Cutting the Risk:
Self Harm Minimisation in Perspective

Teaching and Learning Guidelines

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Edited by Mark Cresswell

The Tudor Trust
Together - working for well being
Cutting the Risk:
Self Harm Minimisation in Perspective

This project is dedicated to
Helen Blackwell and Ian Murray
Cutting the Risk: self harm minimisation in perspective

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DVD

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Teaching and Learning Guidelines
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STEPS

**Stand Tall Sister**

Stand Tall Sister –
Your muscles support unique skin.
Crosses in public borne
Unlock cupboard secrets.

Stand tall sister -
Strong arms hold paper
And words to set an audience
alight.

Stand tall sister!
Strong hips dance their rhythm,
Bear your daughter,
and alone support her.

Stand tall, stand tall
Illness has no hold on intellect,
Their meaning -
You dissect
And hand it back
cross-stitched.

Stand tall, stand tall
Laughter like hot-day water
Strikes a bell.
Revive me spirit

Give me a hand to hold
Stand shoulder to shoulder
and women
Protect your daughters.

Kaety Moore ©

Kaety writes: this poem describes the strength and solidarity I gained from being in the women’s support group

Spring, 1995, twelve people gather in a room. It’s the first meeting of STEPS, the self-help group for women who self-harm. Everyone there self-harms for different reasons. Some experience acute depression; some have extreme highs. Some have survived life-long physical and sexual abuse; some are struggling with study stress and bullying at work. Some hear voices, some have beliefs about the world that other people don’t share. Their self-harm takes different forms. Some cut themselves, some swallow objects, some insert objects, some bang limbs and other body parts. Many take overdoses, may experience acute distress around eating and substance misuse.

Over the next five years, they do not, contrary to expectations, teach each other new and exotic ways of self-harming. They talk about what’s going in our lives, how they feel. They offer each other support. They go on holiday with each other. They share information on services. They produce a newsletter. They network with other organisations. They keep each other going.

Many women in the group feel deeply let down by services. Some have been refused treatment for injuries. Many have been treated roughly, and stitched with inadequate anaesthetic. All have been judged, rejected, ridiculed and punished for the fact that they self-harm. Some are so scared that they don’t seek medical attention, even when they really need it. Few have a medical background. Few know for sure where – or what - their arteries are. Few know what paracetamol does to the body in overdose. Few know how to treat a chemical burn, or how to recognise and respond to signs of infection in a wound. Most only find out when that damage is inflicted. Some do severe, lasting damage; some nearly die.

I know, because I was there.

Clare Shaw, December 2009
1. **Introducing the Cutting The Risk Project**

The impetus for *Cutting the Risk* came from the National Self Harm Minimisation Group (NSHMG) which is hosted by the national mental health charity Together – working for wellbeing.

The group consists of service users, survivors and allies from throughout the UK, who have been active in research, campaigning, education, training and consultancy around self-harm for many years. Together they aim to promote harm-minimisation for self-harm from the perspectives of service users and activists and have been highly influential in the development of national policy and practice on self harm minimisation in the UK.

In 2008 the NSHMG obtained funding from The Tudor Trust to produce teaching materials and resources for lecturers teaching self-harm and self harm minimisation to undergraduate medical and nursing students. The result is *Cutting the Risk*, a project which consists of a DVD supported by Teaching and Learning Guidelines. Along with medical and nursing students, the project is also likely to be of use to others teaching or training in mental health and social care, who wish to raise awareness of self-harm and self harm minimisation perspectives.

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**Part 2: Approaching self-harm minimisation**

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- Accident and Emergency
- General Practice
- Psychiatric ward
- Medium secure forensic unit for people with learning difficulties
- Politics and ethics
**Experts by experience**

Kaety Moore’s poetry and Clare Shaw’s experiences of a women’s support group remind us how the concept of harm-minimisation has been developed by service users. Clare Shaw writes:

“Until I came across the work of the National Self-Harm Network (NSHN), it was an eye-opener for me to realise that, even though I was hurting my body, there were still important things I could do to take care of myself. I learnt from the *Hurt Yourself Less Workbook* (1998) about what and where my body’s major structures were, and how to minimise the risk of damaging them, I discovered the use of advocacy and advance directives, and how to push for better treatment…..it was life-changing - and life-saving.”

A timeline of the history of harm-minimisation (Box 1) shows how service users and their allies organised conferences and publications through which harm-minimisation began to establish itself firmly on the mainstream agenda. In 2004 the National Institute for Clinical Excellence published guidelines outlining the need to give “advice and instructions on harm minimisation issues and techniques” (NICE 2004, 64).
Box 1: Harm-Minimisation – a history

1989: The ‘Looking at self-harm’ conference held in London. The first conference organised by survivors on the issue of self-harm and featuring contributions from the Bristol Crisis Service for Women (BCSW) and Survivors Speak Out (SSO). The concept which would later be termed ‘harm-minimisation’ was introduced here for the first time.

1994: publication of Self-Harm: Perspectives from Personal Experience (ed. Louise Pembroke, Survivors Speak Out). Survivors describe their experiences of self-harm, including issues such as how they have developed their own ‘harm-minimisation’ techniques.

1994: the National Self-Harm Network (NSHN) is established as a survivor-led organisation to campaign for the rights of people who self-harm.

1996: publication of Who’s Hurting Who? Young people, Self-Harm and Suicide (Helen Spandler, 42nd Street) in which young people discuss their experiences of self-harm and suicide, including the value of a ‘damage limitation’ approach to self-harm.


2000: Following the success of the conferences, the National Self-Harm Network (NSHN) publishes Cutting the Risk: self-harm, self-care and risk-reduction.

2003: The Department of Health (DOH) issues the Women into the Mainstream Implementation Guidance which advises service providers to “consider a ‘harm minimisation’ approach rather than an exclusive ‘prevention’ model”.

2004: The National Institute of Clinical Excellence (NICE) guidelines for responding to self-harm state that services should “consider giving advice and instructions on harm minimisation issues and techniques”.

2006: start of the DoH-funded harm-minimisation pilot project at St George’s Hospital, South Staffordshire and Shropshire Healthcare NHS Trust.

2006: The Royal College of Nursing (RCN) debate the issue of ‘Safer Self- Harm’ at their annual congress in Bournemouth.


2007: Beyond Fear and Control: working with young people who self-harm, edited by Helen Spandler and Sam Warner, brings together chapters from leading practitioners and activists on all aspects of self-harm, including harm-minimisation.
Service users’ experiences and research feature throughout the project, alongside more conventional academic sources. This approach reflects recent calls to involve users of mental health services in education and training (Fisher and Holley 2008). As Helen Duperouzel and Paul Moores point out, service users are increasingly emerging as ‘experts by experience’ to inform and enlighten health professionals, indicating a shift in attitudes towards reciprocity and understanding (Duperouzel and Moores, forthcoming). They argue that having a service user tell you their experiences can be extremely powerful, helping to cut through some of the confusion and conflict staff report feeling when working with people who self-harm. Involving service users in training also has a powerful impact on their self-esteem. Paul Moores, a service user, says that his goal for supporting staff training is to:

“try and change things, hoping that I can sometimes think - that new starter there has been educated by me, by what I do and by the things I’ve said, and that staff may even, if it’s just a vague inclination, of what they could be dealing with and change that approach instead of getting frustrated because of that person’s self-injurious behaviour...and possibly try spend a bit more time trying to find out what drives that person to self-injure....” (Duperouzel and Moores, forthcoming).

Cutting the Risk is intended to support participants in critically reviewing their practices. On the DVD, Helen talks about her experience of doing research alongside service users and staff, how really listening to what they had to say gave her the evidence to encourage colleagues and management in her workplace to move towards a consistent harm minimisation strategy.

Cutting the Risk is firmly located within the mental health survivors’ movement and a social model of disability and mental health. Whilst the social model acknowledges that individuals who self-harm are likely to have health-care needs, it shifts the focus from conventional ‘illness’ models towards capturing the experience of discrimination and exclusion which affects many individuals who self-harm. It emphasises that most of the barriers which people who use health services experience are created not by their ‘condition’ but by negative responses and attitudes they receive. Along with the social model, a focus on the survivors’ movement – which has been pioneering the development of harm-minimisation since the late 1980s - is central to understanding the experiences of service users and what might be done to improve service provision for them.

The conventional approach to people who self-harm is prevention with the aim of stopping self-harm. As the DVD shows, health professionals and other health care staff may find
themselves shocked and confused when working with people who self-harm. Any implementation of harm-minimisation approaches entails a fundamental shift in longstanding beliefs and practices by individuals, trusts and policy makers. It also requires a move towards dialogue with people who self-harm and aims to challenge the widespread stigma and negative attitudes reported by people who self-harm (Duperouzel and Fish 2007, Urquhart Law 2008).

The National Institute of Clinical Excellence (NICE) Guidelines (2004) emphasise the benefits of a multi-disciplinary approach, encouraging health care professionals to enter into a dialogue with service users about how individuals attempt to make sense of their need to self-harm. As Harper et al (2007: p 302) argue in an article about teaching mental health to undergraduates, there is a “need to move beyond mainstream psychology and psychiatry and the emphasis on diagnosis and categorisations which may individualise and pathologise people. New paradigms offer possibilities for considering social perspectives including race, gender, sexuality and issues of power in service users’ experiences of the delivery of health care”. They suggest that the undergraduate curriculum should take into account changes in the delivery of mental health services which set new standards and highlight good practice (DoH 2004).

This new curriculum may also include creative and community resources which provide further insights into service users’ experiences. Poetry, music and visual arts, like the powerful work of Kaety Moore featured in these Guidelines, reflect the artistic contribution made by survivors of self-harm and/or psychiatry. Resources and events produced and organised by campaigning groups and organisations celebrate the contributions of people with histories of self-harm through events like Disability Awareness Week and Mental Health Day.

Mark Cresswell points out in part one of the DVD that any discussion of self-harm and self harm minimisation involves questions of power. In his appreciation of the ground breaking publication *Self-Harm: Perspectives from Personal Experience* (Pembroke 1994; Cresswell 2006) he discusses the politics of self-harm, arguing that ‘Some people in society are violated and ‘silenced’; they ‘survive’ this silence through the act of self-harm’. The resources in *Cutting the Risk* are a contribution to this politics, an attempt at understanding the context in which self-harm has occurred, preventing further violations and pathologisation, towards developing practices which enable staff to care to “care with compassion for those who, through self-harm, survive” (Cresswell 2006). The resources are designed to support students and professionals as they develop their own harm-minimisation
practices and policies and offer fresh ways of engaging positively and productively with individuals who self-harm, contributing to a real dialogue between service providers and service users.

**DVD and Teaching and Learning Guidelines**

The DVD is divided into two main parts with subsections, so extracts can be selected for teaching purposes. It features opportunities to hear service users who have experienced self-harm and professionals working in the field tell their stories and experiences at first hand. Part one lasts for twenty minutes and is an overview of the issues. It features vox pops - street interviews with members of the public which give a flavour of the concern and understanding people feel for those who self-harm. There are interviews and testimonies from service users, health care professionals, lawyers and academics, many of whom have worked together as activists and trainers in campaigns to promote self harm minimisation approaches in the field of mental health.

Part two covers the issues surrounding the implementation of self harm minimisation approaches in different health care settings: an Accident and Emergency department, a psychiatric ward, a GP’s surgery, and a medium secure forensic unit for people with learning difficulties. The final section explores some of the ethical and legal issues surrounding the implementation of self harm minimisation strategies.

The Teaching and Learning Guidelines include a series of learning activities which are written from an action learning perspective. Activities include problem based learning, interviewing skills, different kinds of role play, decision making in teams, group work and case studies. General guidelines for teaching and learning methods can be found later in this introduction. Detailed instructions for learning activities (in yellow boxes) include specific learning objectives, links to the DVD, resource sheets, further information and appendices with teaching materials. References and weblinks are included at the end of each section and there is a bibliography at the end. Learning activities may be chosen depending on time available, the focus of the theme or topic and the group of participants.

**Cutting the Risk: Outcomes**

The resources and learning activities in *Cutting the Risk* have been designed to enable participants to achieve the following knowledge, skills and understanding.
Knowledge and understanding

• understand and appreciate the experiences of people who self-harm.
• identify patterns of self-harm and the impact of gender, ethnicity, sexuality and age.
• understand the effect that negative attitudes in staff has on individuals who self-harm.
• find ways of challenging the myths and stereotypes about people who self-harm.
• appreciate how practitioners reflect on their work with people who self-harm.
• understand the issues in developing a self harm minimisation policy and practice.
  including medical, legal and ethical issues and patients rights.
• identify and understand best practice in formulating care plans for individuals who
  self-harm in various clinical settings.
• the importance of multidisciplinary teamwork and the respective responsibilities and
  roles of team members.

Skills and reflective practice: students should be able to:

• identify and challenge negative beliefs, attitudes, myths and stereotypes surrounding
  people who self-harm.
• develop their capacity for reflective practice through becoming more aware of their
  own and others emotional responses and assumptions about patients who self-harm
  and how these might influence their approach to such patients and professionals.
• use good listening and communication skills and practice an empathic interviewing
  style appropriate for interviewing vulnerable and distressed patients.
• show sensitivity to the concerns of service users, their friends and families.
• identify effective self harm minimisation policies and practices in various clinical
  settings.

Box 2: Note on language

Throughout the DVD medical professionals and individuals who self-harm, or who have self-
harmed in the past use their own definitions - patients, clients and service users, psychiatric
survivors respectively. In the Teaching and Learning Guidelines the term ‘service user’ is
used to describe those who access or receive services in relation to their self-harm. This
may be through directly accessing Accident and Emergency departments for treatment or
through being a recipient of services in an inpatient setting in which the management of self-
harm becomes an issue.
While the project resources are designed to be used with undergraduate students it may also be used by a wide range of health and social care practitioners so the generic term participants is used throughout.

**Supporting learning**

The guidelines provide creative opportunities and ideas for delivering teaching and training and enhancing learning. These are designed to supplement the wide range of learning opportunities offered to medical students and provide an additional means of enabling medical students and others in health care to work towards gaining the knowledge, understanding and competencies required by the General Medical Council (GMC 2009), on their journey from novice to expert.

**Problem based learning**

Problem based learning and work related learning is becoming widely used in higher education, especially in health and social care and there are now medical degrees in which the curriculum is almost entirely problem based. If readers are interested in further discussion about the issues involved, there is a problem based learning special interest group in the Health Sciences and Practice subject centre of the Higher Education Academy. This can be accessed at www.health.heacademy.ac.uk/sig/problembased. Further ideas for active learning and research into the impact on student learning can be found in an Open University research project on problem solving in the workplace (Hoy 2009).

Problem based teaching methods require a high level of responsibility from participants for their own learning. They provide opportunities for active learning which encourage participants to engage meaningfully with teaching resources, to develop deep learning and critical reasoning, and to develop their communication skills through team work.

In *Cutting the Risk*, participants are encouraged to engage with the experiences of service users and professionals about their work as well as their own attitudes and assumptions. Participants learn through case studies and issues derived from the workplace which enable them to work towards gaining ‘competency, care and conduct’ as they begin to perform tasks and roles to the standard required of health professionals (Eraut 1994). Two of the case studies and some of the other teaching and learning resources, draw directly on ideas
and materials generated by a group of professionals and service users who participated in a workshop early in the Cutting the Risk project. As they work their way through the process they are encouraged to reflect on their own and others thinking and practice and, as they become more familiar with workplace and clinical settings, they may begin to make their own contributions from the workplace.

