'Change can only be a good thing:' staff views on the introduction of a harm minimisation policy in a Forensic Learning Disability service

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Accessible Summary

- Staff were asked for their views on using harm minimisation with people with a learning disability who self-harm.

- Staff felt that this policy could benefit some, but not all of the clients.

- They felt that staff and clients should be able to choose whether to be involved in using harm minimisation.

- Staff were mostly in favour of harm minimisation but were worried about the level of their responsibility.

Summary

Background: Recent local research about personal experiences of self-injury, and discussions about the use of harm minimisation with service users who self-injure were the motivation behind this study to glean staff opinions and advice about the introduction of a harm minimisation policy.

Method: An online survey was designed and all staff were invited by email to take part. The survey used multiple-choice questions as well as providing room for open comments.

Results: Eighty five percent of the seventy-one staff that responded were in favour of the introduction of a harm minimisation policy. Common requests for inclusion were: clear, individualised guidelines which include roles and responsibilities, staff and client support systems, client education and staff training, and advice about duty of care issues.

Conclusions: This exercise has been invaluable in the production of a harm minimisation policy. Services should consider implementing this type of policy on an individual basis.

Introduction

Harm minimisation is a concept originally applied to drug users, where services would provide support such as needle exchange and access to less harmful

substances. This approach recognises that there will always be people who want to take risks, and so gives them information and help to promote their safety; with the hope of reducing any further harmful consequences.

Recently there have been discussions about using the harm minimisation model with people who self-injure whilst living in residential services. The definition of harm minimisation in this context is allowing the client to injure themselves safely and giving advice on: how to care for wounds, how to cut more 'safely'; and how to use clean instruments. Growing numbers of professionals - along with service users - are now advocating this approach: accepting that service users need to self-harm and therefore not working to prevent their self-harm but rather, to enable service users to limit the physical damage of self-harm (Harm-Ed, 2008).

Traditional treatment techniques in residential services have involved confiscating items which could be used to self-injure, physically preventing people from self-injuring (Harker-Longton & Fish, 2002, Waterhouse & Marriott, 2010) or even punishing people for self-injuring (McAllister & Davis 2001), however research suggests that taking away someone's ability to self-injure removes their method of coping, increasing traumatic feelings - and potentially increasing the risk that they will self-injure in more dangerous ways, or attempt suicide (Holley & Horton, 2007). The National Institute for Health and Clinical Excellence (NICE; 2004) acknowledge the danger of attempting to prevent self-injury, which may lead to the behaviour increasing or being driven 'underground'. 'Differing motivations forself-harm and different modes of injury require that therapeutic responses vary. Yet, according to the literature and personal observation, nursing responses tend to be uniform and inflexible. Not only are such responses inadequate for effectively dealing with individuals who self-harm, they also have unintended, hidden deleterious consequences for nurses and nursing.' (McAllister & Davis 2001 : 391).

Service user activists such as Louise Pembroke have long promoted the concept of harm-minimisation for people who self-injure. This approach is defined by Pembroke as accepting and respecting service users' need to self-injure, service providers not automatically removing implements from inpatients, and imparting

basic skills in wound care and physiology in order to limit the physical damage of self-harm 'Harm minimisation is about accepting the need to self-harm as a valid method of survival until survival is possible by other means.' (Pembroke, 2007: 166). Health workers have been increasingly recognising that interventions focusing purely on cessation of self-harm can be ineffectual and even lead to increasing the very risks sought to be reduced. 'Therapeutic approaches that are based on open-minded, non-judgmental listening and on harm minimisation rather than abstinence may be more effective than current treatment approaches that forbid any form of deliberate self-harm' (Mangnall & Yurkovich 2008: 175). The approach in this context therefore involves making self-injury as safe as possible, whilst alternative coping strategies are considered.

Although there is little published research about the application of harm minimisation with people who self-injure, there has been significant progress towards policy development. The Royal College of Nursing debated the issue of 'safer self-harm' at their congress in 2006. Chris Holley, who introduced the discussion, led a pilot harm minimisation scheme at Staffordshire NHS Trust. Funded by the Department of Health, the scheme is looking at how self-harm can be safely facilitated (see Sutton, 2008). Pengelly et al (2008) describe the development of a harm minimisation handbook in a forensic psychiatric service. They gathered views from service users, a psychiatrist, a psychotherapist, a GP and a solicitor and concluded that harm minimisation should be just one part of a continuing and comprehensive care plan, and the service user should give informed consent as well as being involved in the decision making process.

