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Harm minimisation after repeated self-harm: development of a trust handbook

Repeated self-harm without suicidal intent occurs in approximately 2% of adults (Meltzer *et al*, 2002). Service users report that professionals can respond to self-harm with unhelpful attitudes and ineffective care. Although evidence for effective treatments is poor (Hawton *et al*, 1999), this therapeutic pessimism is not found in the self-help approaches promoted by voluntary organisations such as Mind: 'If you feel the need to self-harm, focus on staying within safe limits' (Harrison & Sharman, 2005). User websites frequently offer advice on harm minimisation: 'Support the person in beginning to take steps to keep herself safe and to reduce her self-injury – if she wishes to. Examples of very valuable steps might be: taking fewer risks (e.g. washing implements used to cut, avoiding drinking if she thinks she is likely to self-injure)' (Bristol Crisis Service for Women, 1997).

Recent studies suggest manual-assisted cognitive–behavioural therapy can be a cost-effective method of reducing self-harming behaviour (Fagin, 2006). Our conversations with local mental health workers revealed that many did not feel skilled, comfortable or empowered to discuss harm minimisation strategies with service users. Staff were concerned that this approach could be construed as encouraging self-harm, leaving them open to complaints.

For these reasons, we decided to develop a handbook for use within Selby and York Primary Care Trust to promote collaborative working between people who repeatedly self-harm and front-line health professionals. This paper specifically focuses on the issues that arose surrounding harm minimisation.

Method

The *Alternatives to Self-harm Service User Handbook* (Pengelly & Ford, 2005; for further details and guidelines for its use contact N.P.) was developed to assist in the engagement, formulation and early stages of intervention with working-age adults. The content was based on the following sources:

- the scientific literature and Cochrane database
- professional and user-led websites
- interviews with 6 service users who had long histories of self-harm
- correspondence with 6 nurse consultants and 4 managers in other areas of Britain (these were personal contacts of the authors and/or known to be involved in developments within self-harm teams). Two units, the Manchester Deliberate Self-Harm Team and the Maudsley Crisis Recovery Unit, supplied documentation on their approach to self-harm
- multidisciplinary discussion at meetings of the York and Selby Primary Care Trust's Clinical Governance Committee.

The self-harm handbook uses a cognitive–behavioural model (Beck, 1976) to address causes and maintenance cycles for repeated self-harm. Within each section (Box 1) users are encouraged to write personalised responses.

A draft was sent for local consultation to 3 user groups (MIND, Mainstay and Survive) and 20 mental health professionals (including 9 psychiatrists and 4 professionals from psychological therapies). We obtained a legal opinion from the York and Selby Primary Care Trust's solicitor regarding the specific inclusion of advice on harm minimisation within a National Health Service (NHS) publication. This solicitor reviewed information currently available to the public on websites including NHS Direct and the Mental Health Foundation, and consulted with another legal colleague. We then requested comments from the Royal College of Psychiatry, and Nursing and Midwifery Council.

Results

Thirteen professionals and six service users provided written feedback, and the handbook was modified accordingly. The range of views on harm minimisation is summarised below.

Service users' views

Box 2 contains quotations from community and in-patient service users regarding their experiences of care

special articles

Box 1. Areas covered in the *Alternatives to Self-Harm* handbook (Pengelly & Ford, 2005)

Myths about self-harm

- Providing factual information. Promoting discussion of beliefs and attitudes held by self and others

Looking after yourself

- Identifying support networks. Establishing crisis plans before exploratory work

Understanding *your* self-harm

- Identifying links between life events, current circumstances and self-harm
- Clarifying the thoughts, feelings and behaviours that maintain vulnerability to self-harm (vicious circle or flower)
- Understanding triggers to self-harm and its consequences
- Summarising understanding through stories, diagrams or pictures, e.g. drawing a personal map

Finding alternatives to self-harm

- Information about options for therapy and self-help groups
- Working on painful life events: structured problem-solving
- Techniques to change thoughts, feelings and behaviours: diaries, identify and test out more helpful beliefs and actions
- Comforts and distractions. Using support. Setting goals
- Harm minimisation (Box 3)

What next?

- Promoting choice about what and when to change
- Developing an action plan. Recording achievements
- Some resources, websites and further reading

Box 2. Care following acts of self-harm: service users' comments

- I need time to talk to someone with a good understanding after I self-harm
- I want self-responsibility, with medication not being forced
- I value being involved in decisions about my treatment
- I want trust and choice (regarding removal of potentially harmful objects)
- Privacy and dignity are important to me
- High observation levels increase my desire to self-harm and made me angry
- Removing my personal belongings makes me feel punished and resentful and more determined to self-harm
- Staff with a positive attitude – professional and supportive – are the most helpful

following self-harm. Most believed that guided self-help advice was well overdue: 'If this handbook had been available a few years ago, I may not have had the scars I have now'. Users valued an accessible resource they could work through with professionals that encouraged coping strategies and new patterns of thinking. Users supported a harm minimisation approach as a 'shift in professional attitudes' away from expecting users to 'stop self-harming altogether', towards more realistic goals such as reducing the number of episodes of self-harm and/or severity of injuries.