The process of problem based learning consists of the following stages. Depending on the nature of the task, some or all of these stages may take place inside or outside the classroom. For instance participants may begin their work on stages one and two together

1. What is the problem, the situation and/or the scenario?
2. What are the issues and learning required in order to understand what is needed?
3. What resources will be provided? For the immediate scenario? websites, media, service users, organisations, professionals?
4. How will reporting back on what has been learned be managed? What has been learnt? Any gaps in understanding?
5. What form will the action plan take (e.g. care plan)? How will it be agreed and implemented? What are the issues and who will be involved?
6. Reflecting on group processes and completing a professional development journal.

Learning in communities of practice

Problem based learning requires participants to work together and take a high level of responsibility for their own learning. Learning becomes not so much a measure of the degree to which it is possessed by individuals but an indication of ‘constructive alignment’ (Biggs 2003). This cognitive process encourages students to construct meaning through relevant learning activities, through learning to become a professional in the process of creating ‘communities of practice’ which emphasise social relationships and the context in which this takes place. “Learning is in the condition that brings people together and creates a point of contact that allows for particular pieces of information to take on relevance; without the points of contact, without the system of relevancies, there is no learning, and there is little memory. Learning does not belong to individual persons, but to the various conversations of which they are a part” (Wenger 1999).
**Emotional intelligence**

If learning involves working with others and a deeper level of engagement with ideas and materials, it may also raise emotional challenges for participants. If participants are asked to improve their communication skills, which are so central to medical life, through re-negotiating their relationships with service users and each other then emotional responses will be sure to emerge. Top of the list in audits of what service users say they want from staff are effective and empathic inter-personal skills. But research suggests that staff working with people who self-harm often find encounters stressful, sometimes shocking and may feel conflicted about their role and responsibilities. If we are asking participants to really listen to service-users' experiences and challenge conventional approaches to self-harm, it is important to provide time and space for participants to de-brief on their responses and reactions, to recognise that they may need support with the development of their ‘emotional intelligence’ and how they will obtain support for themselves. Having emotional intelligence may be understood as:

- Knowing your emotions.
- Managing your own emotions.
- Motivating yourself.
- Recognising and understanding other people's emotions.
- Managing relationships i.e. working with the emotions of others.

**Learning activities used in problem based learning**

**Keeping journals - reflective practice**

The aim of many of the learning activities is to provide an opportunity for participants to critically reflect on their own and others personal and professional development. Responses to learning activities can be recorded in professional development journals in which participants consider themes such as observations and reactions to group process, how they reach decisions on what they are doing and why they are doing it and the relevance of theory and other resources. As Brookfield argues, “reflective practice involves more than cognitive activities such as logical reasoning or scrutinising arguments for assertions unsupported by empirical evidence. Thinking critically involves our recognizing the assumptions underlying our beliefs and behaviours. It means we can give justifications for our ideas and actions. Most important, perhaps, it means we try to judge the rationality of these justifications. (Brookfield 1995). In the context of self harm minimisation it is even more important to find ways not just to recognise but to challenge the stigma and prejudice against people who self-harm.
Critical incidents

A critical approach is useful for encouraging participants to think systematically about significant events or incidents. This approach is an opportunity to explore the standpoint of each person in the incident, how they might react and why (Brookfield 2007). In the process participants should become increasingly aware of their own viewpoint, how they relate to service users and team members and the use they make of theoretical and research literature. These critical incidents are useful for reflecting on experiences in the workplace - clinical interviews, case team meetings or an encounter in a public space such as accident and emergency are examples which are included in these Guidelines. Incidents, sometimes known as ‘hot moments’ may only last for a few minutes; other events take place over a longer period of time. Incidents may be provided in the form of pre-prepared case studies or derived from the experiences of participants. A critical approach includes:

- A description of the significant event or practice.
- A discussion of context, significance and typicality including how an event is interpreted and the feelings and attitudes associated.
- How the situation or event is confronted, revisited and reconstructed and how new ways of proceeding are considered.
- The impact of prior experience and lived experience.
- Relevance of theoretical perspectives and research.

Facilitation

Facilitators in problem based learning need rather different skills from traditional teachers. It is helpful to be adept at listening, questioning the rationale for any judgments, provoking activity, knowing when to intervene in the group process, and when to sit back and let participants resolve their own difficulties and reflect on process. This does not mean taking a passive role, however, as supporting participants in difficulties and ensuring that participants keep making appropriate connections with theory is important. So facilitators may sometime be a role model, a coach, a critic, or even an impressed observer. In general effective facilitators:

- encourage participants to actively participate.
- create a safe and supportive environment.
- value each students contribution.
- relinquish power to enable a partnership to develop.
are continuing co-learners.

**Supporting group work**

Participants will find it easier to work together if the facilitator has helped them get to know each other. There are many ways of doing this and here are two suggestions.

**Introductions: pairs**

Objectives:

- to ensure that participants get a chance to really meet each other.
- to practice listening skills.

**Method**: ask people to work in pairs with someone they don’t know very well. Ask them to introduce themselves to each other and tell the other person one thing they would like the group to know about them/something they are looking forward to in that class (facilitator decides something which is appropriate). Ask each pair to introduce each other to the rest of the group including the one thing they want the group to know.

**Introductions: what’s in a name?**

Objectives

- to gain insight into what’s is important to participants

**Method**: ask each person in turn say their name (first or second names) and tell a story about how they got their name. If people are stuck, prompt by suggestions could include who gave you your name and how you name might have influenced your life.

**Facilitating group dynamics**

Problem based learning entails working in groups. Participants often report that group work is enjoyable, challenging and fun, helping them retain information and share their experiences with others. A lot of work can get done if everyone knows what is expected of them. However, group members may also experience difficulties with communicating openly which can result in difficult group dynamics. Groups may, consciously or unconsciously, begin a process of inclusion and exclusion of group members leading to unequal working relationships. A good size for most small group work is four or five people - any more makes the group dynamic more complex to negotiate. To help groups work towards a sense of membership, group consciousness, shared sense of purpose, interaction and the ability to
act in a united manner try using some simple guidelines which can help facilitate effective
group work.

- ask everyone to suggest a few ground rules and take responsibility for making it a positive learning experience.
- write down and explain group work tasks which should have a time limit.
- allocate group tasks or ask group to share them out: scribe, chair, timekeeper, one or two people to feedback etc. Check that the jobs are rotated so that same people don’t do everything.
- encourage interaction through practising questioning skills (see Box 3 below). A quick way to do this is to give each participant a different type of question and ask them to make sure they use it during the discussion.
- encourage respect through active listening: members should allow others to express opinions and give information without being judgmental.
- discuss the importance of body language and the messages conveyed in the way we sit or stand and the space we take up in the room.
- encourage participants to practice effective communication skills through speaking directly to each other and owning what they say, attempting to resolve any misunderstanding and becoming aware of both their verbal and non-verbal behavior.
- Form ‘critical friendships’ - invite participants to work in pairs over time with someone with whom they can share difficulties and anxieties and give and receive advice and support.

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<td>Open Ended</td>
<td>What's Going On? What do you make of this situation?</td>
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<td>Diagnostic</td>
<td>How do you interpret and explain &quot;A&quot; and &quot;B's&quot; impact on the situation? What else might be going on, possibly behind the scenes?</td>
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<tr>
<td>Challenge</td>
<td>Why do you say that? How would you explain? Where is the evidence for what you say?</td>
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<tr>
<td>Extension</td>
<td>What else? Can you take us further down that path?</td>
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<td>Combination</td>
<td>How would you relate your points to those mentioned by …?</td>
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<td>Priority</td>
<td>Which issues do you consider most important? Where do you start? How would you rank these?</td>
</tr>
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<td>Action</td>
<td>What would you do in person X's shoes? How?</td>
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<tr>
<td>Prediction</td>
<td>What do you think would happen if we followed care plan A? What do you expect might happen? How will he/she react?</td>
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<td>Generalising and Summarising</td>
<td>What inferences can we make from this discussion and case? What generalisations would you make? How would you summarise the three most critical issues?</td>
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Developing and supporting role playing

Role plays can work well if participants are well prepared for them through warm-ups which help them feel less embarrassed or exposed. If facilitators decide that it is appropriate to use role plays in problem based learning they may find the following ideas useful to prepare participants.

**Hot seating**

**Objective:**
- to find out what might lie behind someone’s behavior and to gain some insights into their thinking and feeling.

The insights can be used by whoever is doing the role play to build a character and strengthen their performance and make it more ‘real’ and less personal. Groups of up to 10 or 12 people work best.

**Method:**
1. Decide who the characters are in a case study. For instance, a junior Doctor observes Alison, a young service user in A and E with a history of self-harm who has cut herself and has been treated in a dismissive way by a nurse. The Doctor doesn’t quite know what to do about it. Other health care staff are present but no one does anything.
2. Ask for volunteers to take on the role of each character: Alison, Doctor, Nurse and another member of staff. Anyone can play anyone – e.g. you do not have to match gender, age or ethnicity.

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<tr>
<th>Priority: Which issues do you consider most important? Where do you start? How?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action: What would you do in person X's shoes? How?</td>
</tr>
<tr>
<td>Prediction: What do you think would happen if we followed care plan A? What do you expect might happen? How will he/she react?</td>
</tr>
<tr>
<td>Generalising and Summarising: What inferences can we make from this discussion and case? What generalisations would you make? How would you summarise the three most critical issues?</td>
</tr>
</tbody>
</table>
3. Hot seat each one in turn. The person in the hot seat will sit in front of the rest of the group who are seated in a semi-circle and ask questions. The actor who is being hot seated should respond by drawing on his or her experiences and imagination.

4. Questions should be designed to find out more about the person and what makes them tick. Questions should not be too confrontational and closed ended questions avoided. Examples of questions for the Doctor might include: What is your name? Age? How long have you worked in A and E? How are you getting on in A and E? How long had you been on shift when the incident happened? When did you last get a break? How would you describe what happened to Alison? What did you feel when you saw what happened to her? Do you know anyone who has self-harmed? What kind of training have you had? What is the self-harm policy in your department? Why do you think the other staff did nothing? What would you like to have done?

Freeze

Objectives:
- to warm participants up for role play
- to provide a learning activity which can be used instead of a traditional role play

Method:
1. Choose a scenario which is relevant to the topic or theme. For example: suggest that an inexperienced Doctor is trying to communicate with a young service user who is reluctant to talk.
2. Two participants begin improvising the situation between the Doctor and service user in front of the rest of the participants.
3. At any moment anyone in the class, including the facilitator can say "FREEZE." The role-players must stop where they are. Then the person who froze the action gets up, taps one of the role-players on the shoulder, and takes his or her place in the scene. The new role player now resumes the scene by talking first, but can introduce any new dialogue or action he or she wishes. The new role player can modify the scene slightly, take it in a very different direction, or completely change the topic of the scene.
4. The role players continue to improvise the new scene until someone else from the class says "FREEZE" and steps in to alter the scene once again.
5. This process of improvising, freezing, and altering the scene continues until as many people as possible have taken turns participating in the role play. If agreed other characters can be introduced.
**Body language awareness role play**

- to warm participants up for role play
- to provide a learning activity which can be used instead of a traditional role play
- to sensitize participants to the importance of body language in communications

**Method:**

1. Ask participants to form small groups. Each group should choose a scenario which is relevant to an encounter in a clinical setting/or any situation.
2. Rehearse the scene as a role play but without sound and by slightly exaggerating gestures.
3. Each group shows their scenario (with or without a title) to the rest of the group who must try and guess what it happening from the body language.
4. Review body language such as hand gestures, cultural, gender and status differences.

**Some pointers for effective role play**

- Keep role plays simple and be clear about the purpose of the role play and what you want people to get out of it. In these guidelines suggested role plays are designed for skills development not assessment.
- Mini role plays between two people help prepare the ground for longer ones. If you have a longer role play choose a small part of it to build up confidence.
- Role playing briefs should contain enough information for characters to engage in a believable and relevant conversation, which should be in line with the objectives. Give as much detail as is necessary - too little and there won't be enough to sustain a conversation, too much and people will be swamped with information, most of which they won't remember.
- Ensure that participants understand the objectives for a role play; they could suggest some of them based on what they personally need to achieve.
- Observers should give specific constructive feedback based on what they saw and heard and should be something the role player can use. Feedback should be SMART (specific, measurable, agreed, realistic, time-bound) and not judgmental.

**Stages of a role play**

1. Decide and clarify objectives with the group
2. Each group will consist of the number of people in the scenario plus two observers to give feedback. Ask for volunteers rather than designating roles. It is helpful to designate a specific space or stage in which the role play takes place to help keep actors in role and designate boundaries.

3. Prepare by hot seating characters or discussing the characters and what they are trying to achieve.

4. Enact the role play

5. After the role play ask the actors to re-group and de-brief away from the role play space to help them keep their boundaries. Check out how the actors are – sometimes role play can be emotionally demanding

6. Observers give feedback on any communication skills. Actors respond and discuss what they felt and what they learnt from their role play.

7. The whole group discusses what they have learnt. How effective was the role play in resolving the challenge? What gaps remain and what further information or skills are needed?

8. Individuals will need time to make a note of what they have learnt from feedback and the experience.

**Fishbowl: an alternative approach to role play**

This method involves a team work approach and can take the pressure off individuals. It is useful for scenarios like case conferences where members of a team might be discussing the best way forward for a service user. Everyone gets a chance to practice and can consult their group and ask for support.

1. Tell everyone the scenario or problem and ask for volunteers to play the two or three parts in the scenario. Give a brief on the scenario and characters.

2. Designate a role play space and ask the actors to take their places in it. The rest of the participants will be divided up into two or three groups (depending on the number of actors) and should seat themselves behind and around the actors.

3. Start the role play debate or discussion. If an actor gets stuck he or she can ask someone from their group to take their place and continue. If a group member decides that he or she has something to offer the discussion team and can offer a different perspective from the actor currently in the role play space, they tap the actor on the shoulder and take their place. This can continue until everyone who wants to has had a turn in the role play.

4. The facilitator leads a de-briefing session or if observers have been appointed they can also give feedback on what they saw.
References: weblinks

Higher Education Academy for Teaching and Learning  www.heacademy.ac.uk.

See subject centres in Medicine, Dentistry and Veterinary (MEDEV)  
www.medev.heacademy.ac.uk  subject centre in Health Sciences and Practice  
www.health.heacademy.ac.uk  
Teaching mental health in higher education  www.mhhe.heacademy.ac.uk  
training’ URL: http:// www.mhhe.heacademy.ac.uk

General Medical Council ( 2009) see sections on: Good clinical care, Relationships with  
patients and Working with colleagues in Professional Vales and Fitness to Practice for  
Undergraduate Medical Students. URL: http:// www.gmc-uk.org

www.open.ac.uk/pbpl/projects/learning_in_action

Mental Health Media.  URL: http:// www.mhmedia.com for training materials including visual  
resources  
MIND. URL: http:// www.mind.org.uk

Royal College of Psychiatry ‘Better services for people who self-harm’ URL:  
http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement/self-harmproject.aspx

Royal College of Nursing.  URL: http://www.rcn.org.uk/

Self help organisations and websites

National Self-harm Network: campaigning and information for people who self-harm,  
including details of support groups PO Box 16190, London 3WW

Bristol Crisis Service for Women: helpline and information PO Box 654, Bristol BS99 1XH  
Tel. 0117 925 1119 (helpline Fri/Sat nights 9pm-12.30)  “Self-injury resources and  
bibliography” (not just for women) available from www.users.zetnet.co.uk
42nd Street: support for young people, including suicide and self-harm project. 4th Floor, Swan Buildings, 20 Swan Street, Manchester M4 5JW

Basement Project: information and support for people who self-harm PO Box 5, Abergavenny NP7 5XW leaflet, “Self-Harm – Staying Safe” available from http://freespace.virgin.net/basement.project

Books and articles


Brookfield, S (1995) Becoming a critically reflective teacher (Jossey Bass)


Cutting the Risk: harm-minimisation in perspective

Part One: Teaching and Learning Guidelines

This section is structured around Part One of the DVD, which lasts for about 20 minutes. It provides an overview of some of the issues and is intended to deepen understanding of the experiences of people who self-harm and what might be done to develop best practice. It also aims to raise awareness of the complex issues surrounding self-harm and self harm minimisation approaches. In part one of the DVD, members of the public talk about their understandings of self-harm and service users talk about their experiences of both self-harm and the care they receive.

