make it worse, because they find other ways to harm themselves; less safe ways,*
26 *more risk of infection...or worse still, by other means that are even more dangerous.”*

1 Those with experience of implementing harm reduction practices reported that the approach
2 appeared to link with a reduction in the frequency of self-harm and could help some people
3 learn alternatives to self-harm:

4 Hi2: *“We had that plan, and it worked, because over a gradual period of time, I think
5 we observed that the frequency of her self-harming was less. Within two, three
6 weeks, she didn't come for it [self-harm kit] as often”*

7 Hi6: *“We thought ‘let’s just try and see if it works’ and it did, it did work.”*

8 **3.2.2 Roles and responsibilities**

9 This theme captures participants’ views of their role in supporting people who self-harm, and
10 whether it was their responsibility to prevent people from harming themselves. Many
11 practitioners saw harm reduction as being in conflict with their fundamental beliefs about
12 clinical practice, and the role of the hospital in supporting people who self-harm:

13 Lo5: *“I mean to me its professional neglect because we as nurses, it’s one of the
14 things that we always have to adhere to- prevention of harm, harm to self and to
15 others. So if that person is engaged in an activity which can result in harm then it’s
16 basically, you have neglected your own duty, you know.”*

17 Hi1: *“Cos it’s in a hospital, you know, the one reason why a person might be in
18 hospital, for self-harm, is to sort of prevent them from doing any more danger to
19 themselves. So it’s encouraging them to do that, you know, they might as well not be
20 in hospital”*

21 Several felt they had a legal responsibility to prevent people from hurting themselves and
22 were concerned that they would be held legally accountable if someone under a harm
23 reduction care plan suffered a serious injury or took their own life. Participants who were
24 against harm reduction frequently described it as a way of promoting or encouraging self-
25 harm:

1 *Hi5: "I think it's encouraging them even more... you're kind of promoting what they*
2 *are doing. You are kind of encouraging them."*

3 *Lo6: "will there ever be anybody there to say, you know, 'you shouldn't be doing that.*
4 *You can't do that. You can't live your life harming yourself in that way'?"*

5 A number of practitioners rejected the idea of harm reduction because they saw themselves
6 as having a moral duty to stop self-harm:

7 *Hi1: "I don't think that's a reason for people to self-harm, because they're upset, or*
8 *you know...that's not a good enough reason for me."*

9 *Hi5: "I don't think so by harming yourself it helps you to cope, no I don't think so. That*
10 *is not the way of coping...there are other ways to cope"*

11 A further issue for practitioners was the emotional impact on them if they were expected to
12 watch people hurting themselves:

13 *Hi5: "I need to help them, you know... I don't think I would be able to stand, stand it.*
14 *Yes. So I can't even work in such environment, because I am too emotional when it*
15 *comes to that, yeah"*

16 *Lo10: "I don't think I can be brave enough to stand and watch when someone is*
17 *cutting themselves"*

18 Although many of the participants believed it was their responsibility to prevent people from
19 self-harming, at some point during their interview they also conceded that in practice, this
20 was very hard to achieve:

21 *Hi8: "I don't think you can ever really stop [a person from self-harming]....you can't*
22 *ever change a person because a person will only change when they want to,*
23 *willingly."*

24 *Lo10: "To be honest with you, when somebody wants to cut, they want to cut. And*
25 *they will use all the tricks in the book to get away from you".*

1 Using the metaphor of a “*tool belt*” Lo3 questioned whether practitioners actually had the
2 skills to help people to stop self-harming:

3 *Lo3: “do I have the tools in my tool belt to be able to help somebody to change their*
4 *view about self-harm; help them to change the fact that they self-harm? I don't know*
5 *if I do, really. I don't know if any of us do”*

6 A number of participants in favour of a harm reduction approach described a conflict
7 between what they believed would be best for people who self-harm, and their own need to
8 protect their patients. Those who had implemented harm reduction practices gave accounts
9 of how, in time, they had learnt to accept an individual's need to self-harm:

10 *Lo8: “You know, it's odd, but it works for them, and one of the things I always say to*
11 *people, if you can't replace somebody else's coping mechanism, don't mess with it...*
12 *I think it's part of training and part of learning and also part of your acceptance that*
13 *you're only as good as the person who lets you do the interventions... so really you*
14 *just have to accept it, but it takes time to learn, it just takes time”*

15 Several participants believed that allowing people to take responsibility for their self-harm
16 could be empowering and could give service users and practitioners an opportunity to
17 explore the meaning of the behaviour. Some also believed the restrictions placed on people
18 in order to prevent them from self-harming might also be conceptualised as being punitive or
19 an infringement of their rights:

20 *Lo3: “I think we have to acknowledge an individual's need and sense of self....who,*
21 *really, are we to stop them? We've got no right to tell people what they can and can't*
22 *do.”*

23 Those who had implemented harm reduction felt that it had a positive impact on service
24 users' wellbeing. They saw harm reduction as a way for practitioners to show they
25 understood a person's need to self-harm. By reducing a sense of stigma associated with the

1 behaviour, and fostering a feeling of acceptance and belonging, these practitioners believed
2 it had a therapeutic effect and could play an important role in a person's recovery:

3 *Hi2: "it's a secret, and it's a guilt feeling, of course; something that he doesn't want*
4 *anyone to know, because he might be excluded and not accepted. So when he felt*
5 *accepted, that had a very positive reaction within himself that really made him*
6 *decide...that's when he started showing his motivation and all these plans...he was a*
7 *different person totally."*

8 **3.2.3 Implementing harm reduction for self-harm**

9 Four participants, working on two wards, had implemented harm reduction practices with
10 people who self-harm by cutting. Each ward took a different approach and this section
11 summarises what they said about how and why it was implemented. Practitioners on one
12 ward (ward 1) were advised to adopt a harm reduction approach when they consulted a
13 psychologist during a particularly stressful time in which a large number of people were self-
14 harming on the ward. In contrast, on ward 2, members of the nursing team learnt about the
15 approach during a period of planned specialist training and it was later adopted on the ward.
16 Yet both teams decided to adopt a harm reduction approach because they had found it
17 impossible to prevent people from self-harming and were unable to provide them with a
18 more effective way of managing their feelings:

19 *Hi2 (ward 1): "We had to support her, because there was nothing we could do"*

20 *Lo8 (ward 2): "When practitioners stop that particular person, you find that the next*
21 *time she'd do it even worse...it [medication and de-escalation] does not work until*
22 *they are actually done what they wanted to do, then they will get the relief. And you*
23 *find that it was actually better than the PRN. So you're left wondering, what do you*
24 *do?"*

25 In these situations some practitioners were able to accept a harm reduction approach;
26 however others found the adoption of harm reduction very difficult. On both wards, the team

1 went through a lengthy process of consultation involving a number of meetings with the
2 nursing team and a psychologist, where they discussed implementation of the new
3 approach. During these meetings, the rationale for harm reduction was explained and
4 practitioners had an opportunity to voice their concerns. Some found that these preparatory
5 discussions led them to change their views, for example, Hi6, who initially felt it was wrong to
6 allow people to self-harm, explained how this helped her to accept harm reduction.

7 Hi6 (ward 2): *"I suppose it's just being listened to, you know talking to the*
8 *psychologist and knowing how the person understands how you're feeling and just*
9 *giving advice that you, sometimes, there's nothing you can't do about it."*

10 For some practitioners the adoption of an understanding and accepting approach was a key
11 part of harm reduction, which was conveyed to people during conversations about their care
12 plan:

13 Hi2 (ward 2): *"you actually convey to the patient, and give a proper rationale of why*
14 *you're providing them with that, and encourage them to - not judging them, but telling*
15 *them, "Yes, we understand it's something that you can't help. You're doing it, so we*
16 *have accepted it"*

17 Ward 1 did not implement harm reduction until they had agreement from the whole team. On
18 ward 2, however, there was a lack of consensus about implementation and this led to
19 inconsistencies in the team's approach:

20 Hi2 (ward 1): *"If you haven't got a team agreement, that it seems - a new strategy*
21 *doesn't work. It's a peer-ship thing. It just collapses...you need to discuss it with all*
22 *your team, and come as an informed, agreed decision."*

23 Lo8 (ward 2): *"So at times you find that somebody may have been stopped from self-*
24 *harming the previous shift and in the following shift they are allowed to do it. I know it*
25 *creates inconsistencies and divides in team, but at the end of the day we're not all*
26 *the same and we're not able to all able to cope with the same"*

1 Ward 1 provided people with a “kit” that could be used to clean their wounds and, on some
2 occasions, sharps for them to self-harm. On ward 2 the team permitted people to self-harm
3 but did not provide them with any materials. On both wards harm reduction meant providing
4 advice about how to self-harm safely and clean wounds:

5 Hi2 (ward 2): *We'd provide the same care plan, more or less; just revise it, but*
6 *provided him with sharps”*

7 Lo9 (ward 1): *“Then we usually talk about how they can have safety if they really*
8 *want to self-harm and the areas they can do it. So we talked about where to cut and*
9 *where not to cut”*

10 To minimise any impact on others on the ward, people were asked to self-harm in private
11 and people who were considered to be at risk of suicide were not permitted to self-harm. If
12 someone self-harmed seriously then they were advised to take themselves to A&E. One
13 ward found that people initially experienced a negative response from A&E practitioners and
14 were made to wait a long time for treatment. In response to this problem, the ward manager
15 had to broker a discussion with the A&E department about whether the department might
16 consider responding in a more sympathetic way.

17 **4. Discussion**

18 This study aimed to explore perspectives and experiences of harm reduction practices for
19 self-harm amongst practitioners working on mental health wards. To our knowledge this is
20 the first study to explore this important issue within mental health services. We measured
21 attitudes towards harm reduction for self-harm amongst inpatient staff and then explored
22 possible explanations for these views. Perhaps inevitably, the results from our survey
23 indicate that practitioners have mixed views of harm reduction, including those working on
24 the same ward. A greater number of participants felt people had a right to self-harm,
25 however most did not believe that people should be allowed to self-harm in a safe
26 environment. These findings indicate that whilst many staff may agree with harm reduction in

1 principle, most are reluctant to implement the approach in practice. Our findings suggest that
2 the introduction of harm reduction into routine practice with people who self-harm is likely to
3 be difficult in the continued absence of clearer clinical and legal guidance.

4 Interview participants with no experience of harm reduction were concerned that self-
5 harm would increase in severity, and were unsure how to determine whether a person
6 should be encouraged to have a harm reduction care plan. Some disagreed with the
7 approach because it challenged their core beliefs about the morality of self-harm, or the
8 ethics and potential legality of allowing individuals to continue harming themselves. Others
9 took a more positive view and felt it could be beneficial. Four participants were working on
10 two wards which were implementing harm reduction practices with people who self-harm at
11 the time of the study. Teams decided to adopt this approach because they were unable to
12 prevent people from self-harming. Practitioners who had implemented harm reduction
13 practices reported positive outcomes including a reduction in incidence and severity of self-
14 harm, empowerment of service users and improved therapeutic relationships.

15 We found that harm reduction is being implemented on mental health wards with
16 people who self-harm by cutting and that practitioners who had used this approach felt it was
17 beneficial. Harm reduction has been advocated by some people with lived experience of
18 self-harm for a number of years, who find that being prevented from self-harming causes
19 them more distress, can lead to an escalation in their self-harming behaviour, is stigmatising
20 and detrimental to their relationship with professionals (Duperouzel & Fish, 2008; Lindgren et
21 al., 2011; Pembroke, 1994; Shaw, 2012). In line with these accounts, practitioners who had
22 implemented harm reduction felt it had contributed to a reduction in the incidence and
23 severity of self-harm (by cutting) and believed it had a powerful impact on an individual's
24 recovery because it meant that they had felt accepted and understood. These practices are
25 controversial and evidence for the impact of harm reduction as applied to self-harm (or its
26 mechanism of action) is currently very limited. Nevertheless, the approach has been
27 successfully adopted in other settings, for example, harm reduction programmes have been