A psychiatrist's view

'The handbook is a well-reasoned approach to a widespread problem. We should feel comfortable in not judging someone's behaviour as good or bad. Individuals often do not tell their friends or family and borderline personality disorder is common (Ferreira de Castro *et al*, 1998). If our only approach is to say "don't do it at all" then many will find that unhelpful and may not continue to access services. It would be impractical (and probably unlawful) to detain everyone who self-harms under the Mental Health Act 1983. Access to specialist psychotherapy often depends upon individuals first achieving stability and coping strategies. A structured approach can assist this (Blenkiron & Milnes, 2003). However, there is a difference between telling individuals that some people find alternatives helpful and recommending that they use alternatives. The decision to self-harm must always be the patient's. Any integrated approach also needs to address the underlying causes.'

A psychodynamic psychotherapist's view

'The handbook takes a "common sense" approach to self-harm and reads as a supportive and helpful document. Much of it I would endorse but I would omit the sections on damage limitation and alternative forms of self-harm. There is a legal argument that suggesting alternative forms of self-harm may be cited as encouraging someone to injure themselves. There are also psychological and/or psychodynamic reasons why I think these sections are unnecessary and might be risky as they could be misinterpreted or used to excess. Snapping rubber bands on wrists, pinching or using toothbrushes on skin could lead to bruising or bleeding. Hitting with pillows may cause injuries. Taking a bath a little hotter or colder than usual could result in burns or hypothermia. Squeezing ice is ill-advised and biting into something strongly flavoured could lead to some highly dangerous and creative choices. Advice to use clean, sharp instruments when cutting will, I suspect, have no impact on those who deliberately choose dirty pieces of glass or rusty blades. Similarly, some people choose to cut where there is a risk of damaging a large artery, vein or other important structure. The personal meaning of self-harm and the motivation behind this behaviour need to be explored with the patient. Unconscious determinants of self-injuring behaviour might not respond in predictable ways to simple advice on alternatives to self-harm and damage limitation'.

A general medical view

There are precedents in medicine that support harm minimisation when advice to avoid risky behaviours is rejected. Doctors can legally prescribe the contraceptive pill to competent girls under 16 years of age without parental consent, when unprotected intercourse is likely (Gillick *v.* West Norfolk and Wisbech Area Health Authority, 1985). In sport, the clinician's duty to users of performance-enhancing drugs includes 'discouraging reckless dosing, ensuring access to needle exchange and

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special articles

appropriate monitoring' (British Medical Association, 2002). Maintenance treatment with methadone, buprenorphine or injectable heroin is advocated for opiate addiction (National Treatment Agency for Substance Misuse, 2003).

A solicitor's view

'I am bound to say that the safest legal position is to tell people not to self-harm and/or detain them so as to prevent it. However, I suspect practitioners will think these options are often unrealistic. The handbook does represent a broadly lawful approach. Implementing it will put the Trust at the cutting edge of the legal and medical fields. Reasonable arguments exist which could defend potential legal challenges, as follows:

- Suicide Act 1961: it is a criminal offence to aid, abet, counsel or procure someone else's suicide. A practitioner may believe they are assisting someone to harm themselves more safely but the Crown Prosecution Service may see matters differently if professionals are reckless as to whether the patient dies.
- The Human Rights Act 1998: Article 2 of the European Convention on Human Rights (the right to life) and Article 3 (provision against torture, cruel, inhumane or degrading treatment) will not be breached where it can be shown the handbook represents medical treatment given in the patient's best interests.
- Assault and battery: the handbook should emphasise that the professional does not want the patient to harm themselves but understands their choice to do so. Harm minimisation probably cannot be practised with patients incapable of giving informed consent.
- Negligence: a civil claim for damages could be dealt with if supported by a responsible body of medical opinion, even if others take a contrary view (Bolam *v.* Friern Hospital Management Committee, 1957).

I cannot guarantee there will be no complaints, but steps can be taken to address any claims and provide a persuasive defence:

- consult widely regarding harm reduction, for example, consult professional organisations
- do not provide the means for self-harm to patients
- combine advice on coping with support to address underlying problems
- offer the handbook to specific patients, not the general population
- draw up a multidisciplinary protocol for staff use, including patient selection, risk assessment, record keeping, clinical review and audit.'