Part One: Objectives

- To clarify definitions of self-harm, self-injury and self harm minimisation
- To review patterns of self-harm and who is at risk
- To enable students to reflect on their own attitudes and those of other professionals working with people who self-harm
- To critically review popular views and stereotypes about people who self-harm
- To understand the relevance of culture and society in understanding distinctions between socially acceptable and socially unacceptable forms of self-harm
- To understand how self harm minimisation approaches developed and the campaigning role played by service users
- To appreciate experiences of people who self-harm and the impact of negative treatments
- To explain the relationship between self-harm, mental disorder and suicide
- To critically review the main explanations for why people self harm
- To clarify key differences between harm cessation and self harm minimisation approaches
1.0 Self-harm in context – introducing the DVD

The learning activities below enable a broad introduction to Part One of the DVD.

**Learning activity 1.0.1**

**Objectives of learning activities 1.0.1 and 1.0.2:**
- to introduce the Cutting the Risk DVD
- to practice active listening skills
- to appreciate similarities and differences in the issues raised by service users and professionals

Instructions are for groups of up to about 20. If you have more than 20 or so students or have less time alternatives are suggested in italics. Try one or more of the following exercises.

Ask students to watch DVD part one (20 mins).

Instruct each person to make a note of something in part one which resonates with them or in which they were interested. In small groups of about four people (or pairs) discuss their responses and why they felt like that - including emotional responses. This is a listening and recording activity so discourage advice giving.

Each small group chooses a scribe and records the responses they consider to be most important on flip chart paper. These are then displayed and each group chooses a spokesperson to report back to the main group (each pair turns to pair behind/infront and discusses their responses. Lecturer then asks for some responses and records these on whiteboard). Lecturer then reviews some of the issues and responses and places them in context.

**Learning activity 1.0.2**

Give each person a slip of paper on which is listed a specific person in DVD part one – some will have the same slip - and ask them to make a note of what the person says and any responses and questions they have to what has been said. Ask the group to form small groups consisting of one (or more) of each of the people on the DVD and discuss their responses (give each row of people a person to follow, then ask them to discuss their responses in pairs). Lecturer now asks for some responses to each person in turn, noting responses on whiteboard and reviews the issues arising from feedback.

**Resources for activity 2: names of people appearing in DVD part one**

Members of the public; Hannah Schwartzman, service user; Clare Shaw, Director harm-ed Training; Mark Cresswell, sociologist, Iain Rider, psychiatrist; Louise Pembroke, writer and survivor activist; David Cottrell, clinical academic.
1.1 Working definitions of self-harm

This section accompanies Part One: Section One (What is self harm?) of the DVD. The resource sheet offers working definitions of self-harm and self-injury and distinguishes between self-harm and attempted suicide. It also gives examples of socially acceptable and socially unacceptable forms of self-harm and places self-harm in a clinical context.

Learning activity 1.1.1 What is self-harm?

Objective: to review and clarify definitions of self-harm and self-injury

Students may work in pairs. Ask them to recall and record the definitions of self-harm and self-injury given on the DVD. They can also add their own definitions. They should then compare their definitions with those below. In feedback discuss responses, including the relative advantages and disadvantages of the quotes provided below - in terms of personal meaning, relationship to suicide and medical definitions.

Self-harm can be defined as “self-poisoning or self-injury irrespective of the purpose of the act” (NICE, 2004: 16).


“[W]e use the term 'self harm' to mean a situation where someone brings about harm to his [sic] own body, usually without wanting to die” (RCN 2009).

“An act with a non-fatal outcome in which an individual deliberately initiates a non-habitual behavior that, without intervention from others, will cause self-harm or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences” (WHO/EURO Multi-Centre Study on Parasuicide, 1992).

Self-harm can be defined as “non-accidental actions which cause direct physical harm, without suicidal intent. These may include cutting, burning, poisoning, or overdosing, for example” (harm-ed 2009).
Self-harm is a perplexing subject for both medical students and medical practitioners alike. Whilst academic research has escalated since the mid 1980s, there is no clinical consensus as to its definition, cause, prevalence or treatment. In the research literature one can find references to self-harm, self-injury, self-mutilation, parasuicide, intentional self-harm, self-cutting, self-poisoning, self-directed violence, and attempted suicide. These terms are sometimes taken as synonymous or, conversely, as referring to distinctively different behaviours. In spite, or perhaps because, of this ambiguity, self-harm is often taken as an umbrella term which incorporates “intentional self-poisoning or self-injury irrespective of motivation” (Hawton et al 2003: 537). This definition forms the basis of the recent NICE (National Institute of Clinical Excellence) guidelines on the immediate assessment and treatment of self-harm, wherein the term is defined as “self-poisoning or self-injury irrespective of the purpose of the act” (NICE 2004: 16).

Whilst broad definitions, such as those given above, offer clinicians a general basis to develop services for all individuals who have self-harmed, they occlude the important distinction between self-harm that is motivated by an intention to end one’s life and self-harm that is without suicidal intent. An extensive body of research has developed which suggests that, in contrast to attempted suicide, non-suicidal self-harm functions as a coping or survival mechanism (Babiker and Arnold 1997), which is life saving rather than life denying (Pembroke 1994) and which regulates or reduces psychological distress (Walsh 2008), (see also, Arnold 1995, Bunclark and Adcock 1996, Favazza 1998, Hooley 2008, McCallister 2003, Spandler and Warner 2007). In this light, where these guidelines refer to the term ‘self-harm’ they are generally referring to this secondary understanding: that of self-harm which is without suicidal intent (see box 1.1.1).

**Box 1.1.1 What is self-harm?**

Self-harm can be defined as “non-accidental actions which cause direct physical harm, without suicidal intent. These may include cutting, burning, poisoning, or overdosing, for example” (harm-ed 2009).

**Self-injury**

One way to illustrate the distinction between self-harm and suicidal behaviours is through the term non-suicidal self-injury (NSSI) or just self-injury (SI) (see box 1.1.2). In the UK, the term self-injury has tended to replace that of deliberate self-injury (Klonsky 2007), self-mutilation (Nock and Prinstein 2004, 2005), or self-inflicted violence in recent years. The primary reason for this is that many service users have found these terms inappropriate, if not outright offensive (McAllister 2003, Pembroke 1994).
Box 1.1.2 What is self-injury?

Self-injury can be understood as “the intentional destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (Klonsky and Muehlenkamp 2007: 1039). This distinguishes it from both suicide attempts and from socially acceptable forms of self-injury, such as body piercing or tattooing, which also cause destruction to bodily tissue (Walsh 2008).

While the term self-injury has its benefits, one danger is that individuals who self-injure become separated, in the eyes of clinicians, from those who self-poison. While there is some research to support the usefulness of this distinction in theory, this should not dictate understandings and outcomes in a clinical setting (see box 1.1.3). Furthermore, definitions of both self-poisoning and self-injury tend to exclude individuals who use other forms of non-suicidal self-harm, such as swallowing objects or tying ligatures. In this light, self-injury is best described as a subset of self-harm which refers to acts which directly damage body tissue, such as self-cutting, self-burning and self-hitting (see box 1.1.2).

Box 1.1.3 Does the method or severity of self-harm determine the intent? The example of A&E

Four fifths of attendances at A&E for self-harm are for self-poisoning. One fifth of attendances are for self-injury. The main method is self-cutting (72.4%) (Horrocks et al 2003).

Method of self-harm

Researchers have sought to show that individuals who self-injure are distinct in motivation (Stanley et al 2001), and characteristics (Hawton et al 2004) from those who self-poison (Fagin 2006). For example, studies have shown that suicidal intent is statistically lowest in individuals who attend A&E after self-injury alone and highest in those who attend after self-poisoning (Harriss et al 2005). Still, categorising individual's motivation or intent according to the method of self-harm used can prove highly problematic, if not dangerous, in a clinical setting. Only an assessment that targets the individual rather than the method can establish the intent and motivation which lay behind the current act of self-harm (NICE 2004).

Severity of injury

While there is some correlation between severity of injury and intent (so, for example, lethal self-injurious behaviours such as shooting or jumping from great heights are nearly always likely to infer a suicidal intent), it is problematic to assume that all severe forms of self-injury imply suicidal motivation. Or, conversely, that minor forms do not require follow up or an assessment for suicidal intent or concurrent suicidal feelings (Lilley et al 2008). The recent NICE guidelines on self-harm assert that all individuals who self-harm, regardless of severity or method, must be offered an assessment of needs and risks (NICE 2004).

Regardless of intent, any form of self-harm may cause accidental or irreparable damage. Examples here include loss of limb function through cutting, suffocation through the use of ligatures, or major liver damage through a perceived minor drugs overdose.
The term ‘self-harm’ helpfully shifts the conceptual focus from that of method or severity of harm towards that of intent and function. This enables clinicians to distinguish between self-harm and suicidal behaviours. In its widest sense, self-harm can mean any non-accidental action or behaviour - especially those which are used to cope with the stresses and pressures of everyday life - which cause harm to our bodies in the short or long term. The list of possible self-harming behaviours here is endless and includes, amongst other things: excessive alcohol consumption or binge drinking, overworking, unhealthy eating, under eating, and lack of sleep. These behaviours are often deemed socially acceptable and, in some contexts, are actively encouraged. It is therefore questionable why particular forms of self-harm, such as skin-cutting, are condemned and pathologised when arguably more dangerous forms, such as smoking or binge drinking, are deemed socially acceptable (Warner 2004). Whilst the focus in these guidelines is on what might be termed socially unacceptable forms of self-harm, understanding that self-harm incorporates a spectrum of actions and behaviours which, to some extent, affect us all, helps overcome some of the stigma and misunderstanding which is sometimes associated with it.

**Self-harm in a clinical setting**

Clinicians often find it helpful to distinguish between direct and indirect forms of self-harm (Walsh 2008). Direct self-harm refers to any action which deliberately, concretely and immediately (or almost immediately) hurts the body. Indirect self-harm refers to the indirect or unintentional consequences of other self-harming behaviours. Here self-harm may be accumulative, or deferred, and there may be a denial of self-injuring intent, such as a denial that one’s anorexia has become life-threatening, or that one is an alcoholic (see Box 1.1.4). Where we refer to self-harm in these guidelines, the focus is on direct self-harm.
Self-harm and suicide

Professionals working with people who self-harm are often very concerned about the possibility of suicide. And, as Part Two of the DVD shows, this may underpin resistance to the development of self-harm minimisation approaches. Whilst suicidal behaviors are different from acts of self-harm, this does not mean that there is no relationship (Muehlenkamp 2005). A large proportion (50% community and 70% inpatients) of individuals who self-harm have reported attempting suicide at least once (Klonsky and Muehlenkamp 2007). The fact that individuals who self-harm may die by suicide at some point in their lives may, in part, be due to similar psychosocial risk factors (Muehlenkamp 2005). It can also be attributed to the stigma, negative responses and feelings of shame that some individuals can experience after having self-harmed (McAllister 2003). Whilst it is problematic to conflate acts of self-harm with suicidal behavior, it is equally problematic not to respond to the despair that underpins many acts of self-harm, or see acts of self-harm as of lesser value to suicide attempts (Babiker and Arnold 1997).

Key Texts

1.2. Who self-harms?

The learning activities and resource sheet in this section support Part One: Section Two (Who self-harms?) of the DVD.

**Learning activity 1.2.1: quiz - who is at risk of self-harm?**

**Objectives:**
- to raise awareness about patterns of self-harm
- to begin discussion of why specific groups may be at risk

Hand out Appendix 1: Quiz. Ask each person to complete it individually then check their answers with one other person. Display or handout answers and go through how people responded together to identify what people understand and where there are gaps and questions. Or ask each person to complete individually and go through answers with the whole group. Check out how people arrived at their answers and any queries they may have.
**Resource sheet: Who self-harms?**

**Rates and patterns of self-harm**

One of the most striking things about self-harm is that it largely goes unreported. Statistics which are available tend to be gathered from A&E departments or from groups deemed at higher risk of self-harm. These include psychiatric inpatients, adolescents, and victims of child sexual abuse (Crowe and Bunclark 2000, Miller and Smith 2008). One important exception can be found in a report by Meltzer et al (2002) which presents findings from a large scale survey (8040 people) carried out by the office of National Statistics. They show that 2% of men and 2.7% of women report having self-harmed at some point in their lives, and that the reporting of self-harm decreases with age (see Table 1.2.1). A further example can be found in Briere and Gil (1998). They show that 4% of the general population report having a history of self-harm.

<table>
<thead>
<tr>
<th>Age range</th>
<th>Percentage of respondents who have ever self-harmed</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>5.3</td>
</tr>
<tr>
<td>25-34</td>
<td>3.9</td>
</tr>
<tr>
<td>35-44</td>
<td>2.3</td>
</tr>
<tr>
<td>45-54</td>
<td>0.9</td>
</tr>
<tr>
<td>65-74</td>
<td>0.3</td>
</tr>
</tbody>
</table>

From Meltzer et al (2002)

Without large scale epidemiological surveys it is difficult to evaluate the extent to which self-harm occurs within different groups (Babiker and Arnold 1997). Still, a wealth of research does suggest that self-harm is more common in oppressed or marginalised groups such as victims of physical, sexual or emotional abuse; South Asian women; young people (particularly young women); gay, bisexual, and transgendered men and women; and individuals who are dependent on alcohol or street drugs (see box 1.2.1). What this means is that, while the meanings of self-harm are often individual and personal, the roots are frequently related to wider social forces, such as through experiences of sexism, racism, abuse, trauma, bullying and homophobia (NICE 2004, Spandler and Warner 2007). Medical practitioners can rarely address these wider social problems but an understanding of them, along with an awareness of one’s own prejudices, can help ensure that services do not exacerbate the discrimination, oppression and feelings of powerlessness that individuals who self-harm often feel (Babiker and Arnold 1997).

While the focus on certain risk groups is well-established, recent research has sought to show that self-harm amongst other groups within the general population may be more common than thought. A large-scale survey by Hawton et al (2004), for example, found that individuals who presented to A&E departments after self-cutting were most likely to be male, single and have a history of self-harm; thus questioning the stereotype that it is young females who are more likely to attend A&E after self-injury.
**Box 1.2.1 rates and patterns of self-harm**

Self-harm occurs at a rate of between 1-4% in the general adult population (Nock 2009, Nock and Prinstein 2005)

Only 36% of individuals who self-harm receive medical attention; 50% receive some form of help from medical or psychiatric services (Meltzer et al 2002).

Approximately 20% of adult psychiatric inpatients, and 40-80% of adolescent psychiatric inpatients, self-harm (Klonsky & Muehlenkamp, 2007).

Self-injury occurs in 17% of adults with a learning disability (Collacott et al 1998)

**Groups with higher rates of self-harm**

**Adolescents**

There has been a 250% increase in the rates of self-harm amongst adolescents since the early 1980’s (i.e early 1980’s – late 1990’s) (D’Onofrio 2007). This may, in part, be due to an increase in reporting.