1 shown to reduce prevalence of HIV infection amongst sex workers and people who inject
2 drugs (Hananberg et al., 1994; Aspinal et al., 2014), drug overdose deaths (Wheeler et al.,
3 2010), and alcohol consumption amongst young people (Midford et al., 2014). Our data add
4 to a limited, but growing, body of evidence that harm reduction may be beneficial for some
5 people who self-harm by cutting. Our data also suggest that this approach may not be
6 appropriate for people who use other methods that could pose a greater risk to life such as
7 ligatures and overdoses. Yet, our study is only able to paint a picture of views of this practice
8 amongst practitioners and more research is required to determine the safety, acceptability
9 and efficacy of harm reduction approaches for self-harm.

10 Our findings highlight a number of practical, ethical and legal challenges associated
11 with harm reduction as applied to self-harm. The assessment and management of risk was a
12 significant concern amongst practitioners, as was decision making around who should be
13 eligible for a care plan incorporating elements of harm reduction. NICE recommends that
14 services adopt this approach for some people who self-harm (NICE, 2011) however there is
15 currently no guidance as to how harm reduction should be implemented or what best
16 practice should look like. Some participants felt that, given the amount of nursing support
17 required, current staffing levels would be insufficient if these practices were to be
18 implemented more widely across the NHS.

19 A number of participants questioned whether they would be held responsible if
20 someone with a harm reduction care plan were to harm themselves seriously or take their
21 own life. The legal implications of harm reduction for self-harm are unclear, but could leave
22 services open to legal challenges such as claims of negligence. When developing a Trust
23 handbook for harm reduction Pengelly et al (2008) sought legal counsel and were advised
24 not to provide the means for self-harm. Yet we found that this practice is still being
25 implemented on mental health wards. Future research needs to explore the complex
26 medico-legal issues relating to the adoption of harm reduction as clinicians who adopt harm
27 reduction are operating within an ill-defined area as far as clinical responsibility is concerned.

1 Organisational support for the adoption of such practice should always be in place.
2 Moreover, a robust legal framework should underpin the practice, yet this is currently
3 lacking. Future research would strongly benefit from the input of ethicists and lawyers to
4 help us fill this conspicuous gap.

5 Our findings suggest that there are likely to be strong and opposing views about
6 harm reduction amongst mental health practitioners, linked to core beliefs about the morality
7 of self-harm and their role as a clinician. For some, this approach challenges the
8 fundamental principles of what they consider to be ethical clinical practice, for example to
9 protect patients from harm (Department of Health, 2015). In an analysis of the ethical issues
10 associated with these practices, Guttridge (2010) concluded that practitioners are justified in
11 allowing self-harm in the short term, as long as the person can engage with therapeutic
12 strategies which aim to help them manage their distress in alternative ways in the future.
13 She argues that in the long-term, this will allow people to recover, and so “*allowing injury*
14 *(with precautions) may not be harm, all things considered*” (Guttridge, 2010, p90). However,
15 terms ‘such as ‘harm’, ‘risk’ and ‘safety’ referred to in best practice guidance are not clearly
16 defined (National Self Harm Minimisation Group, 2009). If harm reduction was to be adopted
17 by mainstream services, regulatory bodies would need to revisit their codes of conduct for
18 practitioners to ensure they incorporate these practices.

19 Views of harm reduction were closely related to participant’s beliefs about self-harm.
20 This approach explicitly requires clinicians’ to accept a person’s need to self-harm. However,
21 negative perceptions of self-harm have been observed amongst mental health staff, and are
22 thought to be related to strong cultural and religious beliefs (James, 2015). It is therefore
23 highly likely that practitioners who hold beliefs that self-harm is ‘wrong’ will struggle to accept
24 harm reduction. Differing perspectives regarding this approach are likely to cause some
25 conflict amongst staff teams and could lead to inconsistencies in care. Participants who had
26 implemented these practices described the benefits of having a process of consultation
27 leading up to the introduction of these practices. Our data shows that lack of a proper

1 preparatory phase for staff can lead to potentially hazardous inconsistencies in care, as well
2 as an increase in the levels of distress amongst staff. These preliminary findings suggest
3 that the introduction of a harm reduction approach to supporting people who harm should be
4 sensitively managed, in a way which acknowledges these issues and allows people to voice
5 their concerns.