In a survey undertaken in 1999 (see Sutton, 2008), helpful aspects of therapy from the service users' perspectives were 'being trusted to take care of one's own wounds,' 'speaking to a non judgemental person,' and 'no pressures to stop self-injury until other coping strategies are firmly in place'. Unhelpful aspects were a 'ban on self-injury,' 'not feeling heard,' and 'being left alone to cope with the aftermath'.

The research described in this paper was carried out at Hospital C NHS Trust, which is a secure unit for people with learning difficulties. At Hospital C there are a significant number of clients who have used habitual self-injury over long periods of time. Currently they are prevented from doing this, which causes problems for both staff and clients: clients can feel frustrated and preoccupied with finding a way to self-injure and this can impede their treatment (Harker-Longton & Fish, 2002; Holley & Horton, 2007), staff may experience distress (Fish, 2000) and resort to overzealous reactions which can damage the therapeutic relationship (Duperouzel & Fish, 2008). There are moves towards a harm minimisation approach to be used with a small number of appropriate clients.

Literature looking at self-injurious behaviour from the point of view of people with learning disabilities is limited. Harker-Longton & Fish (2002) reported on a case study of a woman with learning disabilities who was living in a medium secure unit. James & Warner (2005) and Duperouzel & Fish (2007) describe staff and clients' experiences of self-injury in a forensic service. Common to all of these studies was the opinion that prevention of self-injury was unhelpful to both staff and clients, and did not stop the client from wanting to self-injure.

Although there is no literature regarding the use of harm minimisation approaches with this group, it has been argued many common issues exist for women who self-harm, regardless of the presence of learning difficulties (James and Warner, 2005). James and Warner conclude that the label of 'learning disability' is too easily used to differentiate them from the general population, and state that failing to recognise this and designing restrictive services that treat women as passive recipients is complicit in maintaining self-injurious behaviour; similar conclusions were made in the case study by Harker-Longton & Fish (2002).

Legal Implications of harm minimisation

Legally the concept of harm minimisation with people who self-injure raises several issues. The Suicide Act (1961) states that it is an offence to aid, abet, counsel or procure someone else's suicide. This means that if a client died as a result of a harm

minimisation policy, the actions of the staff could be construed as criminal, unless it could be proved that the intervention was given in the patient's best interests (Harm-Ed, 2008; Hewitt, 2010).

It is unlikely that the legal position for harm minimisation with self-injury will become any clearer until a case is brought before the courts.

NICE guidelines (2004) now recommend the discussion of harm minimisation with clients who repeatedly self-injury. While this stops short of backing the implementation of harm minimisation, it has succeeded in increasing awareness of the approach. Given the legal issues associated with harm minimisation it was felt within Hospital C that policy guidance should be developed before staff could consider using the approach with any clients. Much of the published literature regarding self-injury and harm minimisation makes reference to the potential for distress to staff members. Therefore as part of the policy development, the current project was undertaken to assess staff views.

Method

A short questionnaire was designed in consultation with Clinical Governance staff at the trust. The question asked for job title and opinions about harm minimisation and policy. The questionnaire was online, available through the trust intranet. A global email was sent to all staff asking for their voluntary responses. The following staff (Table 1) responded:

The majority of staff (n=52) were therefore employed in ward-based positions, meaning that they were most likely to encounter self-injury on a regular basis and more likely to be affected by the implementation of a harm minimisation policy.

No further demographic data was collected from participants as it was felt to be more important to maintain anonymity within a small service.

Results

The results of the questionnaire are below. Open questions were subject to thematic analysis, using QSR NVivo software for Windows. The percentages will not add up to 100 as some comments covered a number of areas.

If the Trust was to introduce a harm minimisation policy, what do you think it should include?