It is estimated that one in ten young people self-harm at some point in their teenage years (Samaritans and the centre for suicide research 2002).

**Gender and sexuality**

In 10-14 year olds, girls are eight times more likely to self-harm than boys. After about aged 20 the sex ration for self-harm reduces to 1.6:1 (Hooley 2008)

Women who have been sexually or emotionally abused in childhood or raped in adulthood are highly likely to self-harm. (Arnold 1995)

Lesbian, gay, bisexual and transgender young people are two to three times more likely to self-harm than heterosexual young people (Camelot Foundation and Mental Health Foundation 2006).

**Ethnicity**

Asian women, aged 15-35 are two to three times more likely to attempt suicide than their non-Asian counterparts (Soni-Raleigh 1996). It is likely that rates are similar for non-suicidal forms of self-harm (Babiker and Arnold 1997).
1.3. Understanding self-harm and mental disorder

This section explores the relationship between self-harm and mental disorder using two divergent approaches. The first ‘structural approach’ seeks to correlate self-harm with a range of mental disorders. The second ‘functional approach’ questions the medicalisation of self-harm and, instead, prioritises the functional aspects of it. The learning exercises and resource sheet support Part One: Section Three (Why do people self-harm?) and Part One: Section Four (Self-harm and mental disorder) of the DVD.

Learning activity 1.3.1: Coping strategies

Objectives:

- To provide an opportunity for students to reflect on their own patterns of coping, self-nurture and self-harm
- To raise awareness of the distinctions socially acceptable and unacceptable forms of self harm
- To practice interviewing skills

Many people who self-harm report that, in times of great distress and anxiety, they may self-harm as a coping strategy to manage difficult feelings and emotions. How do students cope? Give everyone a copy of Appendix 2: Self nurture or self harm. Ask them to work in pairs A and B. Stress that this is a confidential activity and they will not be required to feedback on their specific experiences. A takes B through the questionnaire, then B interviews A. Encourage them to practice sensitive interviewing skills as they go through the sections. Feedback: ask pairs to get into fours and decide on any general points or issues they wish to make to the whole group, especially into any insights into why someone might self-harm.

Learning activity 1.3.1: comparison of structural and functional approaches

Objective: to reflect on the reasons people might give for self-harming and place them in a social context

Ask students to read the case study and discuss which approach, or combination of approaches, might be most useful in understanding how best to support the service user

Case study

A young Asian woman in her early twenties was sexually abused by her father from the age of 2 until the age of 16. She has taken an overdose on two occasions with suicidal intent and received life-saving hospital treatment. She also self-harms by cutting her arms and body as a relief from the experience of excruciating emotional pain, and as an alternative to attempted suicide. She describes herself as compelled to do this, and regards it as an act done to herself by herself which inflicts physical wounds with the intention paradoxically of helping herself rather than killing herself.

Case study adapted from NICE guidelines
The structural approach

The structural approach considers self-harm either as a symptom of mental disorder or as a syndrome in its own right (Claes and Vandereycken 2007).

Neither self-harm nor self-injury constitute distinct diagnoses within the DSM-IV (American Psychiatric Association 1994), although some authors would like to see ‘self-injurious behavior’ (Muehlenkamp 2005) or ‘repetitive self-harm syndrome’ (Favaza and Rosenthal 1993) become an official diagnosis in the next edition. At present only two disorders have self-harm (in the form of self-injury) as part of their diagnostic criteria: borderline personality disorder and stereotypic movement disorder. Within the literature, however, self-injury is related to many other disorders in the DSM-IV, including schizophrenia, major depression, posttraumatic stress disorder, eating disorders, anxiety disorders, and obsessive-compulsive disorder (Simeon and Favazza 2001, White Kress 2003).

By far the most common diagnosis which is given to individuals who self-harm is borderline personality disorder (see Box 1.3.1). Indeed, studies have shown that clinicians often use self-harm as one of the main criterion to diagnose a patient with the syndrome (Rusch et al 1992). The diagnosis is a highly controversial one however and has been critiqued from service users and professionals alike (for example, Aviram et al 2006, Johnstone 1997, Shaw and Proctor 2005).

Box 1.3.1 Borderline personality disorder and self-harm

- Borderline personality disorder was introduced into the DSM in 1980. The disorder has nine classificatory symptoms, of which five or more must be met for a diagnosis (American Psychiatric Association 1994).
- One of the classificatory symptoms refers to ‘recurrent suicidal behavior, gestures, or threats, or self-mutilating behaviour’.
- 75 percent of individuals who are diagnosed with borderline personality disorder are female.

Johnstone (1997) has argued that labelling self-harm as symptomatic of the diagnosis of borderline personality disorder is problematic for a number of reasons:

- The diagnosis appears to provide an explanation for self-harm but, in fact, simply provides a circular argument: “why does this woman cut herself? Because she has borderline personality disorder. How do you know she has borderline personality disorder? Because she cuts herself” (Johnstone 197: 422).
- The diagnosis professionals self-harm, it places the power of interpretation in the hands of clinicians, rather than listening to what individuals themselves have to say about the meanings and functions behind their self-harm.

The diagnosis individualises self-harm, removing it from its social context and from wider social problems such as experiences of abuse, oppression and trauma.

- The diagnosis fails to deal with the, often negative, feelings and reactions that staff have in relation to self-harm. In fact, it may exacerbate negative reactions by allowing staff to distance themselves from service users and label them as difficult, manipulative or untreatable (also see, Aviram et al 2006).
- The diagnosis prioritises treatments whose goal is the cessation of self-harm, rather than addressing the underlying difficulties and distress which may pre-empt the need to self-harm (also see Shaw and Shaw 2007).

Statistics do indicate the prevalence of self-harm within psychiatric populations and, in this light, highlight the importance of offering a psychosocial assessment to individuals who access primary or emergency services after having self-harmed. Still, the relationship between self-harm and mental disorder is one of correlation rather than causation: mental disorder does not invariably lead to self-harm and self-harm does not necessarily infer a mental disorder. Indeed, making assumptions as to the reasons for self-harm on the basis of diagnosis alone can result in unhelpful treatments or responses. It is widely assumed, for example, that self-harming individuals who have been diagnosed with a psychotic disorder enact potentially lethal acts of self-harm in response to command voices (Simeon and Favazza 2001, White Kress 2003). Yet, as box 1.3.2 attests, individuals who hear voices and self-harm may do so for many different reasons than those presupposed by diagnostic schemes.

**Box 1.3.2 Self-harm, hearing voices and ‘psychosis’**

- Self-harm which is known to be as a result of voice hearing, either directly or indirectly, can result in fearful responses from service providers. Voice hearing is usually diagnosed as ‘psychosis’ and is deemed as being beyond the persons ‘control’.
- ‘Control’ means different things to different people. Lack of control or lack of capacity shouldn’t be assumed - ask and work with the person.
- Self-harm does not always occur as a result of a direct ‘command’ voice, it can occur in response to the experience of hearing voices as a method of coping.
- For some people, self-harm helps them to manage their voices, just as for others self-harm might help to avert suicidal feelings.
- A person who hears voices and self-harms can hurt themselves for many different reasons, some self-harm might be as result of voices, some self-harm might not. Everyone who self-harms requires dignity, respect and an appreciation of the distress behind the self-harm, including the meanings and functions of it.
- Many of the triggers for voice hearing can be placed in the context of the person’s life, such as through experiencing various forms of trauma or oppression. Prioritizing these should be central to any intervention.
- Harm-minimisation can be used with people deemed to be psychotic.

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The functional approach

The functional approach considers self-harm as an expression of distress with a communicative function, or as a way of coping with distress – a problem-solving function (Claes and Vandereyeken 2007).

In contrast to the structural approach, the functional approach to self-harm illuminates the different functions that an act of self-harm may serve and places self-harm within the context of human experience. The functions of self-harm are multifaceted, and are related to numerous present and past experiences. Some authors, coming from different psychological viewpoints (such as psychodynamic or cognitive-behavioral perspectives), tend to outline and interpret functions according to their own models of human behavior (Claes and Vandereyeken 2007). Others place more emphasis on exploring individuals own interpretation of their self-harm (Harris 2000, McAllister 2001, Spandler 1996). The list shown in box 1.3.3 is drawn from extensive qualitative research and clinical experience with individuals who self-harm (Arnold 1995, Babiker and Arnold 1997). The functional approach to self-harm is highly beneficial in demystifying self-harm and aiding communication between service users and medical professionals. By outlining the self-preserving aspects of self-harm, it is also useful in distinguishing acts of self-harm from suicide attempts.

Box 1.3.3 The multifaceted functions of self-injury

1) Helps with coping and surviving
- Regulates distress and anxiety, and provides a self-soothing or tension-reducing function
- Provides a way of distracting attention away from distress or anxiety and into something more manageable.
- Helps deal with anger and fears over expressing anger publicly (especially over past mistreatment) by physically turning anger onto the self.

2) Helps with self-management
- Increases a sense of autonomy and control over ones life, especially in situations where control may be limited or removed (for example, in prisons or psychiatric inpatient settings)
- Acts as a conscious or subconscious way to return the self from feelings of dissociation or depersonalisation
- Physically expressing mental pain subsequently allows the self to physically care and comfort itself.

3) Helps deal with experience
- Provides testimony to traumatic and distressing past experiences which may have been denied, minimised or ignored – may be evidence of both courage and suffering.
- Conversely, and rarely, the act of self-injury may seek to replicate or re-enact past trauma or abuse.

4) Self-punishment and sacrifice
- Self-injury may act as a testament to self-loathing
- Self-injury may be used in order to rid or cleanse the self of felt contamination or badness, especially in relation to past experiences.

5) Relationships with others
- Self-injury may be used to communicate with others when individuals feel unable to voice directly what they want to say, or are aware that if they speak it will have little effect.
- There is a widely believed and incorrect assumption that self injury is manipulative or undertaken with the intent to punish others. Manipulation or punishing others are rarely direct intentions of self-injury, even if others feel they are being punished. Occasionally individuals may seek to express anger at others through self-injury or may attempt to gain support or help from someone else through self-injury. When this occurs, it is generally the last resort of someone who feels powerless, or feels that they are unable to obtain this help directly.
**Key texts**


1.4 Towards harm-minimisation

Complementing Part One: Section Five (How do services respond to self-harm?) of the DVD, learning activity 1.4.1 seeks to challenge unhelpful responses made to people who self-harm. In part, it is unhelpful responses such as these which have spurred individuals to call for harm minimisation approaches.

Building on this, the resource sheet expands on the topic of self harm minimisation as introduced in Part two: Section One (Approaching harm-minimisation) of the DVD

Practical strategies for the implementation of harm-minimisation approaches are covered in Part Two of these guidelines. As a precursor to these, learning activity 1.4.2. aims to explore the differences between harm-minimisation and harm-cessation approaches.

Learning activity 1.4.1: popular responses given to people who self-harm

**Objective**: to raise awareness of, and challenge, negative attitudes and treatment of people who self-harm

Review the negative comments by professionals on the DVD. Some examples are listed below. (Source: www.rcpsych.ac.uk/cru/auditselfharm.htm)

Either a) divide students into small groups – half of each group will be designated ‘A’ and asked to construct arguments to justify the comments. The other half of the group, designated ‘B’, are asked to find evidence and argument to challenge the comments.

Or, b) ask everyone to get into pairs (A and B). A’s task is to justify the comments and B’s is to challenge them.

Or, c) divide the group into two: one half is A, the other B. A’s task is to justify the comments and B’s is to challenge them.

**Feedback**: review any queries or specific examples of difficulties people had in justifying or challenging the comments.

**Comments**

**To colleagues:**
- “It’s best to ignore someone when they have self-harmed then they are less likely to do it again”
- “Self-harm is failed suicide”

**To service users:**
- “Do this again and we won’t treat you”
- “You’re a pretty girl, you don’t need to do that to yourself”
- “You can’t have psychiatric treatment until you stop it”
- “You’ve got loads of scars so another won’t hurt”
- “You are so manipulative, I am fed up with you - you’re just trying to get attention”
- “If you carry on doing that to yourself I’ll get the blame”
Resource sheet: Towards harm-minimisation

The emergence of self harm minimisation

Self harm minimisation refers to an approach, and a range of techniques, which can be used by professionals and service users to limit the damage that can arise from self-harm. It is based on a philosophy that calls for health professionals to accept that many people will self-harm as a coping mechanism and that medical professionals are well placed to assist them in minimising the risks (see box 1.4.1).

The notion of self harm minimisation emerged out of the self-harm survivor movement during the late 1980s and early 1990s (Cresswell 2005, Spandler and Warner 2007). Through numerous conferences, books and published papers, service user activists sought to politicise self-harm by connecting it with wider experiences of abuse, trauma and oppression, and by publicising the punitive responses they often received from statutory services. Given the evidence supporting their basic premise that self-harm was a survival mechanism, rather than a way of ending life, it wasn’t long before harm-minimisation emerged as an alternative to cessation approaches or treatments.

While some medical professionals were using harm-minimisation strategies during this time - often in conjunction with service users – they were essentially working in a vacuum; unable to share best practice or discuss the ethical issues which surround the approach. It is only in recent years that mainstream policy and practice has taken up what activists had been saying for almost two decades: that punitive responses driven towards the immediate cessation of self-harm didn’t work. Two recent examples of policy changes include the NICE guidelines on self-harm (NICE 2004) (see box 5.2) and the recent RCN guidelines on self-harm and harm minimisation (RCN 2009).

Box 1.4.1 Defining harm minimisation

“Harm-minimisation is about accepting the need to self-harm as a valid method of survival until survival is possible by other means. This does not condone or encourage self-injury but is about facing the reality of maximizing safety in the event of self-harm” (Pembroke 2007: 166).

The underpinning philosophy of self harm minimisation shares some similarities with harm-reduction approaches found in drugs, alcohol and sexual health. In these arenas it has become widely accepted that punitive or prohibitive approaches can actually increase harm by perpetuating stigma and driving self-harming behaviours, such as illicit drug taking, underground (Inciardi and Harrison 2000; Marlatt 1998) In a similar fashion, service users, clinicians and academics have sought to show that punitive or cessation approaches to self-harm can result in similar negative effects.

The problems of harm-cessation

“What unites [...] different approaches [to harm-minimisation] is the belief that stopping people from self-injuring at all costs is counterproductive and can actually increase the harm” (Shaw and Shaw 2007: 31).

“I used everything and anything I could get hold of. If I picked up a tack or pin in my shoe I would take it out and use it. I was put on a stricter level, [...] even then I smuggled a pen in my mouth.’ (Duperouzel and Fish 2007: 62)
The primary goal of harm-cessation is to prevent individuals from self-harming. Direct methods - which may be more apparent in inpatient facilities - include the removal of the means to self-harm (such as blades, breakable items, lighters, toxic liquids etc), and special observations of individuals who are deemed at risk of self-harm. Indirect methods include the restriction of services or therapies to individuals who self-harm; disapproving or condematory responses to self-harm in an attempt to make individuals stop; and the use of no-harm contracts, whereby a service user pledges not to harm themselves (O’Donovan 2007). Direct and indirect forms of harm-cessation have come under critique with regards to their therapeutic limitations, their inability to stop self-harm, and their potentially adverse consequences (Arnold 1995, Babiker and Arnold 1997, Hogg 2001, McMyler 2008, Shaw and Shaw 2007). These critiques can be surmised as follows:

- Harm-cessation encourages a moral or disease model of self-harm – viewing it as bad, wrong or pathological. This facilitates the stigmatisation of individuals who self-harm.
- Punitive responses to self-harm may, unintentionally, increase self-harm related risks amongst service users. For example, individuals may avoid accessing services to treat the physical effects of their self-harm or to address their underlying distress.
- By removing choice and control from service users, harm-cessation can exacerbate feelings of shame and powerlessness. This may, inadvertently, encourage the need to self-harm in order to regain a feeling of control and autonomy.
- Trust and communication between service-users and medical professionals can be undermined. Harm-cessation can turn self-harm into a taboo subject, making it harder for individuals to explore the meanings and functions of their self-harm.
- It is virtually impossible to prevent individuals from self-harming in inpatient facilities. When usual methods of coping are removed, individuals may resort to more drastic methods of self-harm, including suicidal actions.

