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Research paper

# 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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ABSTRACT

*Background:* Harm reduction has had positive outcomes for people using sexual health and substance misuse services. Clinical guidance recommends these approaches may be appropriately adopted by mental health practitioners when managing some people who self-harm. There has, however, been very little research in this area.

*Methods:* We explored practitioners' views of harm reduction as a strategy for supporting people who self-harm. The Self Harm Antipathy Scale (SHAS) was administered to a random sample of 395 mental health practitioners working on 31 wards in England, semi-structured interviews were then conducted with 18 survey respondents.

*Results:* Practitioners who had implemented the approach reported positive outcomes including a reduction in incidence and severity of self-harm and a perceived increase in empowerment of service users. Practitioners with no experience of using harm reduction were concerned that self-harm would increase in severity, and were unsure how to assess and manage risk in people under a harm reduction care plan. Some fundamentally disagreed with the principle of harm reduction for self-harm because it challenged their core beliefs about the morality of self-harm, or the ethical and potential legal ramifications of allowing individuals to harm themselves.

*Limitations:* This study was conducted solely with practitioners working on inpatient units. The majority of staff interviewed had no experience of harm reduction and so their concerns may not reflect challenges encountered by practitioners in clinical practice.

*Conclusions:* Harm reduction is being used to support people who self-harm within inpatient psychiatry and some practitioners report potential benefits of this approach. However, this raises particularly complex practical, ethical and legal issues and further research is needed to assess the safety, acceptability and efficacy of the approach.

## 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, 2005; 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

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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 and Salter, 1987; Pallikkathayil and Morgan, 1988; Watts and 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 and 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 and Teddlie, 2003). It is frequently used in applied health research, which most often operates within realist, or pragmatic paradigms (Tashakkori and Teddlie, 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 and Clarke, 2006). Thematic analysis also offered the optimal analytic approach to our data as it produces results which are in principle, accessible to practitioners,