This question was followed by a number of statements which respondents could choose any number. Table 2 shows the percentage ofresponses for each choice. In response to this question, eighty five percent of respondents indicated that 'Well defined guidelines for staff about how to respond to injuries' should be included in the policy, with 'Showing other coping strategies, safer alternatives to self-injury' being chosen by eighty three percent of respondents. The least chosen comment was 'Access to safer self-injury equipment' which was selected by fifty nine percent of respondents (see table 2).

What would you like to be included in a harm minimisation policy?

This was an open question where respondents could give a short comment. Table 3 shows the frequency and themes of responses together with an example of a relevant quote. Half of all respondents would like the harm minimisation policy to have clear guidelines, for areas such as emergency responses, staff ratios and infection control. Staff support was mentioned by 27% of respondents who were worried about responsibilities and duty of care. The need for individual staff to be able to choose whether to be involved in harm minimisation was suggested a number of times. Client education, staff training and client support were other major themes (see table 3).

What support will staff need?

This question was another open question for people to give their own comments (see table 4). Staff training was seen to be very important, with 50% of people mentioning this – including training about alternatives to self-injury and therapeutic approaches. Staff support was also a major theme, with support from management as well as clinical supervision and support networks being popular answers. Clear information was also seen as support in 14% of answers.

Should harm minimisation be applied to all clients?

Seventy eight percent of people thought that harm minimisation should be applied on an individual basis (see table 5), whereas 22% of people agreed that all clients should have access to this approach.

What difficulties would staff face?

When asked what difficulties they thought staff using a harm minimisation approach would face, 62% of comments mentioned personal responses, such as guilt and the

natural reaction to stop self-injury. Staff also made statements about culpability and duty of care (see table 6).

What therapy should clients have access to?

Formal therapies were most often suggested in this open question. CBT (Cognitive Behavioural Therapy), and CAT (Cognitive Analytic Therapy) were very popular, as were support groups and assertiveness training. Staff also mentioned informal support such as talking therapies and outside activities (see table 7).

What should national guidance include for clients?

When asked this open question, staff thought education and guidance were most important, with 75% of responses including something about this theme. Staff commented that clients should be educated about responsibility, their rights and role in harm minimisation, and alternative coping strategies. Organisational issues were mentioned in 25% of comments, including suggestions to employ trained sympathetic staff and avoiding blame culture (see table 8).

A harm minimisation policy:

Table 9 above shows the frequency of responses for each statement, ranging from strongly agree to strongly disagree. Eighty four percent of respondents agreed that a harm minimisation policy encourages clients to take more control over their lives, and eighty three percent agreed that it would help clients to take responsibility for their self-injury. Also notable is seventy five percent of respondents agreed that a harm minimisation policy would help clients develop more healthy ways of coping.

Sixty seven percent of respondents felt that a harm minimisation policy was not likely to increase the risk of suicide in clients. Interestingly, despite these apparently positive responses 52% of respondents had concerns regarding the policy being against nurses' duty of care.

9. Are you in favour of a harm minimisation policy?

Eighty five percent of respondents were in favour of a harm minimisation policy, whereas 15% were not (see table 10).

Discussion

Eighty five percent of staff who responded to this questionnaire said they were in favour of a harm minimisation policy being introduced at their service. This is a large majority, indicating widespread support through the trust for this policy, and endorses previous research which suggested a growing trend for the support of

harm minimisation among professionals (Harm-Ed, 2008). Most respondents (78%) however, did not want a harm minimisation policy to be applicable to all clients, preferring clients to be selected for eligibility. This is in line with other research which suggests not all clients who self-injure can use this approach (Pembroke, 2006a,b, Pengelly et al, 2008).When asked about their concerns about implementing harm minimisation, respondents were most apprehensive about their personal reactions to supervising self-harm and dealing with the aftermath. Many (62%) had concerns regarding their natural reaction to prevent self-harm and the change in their beliefs which would be required for the policy to be effective. They also expressed concerns about being asked to witness self-harm and the distress that this would cause them personally. Previous research supports this, with Fish (2000), and Duperouzel and Fish (2008) describing the difficulties and distress experienced by staff. One of the recommended solutions to this, as described by the staff, would be to only use staff who had volunteered to work within this regime. However, this also reflects common misunderstandings among professionals about the nature of harm minimisation. Details of the policy were left intentionally vague prior to participants completing the survey, to avoid a response bias. This seems to have led to some participants misinterpreting the details of harm minimisation. Pembroke (2006) expressed concern that asking staff to witness self-harm may be viewed as part of the harm minimisation approach, calling it 'unreasonable and unrealistic'.