Self harm minimisation: underpinning values and philosophy

The techniques or ‘doing’ of harm-minimisation should not be divorced from its underpinning values and philosophy. Without these, harm-minimisation will be imparted without the necessary understanding, compassion and staff support (Pembroke 2006b).

- **Pragmatism:** Harm-minimisation draws on a pragmatist approach which seeks to work with self-harming individuals ‘where they’re at’, rather than imposing punitive ideals on them (Marlat 1998). It does not begin by labelling individuals who self-harm as good or bad, right or wrong, or sick or well. Instead it asks, ‘to what extent is self-harm helpful for the individual?’ And, ‘what can be done to reduce the harmful physical consequences of self-harm?’

- **Acceptance:** Harm-minimisation accepts a person’s need to self-harm. It acknowledges that self-harm provides useful and life-preserving functions; these need to be taken into account if it is to be effectively managed. Service delivery must be non-discriminatory, non-judgmental and respectful.

- **Support:** Harm-minimisation does not preclude the exploration of alternative coping mechanisms or the eventual cessation of self-harm. It is not a substitute for psychological, emotional or practical support, and service users should be offered meaningful support for any underlying distress related to their self-harm. This may include access to counselling or talk therapies. Through developing trust and a
therapeutic alliance between service users and professionals, harm-minimisation can be the first step towards eventual cessation of self-harm.

- **Service-user centred**: Harm-minimisation appreciates that service-users are often the best experts when it comes to the functions and meanings of their self-harm. As a non-judgemental approach, harm-minimisation respects the dignity and rights of individuals to have ownership over their bodies, and the right of individuals to refuse or choose treatments for the physical effects or emotional underpinnings of their self-harm. This service-centred approach shares some similarities with the humanist and ‘client-centred’ approach advocated by Carl Rogers (1951), inasmuch as it allows individuals to retain a degree of choice and control over their actions.

- **Law and ethics**: A key principle of harm-minimisation is for medical professionals to ‘do no harm’: staff must always act in accordance with the best interests of service users.
  - **Mental Health Act 2007**: Harm-minimisation has been used with individuals who have been sectioned under the Mental Health Act (and in accordance with care planning). Harm-minimisation will never be compulsorily administered under the Act.
  - **Mental Capacity Act 2005**: All persons who self-harm must be assumed to have capacity unless it is demonstrated otherwise. The techniques of harm-minimisation will not be used with individuals who, at the material time, lack the capacity to make a decision in relation to them and their associated risks.

- **Staff reflection and support** For staff to be non-judgmental and supportive to service users, and to assist in the implementation of harm-minimisation approaches, they need their own training, support networks and service policies. The aims of training should be fourfold: to examine and address negative attitudes towards self-harm; to improve understandings of and responses to self-harm; to acknowledge and address the difficult emotional impact that self-harm often has on staff and carers; and to develop and disseminate self-harm minimisation policies and protocols amongst staff, thus enabling a consistent and supportive approach.

**Harm-minimisation: practical techniques**

“If we are going to harm it is safer to do so with information on basic anatomy, physiology, first aid, wound care, correct usage of dressings and safer ways to harm […] the risk of harming with no information are far greater than the risks of harming with information. If we have no information we have no choices” (Pembroke 2007: 166)

Practical techniques which can accompany the underpinning values of self-harm minimisation include:

- A non-punitive response to self-harm (allowing it to take place in inpatient settings, for example, and in accordance with care planning)
- Verbal or written advice on basic anatomy and physiology (so individuals can avoid cutting arteries and tendons, for example)
- The supply of first-aid information, which includes when an individual should seek medical attention. (An example from the Royal College of Psychiatry can be found here: [www.rcpsych.ac.uk/pdf/Self-harm%20%20%20%20Limiting%20the%20Damage%20Final.pdf])
Providing information on how to recognize and respond to signs of infection
- Providing first-aid supplies, such as steristrips, so that individuals can take care of minor injuries.
- Advice on long term aftercare, such as scar reduction
- Information on the consequences of overdoses
- Discussing the avoidance of alcohol and drugs when feeling the need to self-harm
- Enabling access to clean gear in inpatient settings, and safe disposable of implements
- Flexible, creative and person-centred ideas for the reduction of risks involved in any individual's self-harm. For example, wearing a hat when head-banging or gloves when biting hands; ligaturing without knots and with materials that are easy to cut; setting time limits when punching etc

Box 1.4.2 Harm-minimisation techniques in the NICE guidelines:
- For people presenting for treatment who have a history of self-harm, clinicians may consider offering advice and instructions for the self-management of superficial injuries, including the provision of tissue adhesive. Discussion with a mental health worker may assist in the decision about which service users should be offered this treatment option.
- Where service users are likely to repeat self-injury, clinical staff, service users and carers may wish to discuss harm minimisation issues/techniques. Suitable material is available from many voluntary organisations.
- Where service users are likely to repeat self-injury, clinical staff, service users and carers may wish to discuss appropriate alternative coping strategies. Suitable material is available from many voluntary organisations.
- Where service users have significant scarring from previous self-injury, consideration should be given to providing information about dealing with scar tissue.

From NICE (2004)
Key texts: healthcare staff’s attitudes towards self-harm


Key texts: self harm minimisation


Part One: Conclusions

Learning activity 1.5.1 towards good practice: frequently asked questions

Objectives:
- To provide an opportunity for students to address some of the questions and anxieties which may have come up for them from Part One of the DVD.
- To encourage students to explore best practice guidelines which surround self-harm (these are covered further in Part Two of the DVD and guidelines)

Give out the list of questions below and ask students to work in small groups discussing their immediate responses. Specific guideline responses for answers may be found in Appendix 3 so students can check these themselves. Leave time for students to add questions if they wish.

A quicker way of covering the ground would be to divide students into small groups and give each group two or three of the questions to discuss and then feedback their answers to main group.

- How should people who self-harm be treated?
- Are people who self-harm different from other patients?
- How do I know if someone who self-harms isn’t trying to kill themselves?
- What do I do if someone has self-injured but referral to A&E is not necessary?
- How should I assess someone who has self-injured or self-harmed? (e.g. needs and risks)
- What if a patient refuses a psychosocial assessment?
- When should I refer to a specialist mental health professional?
- To what extent should service users be involved in the treatment of their self-harm?
Appendix 1

Self-harm awareness quiz - how much do you know?

1) What is the average age at which people start to self-harm?  a) 18 years  b) 30 years  c) 12 years

2) What proportion of young people self-harm, according to the National Inquiry?  a) 1 in 40  b) 1 in 15  c) 1 in 12?

3) Self-harm is the single most common reason for admission to general hospital for men and women. True or false?

4) How many times more likely are women to self-harm than men?  a) 10 times  b) 3 times  c) about the same

5) Young Asian women are more likely to self-harm than other young women in the UK. True or False?

6) Other than young Asian women, name three groups with a higher than average prevalence of self-harm.

7) What proportion of people who self-harm will go on to commit suicide?  a) 10%  b) 23%  c) under 1%

8) The country which has the highest rate of self-harm in Europe is  a) Sweden  b) UK  c) Spain
Quiz Answers


1. 12 years is the average age: self-harm most frequently starts in early adolescence.

2. Between 1 in 12 and 1 in 15 (6.5% to 8%) of young people self-harm (Camelot Foundation and Mental Health Foundation 2006). A recent survey found that a total of 22% of young people aged between 11 and 19 years disclosed having self-harmed.

3. True and False: self-injury is the single most common reason for admission to general hospital for women and the second most common reason for admission to general hospital for men.

4. In general, women are 3 – 4 times more likely to harm themselves than men. Research commissioned by the Samaritans states that ‘Young women are four times more likely to self-harm than young men’.

5. Young Asian women are 2 – 3 times more likely to self-harm than other young women. See below for further information on high risk groups of young women.

6. Prisoners: 30% of females in custody harmed themselves compared to 6% males.

   LGBT: 33.3% of lesbian, gay, bisexual and transgendered individuals report having self-harmed.

   Asylum seekers; higher rates have been recorded in detention centres as well as in the community (eg. Woodward [2006 ‘Tories call for a detention centre inquiry’, The Guardian 21.08.06]).

Learning Disability: Self-injury occurs in 17% of adults with a learning disability (Collacott et al 1998).

Homeless: 20% of young homeless people had self-harmed within the last year.

Looked After Children: 61% of respondents reported at least one known incident of self-injury in the last three months.

Young people (18-20) who were unemployed were 6-7 times more likely to be currently self-harming than those who were in work or full-time education.

7. Only 0.7% of people who are seen in hospital for self-harm, with or without suicidal intent, will die by suicide within a year of that self-harm. This figure increases to 2.4% after ten years.

8. The UK has the highest rate of self-harm (Camelot Foundation and Mental Health Foundation 2006) with an estimated rate of between 1-4% in the adult population (Nock 2009)
The Self-Nurturing/Self-Harming Spectrum

Below is a list of activities. Next to each is an arrow: it represents a spectrum that has self-nurturing (looking after yourself) at one end; and self-harming (doing things that are harmful to yourself) at the other. Mark on the arrow where you think you fall in relation to each activity.

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<tr>
<th>Self-nurturing</th>
<th>Self-Harming</th>
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<tbody>
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Appendix 3

Frequently asked questions: good practice for medical professionals

1. How should people who self harm be treated? Are people who self harm different from other patients?

“People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.” (NICE 2004)

“Staff should not behave in a punitive, threatening, dismissive or judgmental manner towards people who self-harm” (RCP Better services)

When treating patients who have self harmed “acknowledge that there is a need to overcome any prejudicial beliefs” and “recognise the need of the patient to receive appropriate treatment by acknowledging their views and offering dignity and respect” (NICE 2004)

“Good attitude is about acceptance, respect, belief, holding hope, working with someone at their own pace to define their own frame of reference, meanings, functions and goals with recognition of the person’s own expertise”. (Pembroke 2008)

2. How do I know if someone who self harms isn’t trying to kill themselves?

“Most people who self-harm do not want to kill themselves.” (RCP leaflet on self harm 2006)

“Self harm and suicide are different. Self harm is about surviving or transcending distress or life circumstances by ‘putting the pain on the outside’, making it physical and therefore bearable. Suicide is about termination of life.” (Pembroke 2008)

“Always ask the service user to explain in their own words why they have self-harmed. Remember, when people self-harm often, the reason for each act may be different on each occasion; don’t assume it’s done for the same reasons.” (NICE 2004)

3. What do I do if someone has self injured but referral to A&E is not necessary?

“If urgent referral to an emergency department is not considered necessary for people who have self-injured in primary care, a risk and needs assessment should be undertaken to assess the case for urgent referral to secondary mental health services.” (NICE 2004)

4. How should I assess someone who has self-injured/self-harmed?

General clinical competencies, for all doctors when presented with self harm, include: simple psychosocial and mental state assessment to detect mental illness, alcohol and drug problems or social crisis; detection of immediate suicide risk and judgement when further specialist assessment is appropriate (NICE 2004)

“Assessment of the service user’s needs should be comprehensive and should include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current intent and hopelessness, as well as a full mental health and social needs assessment.” (NICE 2004)

“The main components of assessment of need after self-harm include:
• Social situation (including current living arrangements, work and debt)
• Personal relationships (including recent breakdown of a significant relationship)
• Recent life events and current difficulties
• Psychiatric history and mental state examination, including any history of previous self-harm and alcohol or drug use
• Enduring psychological characteristics that are known to be associated with self harm
• Motivation for the act." (NICE 2004)

“All hospital attendance following self-harm should lead to a specialist psychosocial assessment. This should aim to identify motives for the act and associated problems that might be amenable to intervention, such as psychological or social problems, mental disorder and alcohol or substance misuse” (NICE 2004)

5. What if a patient refuses a psychosocial assessment?

“People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.” (NICE 2004)

6. When should I refer to a specialist mental health professional?

“[T]he decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment and should not be determined solely on the basis of having self-harmed.” (NICE 2004)

“a comprehensive needs assessment should be undertaken, including psychiatric, psychological and social needs, as well as an assessment of the motivation behind the act of self-harm. Referral to psychiatric services should be based upon the assessment of risk and needs” (NICE 2004)

Primary care: “When physical injuries are dealt with in a primary care setting, there may still be a need to consider referral to secondary care for further assessment and treatment of psychological needs.” (NICE 2004)

“Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed.” (NICE 2004)

7. To what extent should service users be involved in the treatment of their self-harm?

“Healthcare professionals should involve people who self-harm in all discussions and decision-making about their treatment and subsequent care” (Healthcare Commission standards for better health 2004 C17)

“Clinicians should ensure that service users who have self-harmed are fully informed about all the service and treatment options available, including the likely benefits and disadvantages, in a spirit of collaboration, before treatments are offered. The provision of relevant written material with time to talk over preferences should also be provided for all service users.” (NICE 2004)
“Staff should consider carefully the content of any crisis card or advance directive when deciding when and how to intervene” (NICE 2004)

“When assessing people who self-harm, healthcare professionals should ask service users to explain their feelings and understanding of their own self harm in their own words”. (NICE 2004)

8. Does the severity of self-harm correlate with the intent?

“It should be remembered that severity or seeming triviality of the physical aspects of an episode of self-harm do not necessarily correlate with the degree of psychological problem or hurt.” (NICE 2004)

“The severity of the harm is not necessarily an indicator of the underlying distress. It doesn’t follow that what might appear to you to be superficial denotes less distress than someone who needs surgery or the liver unit”. (Pembroke 2008)

9. Does self-harm always require intervention from mental health services?

“All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.” (NICE 2004)

10. What support do I need if I work with people who self harm?

“Providing treatment and care for people who have self-harmed is emotionally demanding and requires a high level of communication skills and support. All staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood.” (NICE 2004)

Sources

Royal College of Psychiatry (2006) Better Services for People who Self-Harm
Part Two: Approaching self harm minimisation

Part Two of the DVD concentrates on the development of self harm minimisation strategies in a range of settings. These include: Accident and Emergency (A&E), a General Practitioner’s (GP) Surgery, an acute psychiatric ward and a medium secure forensic unit for people with learning disabilities. In the final section of the DVD a lawyer discusses some of the legal and ethical implications of implementing self harm minimisation approaches, with a focus on psychiatric in-patient settings.

Learning activities provide practical opportunities for students to apply the knowledge gained in Part One to different clinical settings. Activities include role play for effective communication with service users, and the development of effective care plans in inpatient settings.