6 **5. Limitations**

7 Whilst our study provides novel insights into the perspectives of staff, the study had some
8 important limitations. The majority of staff (n=14) that were interviewed had no experience of
9 harm reduction and so their concerns may not reflect challenges encountered by
10 practitioners in clinical practice. This study was conducted with practitioners working on
11 mental health wards only and so may not be applicable to practitioners working in
12 community mental health settings. The term 'self-harm' is used to describe a wide range of
13 different behaviours, however the majority of discussions in our data were in reference to
14 self-harm by cutting and participants who had experience of implementing harm reduction
15 had only done so with people who self-harmed using this method.

16 **Conclusions**

17 Harm reduction is being implemented on mental health wards with people who self-harm,
18 and these data add to a limited, but growing, body of evidence suggesting that there may be
19 a place for this approach, when implemented carefully and appropriately. However our
20 findings also highlight a number of key practical, ethical and legal challenges. Future
21 research should examine how challenges around risk management and care planning are
22 currently being addressed on wards that are implementing harm reduction approaches.
23 Such research should explore the views of people who self-harm, as well as those who are
24 supporting them, both in hospital facilities and also in the community. Future research should
25 also evaluate the impact of harm reduction on the frequency and severity of self-harm,
26 alongside other clinical and recovery-focussed outcomes, such as quality of life. Research

- 1 findings should be used to develop guidance on the use of harm reduction approaches to
- 2 self-harm and the circumstances under which it should be implemented in practice.

References

- Aspinall, E.J., Nambiar, D., Goldberg, D.J., Hickman, M., Weir, A., Van Velzen, E., Palmateer, N., Doyle, J.S., Hellard, M.E., Hutchinson, S.J., 2014. Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis. *International Journal of Epidemiology*, 43, 235-48
- Birch, S., Cole, S., Hunt, K., Edwards, B., Reaney, E., 2011. Self-harm and the positive risk taking approach. Can being able to think about the possibility of harm reduce the frequency of actual harm? *Journal of Mental Health*, 203, 293-303.
- Bowers L, James K, Quirk A, Simpson, A., SUGAR., Stewart, D., & Hodsall, J., 2015. Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International Journal of Nursing Studies*, 52, 1412–1422.
- Braun, V., Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative research in psychology*, 32, 77-101.
- Cadman, L and Hoy, J., 2009. Cutting the risk: Self harm minimisation in perspective. National Self Harm Minimisation Group.
- Department of Health., 2015. Mental Health Act 1983: Code of Practice. The Stationary office: London.
- Domino G., Westlake I., Gibson L. 1982. Attitudes toward suicide: a factor analytic approach. *Journal of Clinical Psychology*, 38, 257–262.
- Duperouzel, H., Fish, R., 2008. Why couldn't I stop her? Self injury: the views of staff and clients in a medium secure unit. *British Journal of Learning Disabilities*, 361, 59-65.