Respondents also expressed concerns regarding the organisational issues a harm minimisation policy would raise. They were concerned about their duty of care to clients and taking responsibility for interpreting the policy. This could be dealt with by firm guidelines regarding how staff dealt with injuries, and when the policy should and should not be implemented.

Fifty percent of respondents stated that they felt the policy should include guidelines on support for staff, such as supervision from qualified Psychological Treatment Service (PTS) staff or support and advice networks, an option which may mitigate some of the potential distress for staff. Extensive training, support from management, and being sure that they would not be blamed for a client's injuries

was also important to staff. This is consistent with a study looking at staff responses to self-injury, where staff asked for more training and support in these areas (Fish, 2000).   Staff training should address the issue of harm reduction, moving away from prevention and control. A shared understanding of self harm would also be helpful; service user involvement in training can be a powerful way of facilitating this.

With regard to client support, 48% of staff questioned felt that clients should have access to formal therapies such as CBT (Cognitive Behavioural Therapy) or CAT (Cognitive Analytic Therapy). A significant number (42%) felt that clients should be able to engage in informal therapies, such as building relationships with staff and outside activities. This is in line with the basic principles of harm minimisation outlined in Pembroke (2006) which states that harm minimisation is one part of an approach which should also include access to alternative coping strategies and psychosocial work.

Hoping for cessation of harm in service users who self-injure repetitively might be an unrealistic aim because self-injuring is often a way of coping, or surviving distress; it can even be a way to avert suicide. In such cases, it can be better simply to limit the damage caused by self-injury while it continues (Pembroke, 2006a). Many staff agreed that a harm minimisation policy should include guidance on teaching clients about wound care (79%), education for staff and clients on the most serious wounds (73%), and involving clients in their risk management and wound care (72%), strategies which have the potential to limit damage caused by self-injury.

Staff expressed concerns about their culpability and felt that support from management would be important. Taking into account legal issues (see Pengelly et al, 2008 and Hewitt, 2010), this suggests that any harm minimisation policy would need to be robust and have the support of senior management before support staff would feel comfortable acting upon it.

Conclusion

'Nurses who encounter individuals who self-injure on a regular basis face a dilemma. Do they go for prohibition? Or do they allow this to occur in a way that minimises harm?' (Templeton, 2006:1). Debate about the practice of giving clean blades to service users has seen much opposition and many health professionals are opposed to this citing 'duty of care' and their code of practice of 'do no harm', but this may be less harmful than service users using dirty implements.

Duty of care is defined as the legal obligation to be careful in conduct or care so that people are not injured by our actions or our failure to act. It is clear that service users will self-injure even in a restricted environment where vigorous attempts are made to prevent self-injury (Duperouzel & Fish, 2010), so it makes sense to support service users to be safe. NICE (2004) suggest harm minimisation techniques be offered to people who self-injure as a good practice point, although this guidance does not define what constitutes harm minimisation giving little direction for services and carers who without specific guidance will at best do nothing.

With a lack of research in this area, debate is still underway as to how this can be achieved, and what we mean by harm minimisation for people who self-injure, but in the meantime advice and support about safe cutting, infection control, when to seek medical support coupled with support based on mutual understanding and respect cannot perceivably do any harm.

This study has responded to the need for more research into the effectiveness of new, non aversive interventions (Prangnell, 2010). Staff in this study gave extremely in-depth and well thought out responses to the questionnaire, it was clear that staff have clients' interests at theforefront of their minds. The respondents reported that with the correct training and support, they would be willing to work with a harm minimisation policy and gave plenty of advice about how to make it successful. The authors of this paper agree that harm minimisation approaches can be extremely relevant and therapeutic in contemporary care situations. 'This way people heal in their own time. Telling people to stop makes them more secretive, more dangerous, and more dishonest about it. People need to not feel threatened by people that are ultimately trying to help them' (Mental Health Foundation, 2006: 70).

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