Part Two: objectives

- To critically review the strengths and limitations of the NICE (2004) best practice guidelines on self-harm.
- To consider best practice when implementing harm minimisation approaches and techniques in numerous settings.
- To practice effective communication skills when working with individuals who have self-harmed.
- To identify the elements of an effective care plan in an inpatient setting
2.1 Accident and Emergency (A&E)

Introduction

This section complements Part 2: Section 2 (Approaching harm minimisation: Accident and Emergency) of the DVD. It focuses on best practice guidelines for the immediate assessment and treatment of individuals who have self-harmed. It also considers what best practice means for service users and how best practice might be implemented in a busy and time pressured environment, such as A&E. A&E departments are an important focus because they are the main, sometimes only, route through which individuals who self-harm will come into contact with statutory services. Furthermore, research suggests that poor treatment and negative experiences in A&E may increase risks of future harm, including suicide, and decrease the willingness to seek emergency help again (Broadhurst and Gill 2007).

Unlike other services which are showcased in Part Two of the DVD, St James’s Accident and Emergency Department in Leeds does not have a harm minimisation policy. Still, St James’s provides an example of good emergency services for individuals who have self-harmed. In this respect it supports a broad definition of harm minimisation, understood as a non-judgmental, non-discriminatory and needs-led approach to individuals who self-harm. This broad approach may, in and of itself, reduce the risks associated with self-harm.

Learning activity 2.1.1
Objectives: to identify the rationale for good emergency services for people who self-harm in St James’s Emergency Department

1. Ask participants to watch DVD Part 2 A & E section and identify the main elements of the St James’s strategy. Suggested questions for viewing:
   - What problems did A & E staff identify?
   - How are service users treated?
   - What changes have been made in the way staff teams work together?
   - What resources have been developed to support the strategy?

2. In pairs ask them to check their responses and agree two main aspects for feedback

3. Feedback in main group
2.2 Resource sheet: Best practice guidelines for Accident and Emergency departments

The National Institute of Clinical Excellence (NICE) is the body responsible for setting national standards in clinical practice. In 2004, NICE produced guidelines concerning the immediate aftercare of individuals who have self-harmed and present to primary care or emergency services. In the same year, The Royal College of Psychiatrists published their own guidelines on the assessment and treatment of individuals who have self-harmed (RCP 2004). While parts of these documents are informed by legal requirements, they are not legal guides. Instead they seek to draw on the current evidence base, along with the expertise of a guideline development group, to assist in outlining best practice guidance for assessing and treating individuals who have self-harmed.

It is expected that patients will pass through three stages in A&E departments (Broadhurst and Gill 2007). Treatment in each of the stages should be underpinned by principles (Box 2.1.1). These have largely been developed in response to the wealth of evidence of negative attitudes and unfair treatment of individuals who have self-harmed.

<table>
<thead>
<tr>
<th>Box 2.1.1 General principles for all health professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Staff should not behave in a punitive, threatening, dismissive or judgmental manner towards people who self-harm</td>
</tr>
<tr>
<td>-People who have self-harmed should be treated with the same care, respect, autonomy and privacy as any patient</td>
</tr>
<tr>
<td>-Healthcare providers should take full account of the likely distress associated with self-harm</td>
</tr>
<tr>
<td>-When assessing people who self-harm, health care professionals should ask service users to explain their feelings and understanding of their own self-harm in their own words</td>
</tr>
<tr>
<td>-Healthcare professionals should be aware that the individuals reasons for self-harming may be different on each occasion and therefore each episode needs to be treated in its own right</td>
</tr>
<tr>
<td>-Healthcare professionals should involve people who self-harm in all discussions and decision-making about their treatment and subsequent care. To do this, staff should provide the person with full information about the different treatment options available</td>
</tr>
<tr>
<td>-People who self-harm should be given the choice of having a friend, relative or advocate present during assessment and treatment</td>
</tr>
</tbody>
</table>

Taken from NICE (2004) and RCP (2006)

The first stage

The three-stage process begins with a provisional assessment, known as triage, usually undertaken by a nurse. Historically, this has been limited to assessing physical risks but emergency departments are increasingly incorporating combined physical and mental health
triage scales when deciding the priority for treatment. This is to ensure that patients who have self-harmed but do not have life threatening injuries are not left waiting unnecessarily for treatment. A preliminary psychosocial assessment should also be offered at triage to determine:

- the person’s mental capacity
- their willingness to remain for further psychosocial assessment
- their level of distress.
- the possible presence of mental illness.

If, after being assessed, the patient has to wait for treatment then they should be allowed to wait in an environment that is safe and supportive, such as a quiet room. Here the service user should receive regular contact with a named member of staff (NICE 2004).

The second stage

The second stage incorporates treatment for the physical effects of self harm. Like any other patient, individuals who have self-harmed should be offered the same quality of care and range of physical treatments. Consent must also be gained for every treatment or procedure (NICE 2004).

Special conditions apply for patients who are deemed mentally incapable due to, for example, the effects of alcohol or drugs. This may mean that staff will intervene under common law to treat the patient, if it is in the patient’s best interests to do so. It is rare that a patient would be treated for the physical effects of self-harm under the Mental Health Act 2007. A patient can only be treated compulsorily for the physical effects of self-harm if they satisfy the criteria of the Act, and if the self-harm is considered a symptom of mental disorder (NICE 2004).
The third stage

A psychosocial assessment, performed by a member of a specialist mental health team, should be offered to all individuals who have self-harmed. Evidence suggests, however, that many who self-injure (as opposed to self-poison) do not receive a psychosocial assessment, particularly if they have repeatedly accessed A&E for treatment (Lilley et al 2008).

The psychosocial assessment is split into two interrelated parts: a risk assessment and a needs assessment. The risk assessment focuses on the risk of future self-harm or suicide, and the needs assessment on psychosocial factors which may assist in understanding the motivations for self-harm, along with its future management. Many welcome the turn towards needs-led assessments as risk assessments are known to be inexact and with uncertain outcomes (Kapur 2005, Undril 2007).

Psychosocial assessments are not compulsory for individuals: if an individual refuses a psychosocial assessment then they must still be treated for the physical effects of their self-harm and with the same respect given to any other patient (NICE 2004). The psychosocial assessment may take place before, but most likely after, treatment for the physical effects of self-harm.

As self-harm is not, in and of itself a diagnosable mental disorder, referral to mental health services may not always be appropriate. As a minimum duty of care, notes will be passed to a patient’s GP who may then look further into the possibility of therapies or support groups for the individual (NICE 2004).
What best practice means for individuals who self-harm: recommendations from service users

When good care makes a difference.

Louise Pembroke writes:

I had a bad cut, I'd removed skin and knew it was going to need grafting. I covered the wound in cling film because I knew it wouldn't adhere, then bandaged it. The sister at triage actually complimented me on thinking to use the cling film which made me sit up - this person found one positive thing about me in awful circumstances. Another nurse offered to listen to me but said it was ok if I didn't feel able to talk. Because she didn't pressure me, was open, calm and conveyed a sense of care (but without pity) I talked to her a bit. I talked to her about a physical problem that was really bothering me but totally unrelated to my self-harm. She stopped and listened and gave me the reassurance I needed. She then offered me some tea and made sure I was warm. This meant a lot to me that she had taken this much care and I felt much calmer as a result before having surgery. Her care of me also made me want to look after myself after leaving the hospital. She had bothered to - so would I. I recovered much more quickly as a result, I bothered to get some decent food in to aid healing and to look at what I could do to address what was happening in my life. This is what A&E staff don't see, when good care makes a difference.

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The NICE guidelines, as outlined above, have come under critique for not delineating between self-harm and attempted suicide (Barker and Buchanan-Barker 2004), and for sidelining service-user evidence about ‘what works’ in practice (Pembroke 2005, Spandler and Warner 2007). The guidelines also largely bypass the need for staff training, reflection and support in order to improve attitudes towards self-harm. It has been argued that, without this training, the underpinning principles are limited in practice (Pembroke 2006b).

One of the main issues for frontline staff concerns the strains of working in a time pressured environment where saving lives through physical interventions is prioritised over the long term benefits of communicating effectively with patients. A&E doctors and nurses often feel helpless in their ability to understand and address the underlying emotional reasons why someone may have self-harmed (Hadfield et al 2009). Yet, service users indicate that simple communication skills, which are typically used in A&E - such as when talking with any distressed patient or relative - can assist in generating better short and long term outcomes for them.

Doctors in Part One of the DVD give examples of comments and questions which service users report finding helpful. Further examples of these can be found in Appendix 4.
mnemonic CHECKED listed below, developed by the Royal College of Psychiatry, will also help participants recall a strategy for good communications.

<table>
<thead>
<tr>
<th>CHECKED</th>
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<tbody>
<tr>
<td><strong>Company</strong> – would they like you to phone a friend?</td>
</tr>
<tr>
<td><strong>Help</strong> – can you do anything to help them feel safe?</td>
</tr>
<tr>
<td><strong>Environment</strong> – is it quiet, calm and safe from danger?</td>
</tr>
<tr>
<td><strong>Cultural or individual needs</strong></td>
</tr>
<tr>
<td><strong>Keep updating and checking</strong></td>
</tr>
<tr>
<td><strong>Explain everything. Ask for consent and their views.</strong></td>
</tr>
<tr>
<td><strong>Don’t discriminate – treat all patients with equal dignity and respect</strong></td>
</tr>
</tbody>
</table>

Source: [http://www.rcpsych.ac.uk/pdf/CHECKED%20JULY%202007.pdf](http://www.rcpsych.ac.uk/pdf/CHECKED%20JULY%202007.pdf)
Learning activity 2.1.2 Prioritising harm-minimisation techniques

Objective:
- to identify and compare appropriate harm-minimisation techniques and the rationale for each
- to practice negotiation skills

Resources: Case studies (below); information on harm minimisation techniques (see Resource Sheet: Towards harm-minimisation in Part 1.4); note paper

Method One – working with harm-minimisation techniques

- Divide participants into groups and give each group a copy of the case studies. If there are more than three groups, that's fine, as there will be more than one set of feedback notes for each case study. This useful for comparative purposes.
- Ask each group to read and discuss each case study in turn. They should consider the possible harm-minimisation techniques which could be used and give a rationale. They should also discuss the possible risks and how they will go about negotiating the care plan with the service user. Finally, they should consider other factors which may need to be taken into account as part of a broader strategy (for example, follow up by a GP or further input from specialist mental health services).
- They should give feedback after each case study, rather than all together (to avoid confusion).

Method Two – writing and sharing responses

- Ask participants to work in small groups of five or six and give everyone small pieces of note paper and a copy of scenario one, Ibrahim’s story.
- Ask each person to read Ibrahim’s story and write down three possible harm minimisation techniques which could be used on three pieces of note paper. Ask them to fold these (so the writing cannot be read) and mix them up on a table.
- Each group should then take several folded notes and discuss the strengths and weaknesses of each suggestion. They should then come to an agreement about which ones they would prioritise (they could be asked to choose three or four)
- Groups are then asked to consider possible risks, how they will go about negotiating the care plan with the service user and the broader strategy and follow up (for example, contact with GP or further input from specialist mental health services).
- Each group gives feedback on its choices, rationale and the process of selection; compare differences and similarities in their responses.
- Repeat the process with the other scenarios if more discussion is needed.

Method Two – alternative

- Ask participants to work in small groups of five or six and give everyone pieces of note paper. Give each group a different scenario and ask them to prioritise three or four harm-minimisation techniques for the individual in the scenario. Continue from point four above – the difference will be that in feedback you will have three different scenarios to compare.
Case studies: prioritising harm-minimisation techniques

Scenario One: Ibrahim's story

Ibrahim has superficial injuries to his left forearm, after cutting himself with a razor blade. While this is his first visit to A&E, during his psychosocial assessment he says he frequently self-harms to cope with the pressure and stress that he sometimes feels; it makes him feel better and more in control. He indicates that he has been feeling increasingly depressed recently, and that his usual method of coping isn't working. He is not in contact with mental health services and hasn't been to his GP about his self-harm or his feelings of hopelessness and depression.

Scenario Two: Patricia's story

Patricia has a long history of self-harm, she has been diagnosed with a psychotic disorder and currently sees a psychiatrist once a month. She hears voices and self-harms as a way to distract from the distress the voices sometimes cause her. In her most recent episode she was aware that she had seriously injured her arm and it would probably require surgery - hence her visit to A&E. She was calm on arrival and has capacity. She refused a psychosocial assessment on the grounds that it would mean 'just going through the motions' and she already has a good psychiatrist. You are the doctor (or nurse) attending to her on the surgical ward after successful surgery.

Scenario Three: James's story

James has overdosed on 14 paracetamol tablets. He was brought to A&E by a friend and he was intoxicated on arrival. He is now waiting to be discharged after being observed overnight and receiving his psychosocial assessment the following morning. He is currently taking anti-depressant medication, prescribed by his GP, for mild depression. During the psychosocial assessment he says he got really drunk and took the tablets because he has been feeling a bit down lately. He admits this is not the first time he has taken 'too many tablets' but it is the first time he has come to A&E. He now wishes he hadn't taken them and thinks that he probably needs some more support.
Learning Activity 2.1.3
Accident & Emergency: Tom’s story

Objectives:

• To analyse the issues in Tom’s story and explore the perspectives of all involved
• To find ways of working effectively with Tom (including harm-minimisation)
• To practice communication and interviewing skills, including improving working relationships between staff

This learning activity is based on Tom’s story, a case study derived from the experiences of service users and professionals at a workshop held early in the Cutting the Risk project (all names fictional). Different activities are suggested for working on Tom’s story. It is helpful to choose a lead character and this may depend on the group of participants (for example, if it is medical students, focus on Doctor Philips).

1. **Understanding the scenario**: What are the main issues? It may be useful to refer to the processes of problem based learning found on pages 15-16.

2. **Changing practice - role plays**

   • Guidelines for preparing supporting and participants for role play are in the Introduction (see page 22). Start by ‘hot seating’ (page 22) the different characters in the story to deepen understanding.
   
   • **Mini role plays** between two people can be used to start the process (e.g. Tom and Dr Phillips, Shani and Dr Phillips, Janine and Tom).
   
   • **Fishbowl team role play**: instructions for this form of learning are in the Introduction (see page 25). The team here would be Dr Phillips, a nurse and Tom. The task would be for them to try and improve communications with a view to implementing harm-minimisation.
   
   • **Full role play**: ask participants to work in small groups of six for the full role play (Tom, Dr Phillips, Shani, Janine and Tom’s friend and one observer). Participants can take turns playing the different characters of Dr Phillips, Tom, Shani, Janine and Tom’s friend. There are examples of suggested ‘good practice’ questions in Appendix 4 which participants will find useful in developing constructive dialogue and interviewing skills.
**Tom's story**

Tom arrives in A&E with his arm in a dirty, blood stained bandage. He is accompanied by another young man and both seem to be a bit the worse for wear, probably from drink. Tom is a young man in his late teens with a history of self-harm and is already known to A&E staff as he has attended A&E three times before. He mumbles to the triage nurse, Janine, that he has hurt his arm. Janine and another nurse, Shani, raise their eyebrows and mouth ‘not again’. Janine quickly takes his details and tells him to sit down and he will be called. He sits slumped in a corner hiding his arm with his jacket. Once his friend goes to ask what is happening but is told to wait. Other patients come and go but after four hours he has not been called.

Eventually Shani calls Tom’s name and he is shown into a side room where she checks his details with some difficulty as he mumbles angrily. She shakes her head and says she can’t believe he is here so soon after the last time, then leaves him to wait until she returns with the duty doctor, Dr. Phillips. Dr Phillips nods to Tom then goes through Tom’s details with Shani. This exchange goes on behind Tom, who is not included in the discussion and is by now muttering quite angrily.

