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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. Introduction

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

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

2. Methods

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

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

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

subscale. The SHAS has shown high internal consistency (Cronbach's α = 0.89; Patterson et al., 2007).

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

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

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

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

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

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

3. Results

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

3.1   Phase I: Survey study

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

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

3.2   Phase II: Interview study

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

1. Managing risk: perceptions of the risks associated with harm reduction for self-harm.

2. Roles and responsibilities: discussions around the role of the practitioner in supporting people who self-harm, and whether they were responsible for preventing people from harming themselves.

3. Implementing harm reduction for self-harm: accounts from practitioners who had implemented harm reduction practices for people who self-harm by cutting on their wards.

3.2.1   Managing risk

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

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

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

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

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

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

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

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

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

> *Hi8: "How do we measure the scale of self-harming that they're allowed to do? 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:

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

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

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

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

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

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

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

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

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

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

Lo10: *"To be honest with you, when somebody wants to cut, they want to cut. And 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

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

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

3.2.3 Implementing harm reduction for self-harm

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Discussion

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

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

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

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

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

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

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

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

5. Limitations

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

Conclusions

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

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