- Edwards., S.D., Hewitt, J., 2011. Can supervising self-harm be part of ethical nursing practice? *Nurs Ethics*, 18, 79-87.
- European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)., 2010, Harm reduction: evidence, impacts and challenges. Publications Office of the European Union: Luxembourg
- Fish, R., Woodward, S., Duperouzel, H., 2012. 'Change can only be a good thing': staff views on the introduction of a harm minimisation policy in a Forensic Learning Disability service. *British Journal of Learning Disabilities*, 401, 37-45.
- Gutridge, K., 2010. Safer self-injury or assisted self-harm? *Theoretical medicine and bioethics*, 31(1), 79-92.
- Hair, J. F., Tatham, R. L., Anderson, R. E., & Black, W., 2006. *Multivariate data analysis* sixth ed. Upper Saddle River, NJ: Pearson Prentice Hall
- Hanenberg, R.S., Rojanapithayakorn, W., Kunasol, P., Sokal, D.C., 1994 Impact of Thailand's HIV-control programme as indicated by the decline of sexually transmitted diseases. *Lancet*, 344, 243–245
- James, K., 2015. The characteristics of inpatient self-harm and the perceptions of nursing staff. PhD thesis. Kings College, University of London. Available from: <http://ethos.bl.uk/Home.do>
- Joffe, H., 2011. *Thematic analysis*: John Wiley Sons, Chichester, UK.
- Lindgren, B.-M., Öster, I., Åström, S., Graneheim, U. H. 2011., 'They don't understand... you cut yourself in order to live.' Interpretative repertoires jointly constructing interactions between adult women who self-harm and professional caregivers. *International journal of qualitative studies on health and well-being*, 63.
- Mercator Research Group. 2003 Snap Survey Software: Version 7. Mercator research group: <http://www.snapsurveys.com>.

- Midford, R., Mitchell, J., Lester, L., Cahill, H., Foxcroft, D., Ramsden, R., Venning, L., Pose, M., 2014. Preventing alcohol harm: early results from a cluster randomised, controlled trial in Victoria, Australia of comprehensive harm reduction school drug education. *International Journal of Drug Policy*, 25, 142-50
- National Institute for Health and Clinical Excellence (NICE). 2011. Self-harm: longer-term management Clinical guideline CG133. <http://www.nice.org.uk/guidance/CG133>.
- Pallikkathayil L., Morgan S. 1988. Emergency department nurses' encounters with suicide attempters: a qualitative investigation. *Scholarly Inquiry for Nursing Practice* 2, 237–253.
- Parsons, J.T., Schrimshaw, E.W., Wolitski, R. J., Halkitis, P.N., Purcell, D.W., Hoff ,C., Gomez, C.A., for the SUMIT Study Group.,2005. Sexual harm reduction practices of HIV-seropositive gay and bisexual men: serosorting, strategic positioning, and withdrawal before ejaculation. *AIDS*, 19, S13–S25.
- Patterson, P. 2003. Self harm: attitudes and experiences of care. Unpublished PhD Thesis. University of Liverpool.
- Patterson, P., Whittington, R., & Bogg, J. 2007. Measuring nurse attitudes towards deliberate self-harm: the Self-Harm Antipathy Scale (SHAS). *Journal of psychiatric and mental health nursing*, 14(5), 438-445.
- Patton, M. Q.,. 1990. *Qualitative evaluation and research methods*: SAGE Publications, inc.
- Pembroke, L.,. 1994. *Self Harm: Perspectives from Personal Experience*. London: Chipmunkpublishing .
- Pembroke, L.,. 2009. *Cutting the risk: Self-harm, self care and risk reduction*. The National Self-harm Network: London.
- Pengelly, N., Ford, B., Blenkiron, P., Reilly, S., 2008. Harm minimisation after repeated self-harm: development of a trust handbook. *Psychiatric Bulletin*, 32, 60-63.

- Platt, S., Salter, D. 1987. A comparative investigation of health workers' attitudes toward suicide. *Social Psychiatry* 22, 202–208
- StataCorp. 2009. *Stata Statistical Software: Release 11*. College Station, TX: StataCorp LP.
- Saunders K.E.A., Hawton K., Fortune S., et al. 2012. Attitudes and knowledge of clinical staff regarding people who self-harm: a systematic review. *Journal of Affective Disorders* 139, 205–216.
- Shaw, C., 2012. Harm-minimisation for self-harm. *Mental health Today*, September/October, 19-21.
- Tashakkori, A., & Teddlie, C. 2003. The past and future of mixed methods research: From data triangulation to mixed model designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 671-701). London: SAGE Publications.
- Watts D., Morgan H.G. 1994. Malignant alienation. *British Journal of Psychiatry* 164, 11–15.
- Wheeler, E, Davidson, J.P., Jones, S.T., Irwin, K.S., 2010. Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010. *Morbidity and Mortality Weekly Report*, 61, 101–105