Dr Phillips examines Tom’s arm. He ‘tuts’ at the wounds, asks Tom why he has done this to himself and suggests he must be stupid for wounding himself so severely. He does not wait for an answer and Tom just looks at the floor. Dr Phillips administers anaesthetic and Shani, who is watching, tentatively starts to ask Dr Phillips if he is sure he has given enough. She is silenced by a look. Dr Phillips leaves, telling Tom that he shouldn’t do this again and he is wasting valuable time which could be better spent on more deserving patients. Shani then again says to Tom that she thinks he has been quite silly but she is sure he will be OK. She asks him to wait, saying she will be back. Tom says nothing but when she goes he goes to find his friend and they leave without telling anyone.

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Note: This case study was generated at a workshop of service users and professionals held early in the Cutting the Risk project.
**Key texts**


### Learning activity 2.2.1 Working with young people

**Objective:**
- to understand some of the issues facing young people who self-harm

**Resources:** DVD Part 2 Section 3 and Guidelines Part 1.2 ‘Who self-harms’.

One of the key principles which underpin work with young people who self-harm is that the approach should be young person centred. Apart from more formal one to one relationships such as relationships with family GPs, there are other informal self help support groups which young people often find more acceptable.

> “Because self-harm is associated with abuse, oppression, discrimination and attendant feelings of powerlessness and alienation, it is unsurprising that self-harm is particularly common in marginalised groups of young people. These include young people from black and minoritised ethnic communities, lesbian, gay, bisexual or transgendered young people and young people with disabilities” (Spandler & Warner 2007 p.xv)

**Method**

View the DVD section Part 2, Section 3 (General Practice) in which Dr Logan talks about her experiences of working with young people who self-injure.

**Discussion:**
- Why might young people find it hard to take advantage of the resources a GP has to offer?
- What strategies does Dr Logan use to encourage young people to come and see her?
Learning activity 2.2.2  Sita’s story

Objectives:

- to practice interviewing skills in a General Practice setting
- to find ways of ensuring that Sita receives the appropriate response.

Resources: Appendix 4 script for Sita’s story ; Appendix 5 Good practice in communication skills – knowing what to say

Method

Ask participants to work in pairs and read the script out loud, each taking one of the parts to get a sense of the scenario.

Use any of the preparatory methods in the Introduction e.g. ‘hot seating’ the GP and Sita would be useful to deepen understanding of the characters.

The script is intended as a trigger for the improvised role play. A freeze role play may be appropriate for this role play and will also involve several of the participants (see Introduction page 23)

Key texts and resources


Appendix 4

Sita's story

Extract reproduced from an original script with kind permission from Brian Oliver, Utopia Arts
This drama is scripted from stories told by service users and professionals at a workshop held early in the Cutting the Risk project. Sita (not her real name) is a young Asian woman who is visiting the Doctor, not her regular GP, for some sleeping tablets. The Doctor has noticed that she has a bandage around her wrist and has made a comment about it. He has seen her notes and knows that she has self-harmed in the past, although this took place a couple of years before. Sita says she burnt herself. The following is an extract from the drama.

Doctor: Would you say that you are depressed at the moment?
Sita: No
Doctor: Have you been feeling suicidal?
Sita: No
Doctor: Would you say that it's more of a cry for help?
Sita: No

Doctor pauses and looks questioningly at her. So why do you do it?

Sita: I... I do it... so that I can feel better.
Doctor: Feel better? (sighing) Yes, I see. But wouldn't it be better if you could find a way to stop abusing your body altogether?

Sita looks away, embarrassed and annoyed.

Doctor: For people with your disorder it would be a bit like a smoker giving up cigarettes. Difficult at first, admittedly, but once you've broken the addiction you'll feel a whole lot better.

Sita looks even more uncomfortable.

Doctor: Are you eating properly? Plenty of curries and things?
Sita: (taken aback) I eat lots of different things.
Doctor: Are you on any medication at the moment? Lithium? Sulpiride?
Sita: No.

Doctor: When was the last time you saw a psychiatrist?
Sita: I... I haven't.

Doctor: Well, don't you think it's about time you gave it a go? We can arrange for you to see someone.
Sita: I'm not mad.

Doctor: You don't want to spend the rest of your life harming yourself, do you? I mean, what would your husband or boyfriend think?

Sita, who has a female partner raises her eyebrows at this assumption

Doctor: We don't want it to spiral out of control, do we?
Sita: No.

Doctor: So, I'll make a referral to see a psychiatrist, shall I?
Sita: No.
Doctor: You do want to get better, don’t you?
Sita: I’m not sleeping.

Doctor: You have insomnia, as well do you?
Sita: Night time is always difficult for me.

Doctor: In what way?
Sita: When I do manage to get a few hours sleep, I... I have nightmares.
Doctor: What kind of nightmares?
Sita: Nightmares about... the past.

Doctor (looks at watch and laughs) - Yes, well, I have lots of nightmares about the past.
Sita: If I could have a prescription. For some sleeping tablets. That would help.
Doctor: I really can’t take the risk.

Sita: Risk?
Doctor: Given your medical history... If anything happened... Hmm? You see what I’m saying?

*Doctor gives Sita a knowing look, shrugs and leans back in his chair.*

Sita: (angry) I’m not suicidal!
Doctor: Okay, come on now, let’s calm down, shall we?

Sita: I am.

Doctor: Good. Okay. Okay, fine, good... Now, I think the best course of action is if you talk to Karen in Reception.

Sita: (deflated) Karen?
Doctor: She’ll be able to fix you up with an appointment to see your regular GP next week.

*Doctor starts to type notes into computer. Sita stands up to leave*
Appendix 5

Good practice in communication skills - Knowing what to say

Staff may not be sure what to say when faced with someone who has self-harmed or they may feel that ‘they have seen it all before’. The following is advice taken from two sources: an audit, undertaken for the Cutting the Risk project of what service users say they find helpful when using the NHS; and The Royal College of Psychiatrists Change Interventions and Training Materials for Staff and Service Users.

[www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement/self-harmproject/changeinterventions.aspx].

**Advice from service-users**

1. Often there are reasons why people self harm. My immediate priority is to treat your injuries, but then we can explore what might help you.

2. Is there anything I can do to help you feel safer?

3. Hello, my name is ..................Can I check yours? How are you feeling?

4. Is there anyone we can call for you?

5. Would you like to sit somewhere more comfortable/private?

6. Would you like a drink of water?

7. Let me explain what will happen

8. Is there anything you would like to ask me?

9. Do you want to talk about your self-harm?

10. Often it can be scary to talk about self-harm but I am here if you want to talk

11. What do you feel you need?

12. This must be a difficult time for you

13. Would you like me to sit with you?

14. I’d like to try and understand your self-harm

15. Would you like some pain relief whilst you wait for treatment?

16. Would you like a friend, relative or advocate present during your treatment?

17. I’ll explain the treatment options and you can let me know what you’d prefer

18. What has helped you in the past?
• Show respect and warmth – let the person know that they matter
• Acknowledge their emotional distress – and take this into account
• Check if the person has any specific needs (e.g. cultural, gender or disability needs)
• Ask if they would like anyone with them
• If possible, offer some privacy whilst waiting
• Keep the person updated during their stay – don’t let them become isolated and afraid
• Check if there is anything you can do to make them feel more safe
• Offer pain relief (whilst waiting if needed, and during painful treatment, unless there is a medical reason not to)
• Provide adequate dressing whilst waiting for treatment
• Explain what you are doing and why – checking for consent and offering choice
• Don’t make assumptions about why the person self-harmed – let people say in their own words
• Avoid asking questions about self-harm in public areas, like the reception desk or waiting room
• Don’t use language such as “self-harmers”, “repeaters etc” – this de-personalises the individual
• Don’t use relatives or friends as interpreters. The person may have not have disclosed the real reason for the visit.
• Don’t assume that the person will want to be seen by someone from the same ethnic background – this might be their worst nightmare, for fear of the community grapevine
**Part 2: Section 3: An acute psychiatric ward and a medium secure forensic unit for people with learning disabilities**

I said I felt in Pain

I said I felt in pain.
I didn’t say
you could lock me up for feeling.

I said I felt like death.
I didn’t say
you could lock me up for trying.

and no, you don’t agree with me
and yes, I make a fuss

But no, you’re not the oracle
and no, you are not god.

and Yes, this is my body
and Yes, this is my mind

and Yes I’m gonna Shout Out Loud
and Not apologise.

I’ll stand on these two feet of mine
and stretch with these two arms
and sing with these here lungs of mine
and dream with this here heart.

You cannot take my thoughts from me
you cannot take my soul
you thought you owned my body
You cannot take my thoughts from me
you cannot take my soul
you thought you owned my body

But you Never,
Ever will.

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**Introduction**

This section draws on part 2 of the DVD. The focus is on individual and in patient facilities and individuals under the Care Programme Approach (CPA). The first setting is an acute psychiatric ward and the second, a medium secure unit for people with learning disabilities. These are featured in Part 2, Section 4 and Part 2, Section 5 of the DVD.

This section is prefaced by a poem by Kaety Moore’s in which she struggles to retain her sense of self and power over her body in an institutional setting. In the DVD, service users
share their experiences of harm prevention approaches and hear how staff came to introduce a harm-minimisation perspective. Helen Duperouzel and her colleagues reflect on how the research which they carried out on self-harm (Duperouzel and Fish 2007, 2009; Fish, 2007) enabled them to really listen to service user and staff perspectives. This led them to realize the necessity for harm minimization approaches and guidance (see stats below). Chris Holley and her colleagues are currently part of a pilot project on safer self injury (see appendix 7), the key features of which address patients needs through effective care plans and a consistent harm minimisation strategy appropriate to the setting in which they worked. They emphasise the importance of multi disciplinary team work in the context of national guidelines and frameworks.

Lecturers introducing participants to the Care programme approach will find it helpful to refer to the following websites for general guidance and further case study materials.

http://www.cpaa.org.uk/thecareprogrammeapproach
http://www.lincoln.ac.uk/ccawi/CPA.htm

There are three main learning activities in this section.

There are three main learning activities in this section.

1. A guided overview with questions for Part 2 Sections 4 and Part 2, Section 5 of the DVD.
2. Two opportunities to develop effective care plans, for individuals in inpatient settings, informed by personal testimonies from service users
3. Opportunities for participants to reflect on any changes in attitudes, beliefs and practices with regard to self harm minimization
Staff responses to changing practices

Health professionals who intend to move towards harm-minimisation approaches often face a huge shift in their practices and attitudes. Whilst a majority of staff feel positive about a move towards harm-minimisation (Duperouzel and Fish 2009), they also report feeling conflicted about the implications of moving away from a conventional harm cessation or prevention approach. One of the reasons for this is that, “Self injurious behaviour is almost always described in terms of extreme danger, and the drama is used as a rationale for extreme methods of control... just as people’s self injury can become chronic, so too can our impulsive and impoverished responses to it” (Lovett 1996, cited in Duperouzel and Fish, 2007: 59).

The drive to ‘no self-harm’ policies is deeply embedded in in-patient facilities. As Shaw and Shaw (2007) argue: “The approach taken by the hospitals where Clare (see case study below) was treated is typical of dominant practice around self-injury, which is aimed at stopping people from self-injuring whilst they are in hospital. Most services understand themselves as being under obligation to stop their patients from self-harming as reflected in the Mental Health Act (1983) Code of Practice in relation to ‘patients at risk of self-injury’ – that ‘Patients must be protected from harm when the drive to self-injure is the result of a mental disorder’ (DOH and Welsh OFFcie, 1999, 18.30). In many in-patient facilities, attempts are made to enforce harm-cessation by keeping people away from items that could be used for self-injury: For example, rooms may be stripped and service users deprived of personal belongings (O’Donovan, 2007). Still, as outlined in Part 1.4 (towards harm-minimisation) of these guidelines, there is a growing body of opinion that the emphasis on stopping self-harm does not work. In Part 2, Section 5 of the DVD, Paul and Zoe, (service users at Calderstones medium secure unit), talk about how their self-harm escalated under harm-cessation approaches as they became obsessed with finding implements with which to self-harm. “In practice, it appears to be impossible to prevent someone from self-injuring regardless of what restrictions are put in place. Furthermore, as the self-injury takes place in a very ‘out of control’ manner because of the methods used and because of the need for secrecy and urgency, it follows then that the injuries that result are potentially more damaging” (Shaw and Shaw, 2007: 30). This leads to the
situation whereby a harm-cessation approach can actually make self-harm more frequent and severe, and may even contribute towards a patient feeling suicidal.

Health care professionals report conflicting feelings, including being upset when a service user self-harms and also experiencing feelings of anger, inadequacy and guilt (Duperouzel and Fish, 2007). If service users continue to self-harm, staff often feel that they have failed, that service users have let them down or that management will blame them for injuries. “There is…this blame culture within an institution that if [a service user] does cut [him or] herself, when you’re filling critical incident forms in, you’ve got to explain what [he or] she’s done. It’s, ‘how’s she got it?’ [the injury]. ‘Why’s she got it?’ ‘How’s she been allowed to get it? ‘Why weren’t you watching her?’ (Duperouzel and Fish 2007: 62-63). Fear of blame can increase tensions between staff and service users as each negotiate their needs and roles in in-patient facilities.
Learning activity 2.3.2 Ethical issues

Objective: to review ethical issues which surround self-harm including the principle of duty of care

Resources: DVD Part 2 Section 6 (Politics and Ethics); resource sheet titled ‘Duty of Care and Legal Issues’.

Method:
1. ask participants to view Part 2 Section 6 of the DVD, ‘Politics and Ethics’
2. ask everyone to read the following extract and address the questions below:

Sam Johnson - not her real name – is a nurse who spoke about her fears at a Cutting the Risk workshop held in early 2009. She said that her training, especially concerning ethical issues to do with ‘duty of care’, meant that her first priority was to stop someone self-harming so it was especially difficult for her to consider self harm minimisation techniques. She said:

“ When I first started my practice I used to worry that patients who self-harmed would go off and kill themselves or harm other people if I didn’t prevent them hurting themselves even more. In fact, when I first met ‘self-harmers’ I suppose I was a bit anxious about accepting their self-harm might mean I would get into trouble if they ended up killing themselves asking them if they were suicidal in case it triggered off worse self-harm. Actually, I used to worry about that so much it kept me awake at night.”

3. Questions.

1. What does David Hewitt suggest are the difficulties of existing legislation in the context of justifying self harm minimization approaches?
2. What is the Nursing and Midwifery Council’s (NMC) guidance on self harm minimisation?
3. What are the limitations of the current NICE guidelines on the management of self-harm (NICE 2004)?
4. What legal ruling is useful in protecting health care staff when implementing harm-minimisation and why?
5. On reading the resources, how would you reassure Sam Johnson about the use of harm-minimisation approaches?
Learning activity 2.3.3: Developing an effective care plan - Clare’s story

Objectives:
- to appreciate staff and service user perspectives.
- to practice team work, negotiation and communication skills.
- to develop an effective care plan using a harm-minimisation approach.

Resources: Part 1.4; appendices 5, 6 and 7

Method
- Read Clare’s story (below). In pairs discuss any key issues and make a note of them – participants will reflect on these later.
- Form the participants into teams in which they each take on the role of a staff member about to discuss the transition from a harm-cessation approach to a harm-minimisation approach for Clare.
- Giving each team member a concern or standpoint. This helps with the realism of the team work. For example, one team member may be a nurse in charge of close observation who is worried about being blamed if something life threatening happens to Clare. One team member may be an exhausted doctor who has had a long shift. One team member may be a nurse manager who has a brief to implement a harm-minimisation strategy. Participants could suggest ideas from their own experience. (N.B: this team work lends itself to a ‘fishbowl’ role play, outlined in the Introduction.)
- Ask team members to read the extract from Clare’s story below and make a note for themselves, from their role standpoint, of any responses.