Nursing and Midwifery Council

'This is a very difficult and complex issue with no relevant conduct cases or precedents. The individual should ensure familiarity with the Code of Professional Conduct, and respond in the most appropriate way in light of the circumstances. It is essential that the practitioner does not act in isolation but consults with the rest of the clinical team. Correct in-depth records should be kept.'

Royal College of Psychiatrists

'This handbook is commended as a brave attempt to tackle a difficult area. The General and Community Faculty is unable to provide an established view concerning harm minimisation in self-harm. Unlike addiction, there is no evidence base so the use of alternative strategies must rest on common sense assumptions, be subjected to clinical scrutiny, and audited.

There is no definitive advice that can be derived from existing College documents. Any handbook should be used alongside a full psychosocial assessment, a comprehensive care package and the care programme approach. This is consistent with the legal view and the College Council Report CR122 on the Assessment Following Self-harm in Adults (Royal College of Psychiatrists, 2004). In formulating the College's response to the draft National Institute for Health and Clinical Excellence (NICE) guidelines on self-harm, we have asked NICE to consider whether explicit guidance on 'safe' self-harming is appropriate.'

Discussion

On balance, we decided that including harm minimisation strategies in the handbook was a professionally defensible position. Some suggestions, for example taking baths hotter or colder than normal, were removed. Most advice on damage limitation was retained (Box 3). This position was supported by publication of NICE guidelines (2004) on self-harm (Box 4). In accordance with the legal view, we produced multidisciplinary guidelines in an accompanying booklet that specifies how staff should use the handbook. These emphasise that:

- the handbook is not to be given out as a self-help manual: it is designed to be worked through with the professional(s) involved
- it is one part of a continuing and comprehensive care plan
- the service user should give informed consent, be aware of the purpose of the handbook approach, be aware of alternative treatment options, and not be experiencing symptoms of acute mental illness
- staff should complete a monitoring form in order to audit its use.

The handbook was approved for use within Selby and York Primary Care Trust by the Mental Health Clinical Governance Committee for Selby and York Primary Care Trust. It is now available in paper and electronic versions within working age adult mental health teams. Further training in its use, including service users, is in progress. Anyone who is considering using the handbook or any of its guidance should first seek advice and approval from their own trust before doing so.

In conclusion, the opinions of those reading this article are likely to reflect a range of views. Some may believe that endorsing any form of self-harm, even if it is safer, involves collusion with that behaviour. Others will view the approach as a practical response to the requests of service users. The handbook helps support

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Box 3. Harm minimisation advice in the handbook

Alternatives

- Decide not to self-harm for 10 min, monitor how it feels and what helps
- Kick and punch something soft such as a pillow
- Put rubber bands over your wrists and 'snap' them
- Pinch yourself instead of cutting
- Try physical exercise/exertion, such as walking, gardening, tidying
- Slam doors, scream or sing loudly to music
- Draw on your body with red markers or paint (as an alternative to seeing blood)
- Squeeze ice for a short time
- Carry safe things with you to squeeze such as a tennis ball, stones
- Use your creativity – try anything that distracts you from self-harm or increases good feelings, such as yoga, hobbies, talking to friends, phone support lines

Damage limitation

- Do not take tablets. There are no safe overdoses – even 'small' overdoses can kill
- If you feel you must cut, only use clean, sharp instruments to reduce the risk of infection and complications. Keep tetanus protection up-to-date
- Avoid cutting your body where major veins and arteries are close to the surface
- Never share anything you use to self-injure – sharing risks hepatitis and HIV
- Always have access to a well-equipped first aid kit and know how to use it
- Know when to seek medical help, for example for severe injuries, infection and shock
- Avoid alcohol and drug use as you may inflict worse wounds than intended
- Gradually reduce the severity of your injuries. Leave more time between injuries

Box 4. NICE guidance on repeated self-harm (National Institute for Health and Clinical Excellence, 2004)

Self-poisoning

- Harm minimisation strategies should not be offered for people who have self-harmed by poisoning: there are no safe limits
- Where service users are likely to repeat self-poisoning, clinical staff (including pharmacists) may consider discussing the risks with service users and carers where appropriate

Self-injury

- Management of self-cutting: for superficial uncomplicated injuries of 5 cm or less, the use of tissue adhesive should be offered as a first-line treatment. If the service user expresses a preference for the use of skin closure strips, this should be offered as an effective alternative
- Advice regarding self-management of superficial injuries, harm minimisation techniques and alternative coping strategies should be considered for people who repeatedly self-injure. Suitable reading material is available from many voluntary organisations
- Discussion with a mental health worker may assist in the decision about which service users should be offered advice and instructions for the self-management of superficial injuries, including the provision of tissue adhesive
- Where service users have significant scarring from previous self-injury, consider providing information about dealing with scar tissue

professionals working with these dilemmas who cannot retreat behind a decision that recurrent self-harm is not mental illness.

Declaration of interest

None.

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