Questions for the team to consider
- What was the justification for the harm-cessation approach in Clare’s care plan and what has been the impact on Clare?
- To what extent might Clare’s gender or sense of identity be a factor to be considered in planning her care?
- What changes would you recommend for her care plan using a harm-minimisation approach?
- How will you involve Clare in decisions about her care plan?
- How will you manage any risk assessment and doubts raised by team colleagues?
- What factors need to be taken into account in Clare’s new care plan?
- What research and other references would help underpin a harm-minimisation approach?
- What other resources might be needed to support a) Clare and b) staff?
- How will the team allocate responsibilities when working with Clare in changes to her care plan?
Clare discusses her experiences on the DVD. The following is also by Clare - an extract from ‘A dialogue of hope and recovery’ (Shaw and Spandler 2007: 28-29) and is about Clare’s experiences on a psychiatric in-patient unit.

Clare’s story:

“We slept in dormitories of sex with curtains around the bed. I was twenty-two. It had been a very bad day. I found a razor in the washing area and took it to my cubicle. I had to use it as much as I could, as quickly as I could, before I was found and stopped. I hid in the space between my bed and the cupboards, behind the curtain. It was dark in there. I started by cutting my legs. It wasn't enough. I cut my wrists and forearms, again and again, without looking at what I was doing […] I needed over one hundred and thirty stitches and surgery to my left wrist.

During my months on different inpatient units, I cut myself with razors. I re-opened sutures, I inserted objects and rubbed dirt into open wounds, I injured myself with broken glass and crockery, I gouged myself with a fork and I cut myself with a ripped-up can, I punched myself repeatedly, I banged my head on the wall, I overdosed, I hung myself from the back of the bathroom door until I lost consciousness, and daily, I binged and vomited and starved. These were all units which did not allow self-harm. All my self-harm had to take place in private, inflicted as quickly and as severely as possible, using whatever means were to hand. Despite being on ‘close observations’, it was worse than ever.”
Learning activity 2.3.4: Developing an effective care plan - Paul’s story

Objectives:
- to appreciate staff and service user perspectives
- to develop an effective care plan using a harm-minimisation approach
- to practice negotiation and communication skills

Resources: Part 1.4 (Towards harm-minimisation); appendices 5, 6 and 7

Method
- Form the participants into teams in which they each take on the role of a team member about to discuss the transition from a harm- cessation approach to a harm-minimisation approach for Paul.
- Giving each team member a concern or standpoint helps with the realism of the team work e.g. nurse in charge of close observation worried about being blamed if something life threatening happens to Paul; doctor who has had a long shift; nurse manager who has a brief to implement a harm-minimisation strategy. Participants could suggest ideas from their own experience. (N.B This team work lends itself to a 'fishbowl' role play, outlined in the Introduction.)
- Listen to Paul’s story in Part 2 Section 5 of the DVD and ask team members to make a note for themselves, from their role standpoint, of their responses

Questions for team to consider
- What is the rationale for Paul's current care plan and what impact has it had on him?
- How will you involve Paul in any discussion of a change in his care plan?
- To what extent might Paul’s ‘learning disability’ make any difference to your approach?
- What changes would you recommend for his care plan using a harm-minimisation approach?
- How will you manage any risk assessment and doubts raised by team colleagues or management?
- How will the team allocate responsibilities when working with Paul in changes to his care plan?
- What other resources might be needed to support a) Paul and b) staff?
- What evidence will you need to support a harm-minimisation approach?
Learning activity 2.3.5 Mini role play

Objective:
- to practice effective communication skills

Invite participants to role play the member of staff who will negotiate the care plan with either Clare or Paul. Participants playing staff team members will need to have considered their approach to an effective harm minimisation strategy beforehand.
Resource sheet 1: Calderstones - developing a harm-minimisation policy

Why develop a harm minimisation policy at Calderstones?
Strictly harm-prevention policies have failed to prevent people from self-harming and, in some cases, service users have resorted to more intense acts of self-harming which cause more damage.

What are the Calderstones team trying to achieve?
The new policy understands self-harm as symptomatic of some greater distress. The Trust have attempted to develop an approach which whilst not condoning self-harm, tolerate it as a means of coping whilst seeking alternatives. Rather than an exclusive prevention model, the policy adopts an inclusive and empowering approach to supporting clients/patients - working in genuine partnership with them to minimise the damage from self-harm, whilst exploring alternative coping strategies. Staff are urged to adopt a non-judgmental, non-punitive and empathic response to self-harm; and, unless there is a perceived threat to life or threat of considerable injury, the service user retains responsibility over further acts of self-harm and the development of alternatives.

The policy
- Harm-minimisation means that clients who want to self-injure will be allowed to, but in a safer way.
- Harm minimisation includes permitting habitual self-injury (behaviours which service users were already using) alongside incorporating support systems, such as education about life threatening injuries and how to care for wounds.
- The ultimate goal of the policy is to introduce alternative coping strategies.
- The policy would not include providing people with implements with which to harm themselves.

Guiding principle
- The adoption of harm minimisation must be supported by a robust assessment and a reasoned and considered approach which balances risk with the most appropriate response for the individual service user.

What are the aims and objectives of the Calderstones policy?
- To reduce service user distress.
- To provide a needs-led service.
- To accept service users current coping mechanism for dealing with distress, whilst supporting the development of alternative coping strategies.
- To support and guide professionals in the management of care.
- To support service users autonomy in improving and managing their health.
- To respect service users right to reach decisions in partnership about their treatment and care
- To ensure that the individual’s capacity has been established
- To respect the privacy and dignity of service users and staff members.
- To ensure that decisions made in partnership with a service user, in relation to self harm minimisation, have been endorsed by the full multidisciplinary team and recorded formally.
What else should harm-minimisation approaches include?

- Providing the right support (such as problem solving) at times of distress can help a person avoid, delay or reduce the extent of the self-harm. Even if this is not the result, talking is very valuable in helping that person understand their feelings and actions and feel supported and heard.
- Training may be needed to enable staff to appreciate the importance of empowerment and education in equipping service users to make informed choices, in line with accepting limitations and responsibilities.

What support do staff receive?

- Support groups and networks concerning good practice.
- Compulsory clinical supervision.
- Clear and accessible guidelines.
- Training on wound care and harm minimisation techniques, service-user perspectives on self-harm, and how to respond when someone self-injures.
- Clear roles and full support from all managers.

Adapted from Duperouzel and Fish, 2009
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Resource Sheet 2: Ethical considerations - the ‘duty of care’ and harm-minimisation

Section 8 of the Nursing and Midwifery Council’s (NMC) Code of Conduct (2004) has, as its key concept, ‘risk’ rather than ‘harm’.

‘you must act to identify and minimise the risk to patients and clients’

Section 8.1

‘you must work with other members of the team to promote healthcare environments that are conducive to safe, therapeutic and ethical practice’

These considerations are open to interpretation as to what is ‘risk’ and what is ‘safe, therapeutic and ethical practice’ and the lack of clarity or guidance means that they are not overly helpful as regards self-harm/harm-minimisation. As a result, doctors and nurses who wish to promote harm-minimisation for people who self-harm may fear that they are in contravention of their Code of Conduct.

Section 1.3

‘you are personally accountable for your practice…regardless of advice or directions from another professional’

Organisational policies and staff hierarchies do not remove personal accountability. There is a prima facie duty to comply with the rules and policies of an employer or organisation but this may be overridden if the policy does not meet agreed professional standards or fails to serve the best interests of the service user (Tingle and Cribb 2007). Therefore, if harm to the service user is seen to be increased by ‘no self-harm’ policies, this suggests that nurses have an ethical and professional obligation to challenge the policies where they consider them to be detrimental to the welfare of the patient.

However, any staff member contravening the rules and policies of the organization which employs them could face disciplinary action and find that, however morally justifiable their actions may be, the law and their Codes of Conduct do not in practice protect them. It is important to remember that sometimes an individual’s moral duty can conflict with their legal duty. However, this conflict also highlights the difficult situation that professionals wanting to work from a harm-minimisation approach can find themselves in.

The Royal College of Nursing (RCN) are at present in discussion with NMC as regards self-harm minimisation and the impact the Code of Conduct has upon this area of practice. These discussions came about as a result of the RCN congress (2006) where the issue of harm-minimisation was hotly debated and many nurses spoke out in favour of adopting a harm-minimisation approach. There is currently a pilot project being undertaken within South Staffordshire and Shropshire NHS Foundation Trust which the RCN and NMC are monitoring whilst considering any changes to the Code of Conduct.
Legal Considerations

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Negligence – ‘failure to exercise the appropriate level of care’

Where a professionals ‘duty of care’ to a service user is concerned, negligence is usually applied under ‘civil’ law - as tort of negligence (a tort is a civil wrong that does not involve a breach of contract). It can however be applied under criminal law e.g. a doctor who is accused of accidentally killing a patient could be charged with manslaughter. ‘As yet, there are no reported English cases in which a nurse has been successfully prosecuted for manslaughter arising out of a breach of her professional duty to a patient’ (Tingle and Cribb 1997 p.91).

Breach of ‘duty of care’

A clinical professional will be seen to have carried out his duty of care to the patient if the professional’s actions would be endorsed by a responsible body of practitioners in the relevant specialty at the material time – this is known as the ‘Bolam Test’ (Tingle and Cribb 2007 p. 94).

However, the Bolam test is not simply a case of a defendant producing a few other practitioners qualified and experienced in the field, to stand up in court and say that they would have done the same thing.

In Bolitho v. City and Hackney Health Authority (1997) the central passage stated:

‘In cases of diagnoses and treatment there are cases where, despite a body of professional opinion sanctioning the defendant’s conduct, the defendant can be properly be held liable for negligence …In my judgment that is because, in some cases, it cannot be demonstrated to the judge’s satisfaction that the body of opinion relied upon is reasonable or responsible…if it can be demonstrated that the professional opinion is not capable of withstand logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible’

It is difficult to anticipate how the law might be applied should a case concerning ‘negligence’ as a result of a service/individual working from a harm-minimisation approach be presented before it. As it stands, there is very limited evidence to suggest how the law would respond to cases of negligence brought against workers operating from a harm-minimisation perspective. The question would be whether the approach was considered ‘reasonable’ – clearly the view of the National Self-Harm Minimisation Group (NSHMG) is that in certain circumstances, it is not only reasonable but compassionate.
References

Bolitho v City and Hackney Health Authority (1998) AC 232.

Holley C and Mortimer S (2007) Clinical Guidelines for management of self injurious behavior (South Staffordshire and Shropshire Health Care NHS Foundation Trust)


**Principles for developing a care plan**

(Reproduced by kind permission from harm-ed)

**What we did**

- Open and honest communication between service users and professionals.
- Comprehensive assessment which included liaising with other professionals, researching case notes and discussion with the service user.
- Identified needs, care plan negotiated and written in collaboration with the service user.
- Discussion and agreement between service user, nursing, medical and management teams.
- Implementation of care plan.

**Care plan**

- Regular one-to-one sessions to explore and encourage the principles of harm-reduction.
- Staff not to prevent self-harm or to remove implements unless requested.
- Service user to keep implements securely in room, to self-harm privately in her own room, and to request assistance when needed.
- Service user to inform staff of increased risk of serious self-harm; care plan to be reviewed accordingly.
- Capacity assessed and regularly reviewed.
- Risk assessed and regularly reviewed.
- Service user and nursing, medical and management team to be in agreement with care plan – regularly reviewed.

**Procedures for developing a care plan should take account of:**

- Clearly defined need identified through the assessment process.
- Service users preference as identified through the self injury assessment which helps define the purpose and reasoning behind the self injury.
• realistic approach based on the care environment, specific, time limited, linked to a robust assessment of risk, take into consideration the privacy, dignity and safety of others.
• agreed specific therapeutic interventions to support the service user in the development of alternative coping strategies to self injurious behaviours e.g. One to one therapeutic sessions.
• evidence that risks to service user have been discussed including hospital acquired infections/ information on infection control.
• agreement in a partnership with the service user and the care team and if agreed significant others.
• clearly identifiable interventions to secure the physical well being of the service user following an incident of self harm.
• if there is a need to provide physical restraint in the event of an emergency, staff should be aware of any gender issues that the service user might have.

Note re Mental Capacity Act 2005: The general presumption is that service users do possess the capacity to make informed choices about their medical treatment. A finding of ‘incapacity’ would only apply where: ‘a person…is unable:

(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or any other means) (Mental Capacity Act 2005).

Staff should adhere to policies on supervision, risk assessment and risk management, management of infection and standard infection control precautions (adapted from Kapur 2005).
Example of a negotiated care plan (adapted from Chris Holley and Rachel Horton South Staffordshire and Shropshire Healthcare NHS Foundation Trust)

A self harm minimisation care plan was eventually agreed with a service user who had used self injury for the past 20 years to manage her difficult and distressing thoughts. She had been cutting her knees in a controlled way which had not caused her serious harm and was not an attempt to end her life but, rather, a means to bring her relief. The staff team recognised her cutting as an effective coping mechanism but worried about whether this recognition contradicted their obligations under their code of professional conduct. The service user recognised that during previous hospital admissions, when she had been prevented from cutting herself, it had resulted in the adoption of more dangerous forms of self-harm. This had the potential to increase the risk of serious harm and even accidental death. During a subsequent admission to hospital a comprehensive assessment was completed which included: liaising with other professionals involved in her care; researching case notes; and many discussions with the service user. Her needs were identified and a care plan was negotiated and written in collaboration with the service user, nursing, medical and management teams.

The change in practice

- The service user was empowered and involved in defining the team approach. Her views informed the care plan; it was signed (and ‘owned’) by her and by all of the professionals involved with her; it was regularly reviewed.

- She was allowed to cut herself within agreed boundaries. She had been checked as having the capacity to make informed decisions about her care and a comprehensive care plan was developed.

- The care plan included planned 1:1 sessions to clarify the principles of harm-minimisation; to provide support, and the opportunity to discuss her thoughts and feelings.

- Staff agreed not to prevent her from cutting her knees unless she requested this. Staff agreed not to remove her "familiar" piece of glass from her room unless she requested this. She agreed to be responsible for ensuring the glass was kept
securely in her room, in a locked drawer, and that she would limit her self-harm to the privacy of her own room to reduce the risk of distress to other service users on the ward, and their access to the glass.

- The service user agreed to assess her wounds and dress them independently if she felt that they did not require nursing or medical intervention, and nursing staff agreed to provide her with the necessary equipment to facilitate this (dressings, antiseptic etc.) She also agreed that she would be responsible for requesting assistance from nursing staff following an act of self-harm if she felt this to be necessary.

- The service user had stated that she did not wish to receive treatment at the local accident and emergency department, therefore an agreement was made that she would receive medical treatment on the ward, whenever possible. The service user requested that information regarding her self-harm would not to be shared with her family.

- During this process, she was able to identify factors that would be an indication that she was at an increased risk of more serious harm. She identified that cutting her face was such an indicator and that she would be responsible for informing staff of such risks at which point her care plan would be reviewed.

- Honest and open communication between the service user and professionals resulted in an atmosphere of mutual respect and a sharing of attitudes and values. The nursing team was able to openly acknowledge that to witness a service user bleeding from a wound that has been self-inflicted does not naturally lend itself to a calm response; some would find it quite traumatic. The team shared their knowledge and skills; communicated more regularly and supported each other better; debriefed and learnt from each incident and, as a result, are now a stronger team.
References


Duperouzel


Harris, J (2000) Self-Harm: Cutting the Bad out of Me *Qualitative Health Research* 10(2): 164-173.


