This guide has been commissioned by the Department of Health Self-Harm Expert Reference Group (SHERG). It aims to provide accessible information about self-injury for staff working in a range of roles with patients, and to stimulate thinking about practice and professional development.
The Development of the Guide

This guide was produced by Nick Douglas and Suzie Marriott on behalf of the Department of Health Self-Harm Expert Reference Group on Self-Harm (SHERG). The Group would like to thank the following individuals who also assisted with the development of the guide.

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We would like to dedicate this guide to Chris Holley who died June 2011. Chris was an early contributor and supporter of the project. We would like to extend our special thanks to her for all her enthusiasm, hard work and commitment to this important work and to vulnerable people. She touched the hearts of so many with her passion and kindness. Thank you Chris.
SECTION ONE: SETTING THE SCENE

In 2008, a working group at Guild Lodge, under the leadership of Dr. Lorna Jellicoe-Jones and Ms. Alison Elliot produced the Guild Lodge Self-injury Knowledge File (Original document is available from the library at Lancashire Care NHS Foundation Trust). This contained a wealth of useful information about self-injury in secure services. The document came to the attention of the Department of Health Self-Harm Expert Reference Group (SHERG), which concluded that it might usefully be developed and extended for a wider audience of staff working with service-users in secure mental health units. This resulted in the current guide.

Aims of the Guide

This guide aims to provide accessible information for ‘front-line’ staff working in secure mental health facilities about the subject of self-injury, and to stimulate thinking about professional practice. It is written for the range of professionals who may have contact with service-users. This will vary in each setting but is likely to include: doctors, nurses, psychiatrists, psychologists, psychotherapists, social workers, occupational therapists, counsellors, probation officers and support staff. Anyone coming into contact with service-users and having responsibility for service-user care, welfare and rehabilitation can potentially gain knowledge from the guide. Mental health staff working in prisons may find some of the general information useful but should be aware that the guide was not written for the prison context. This is because different and specific measures for responding to self-injury are in place in prisons (Assessment, Care in Custody and Teamwork). Prison-based staff can find more information about ACCT on the website for Her Majesty’s Prison Service.

The Status of the Guide

While the Department of Health has supported its production, it is important to understand the status of the guide: it is not a new policy document and it does not seek to replace any existing policy or practice guidance on working with service-users who self-injure. Rather, it aims to collate information about self-injury in a concise and accessible way to meet the needs of busy professionals. Readers will bring their own bodies of specialist knowledge and experience to the subject based on a range of professional disciplines and approaches. Here we aim to provide a basic grounding, promote new learning and thinking and encourage evaluation and reflection upon existing knowledge and practice. Our aim is also to stimulate productive debate and professional discussion about how staff in secure mental health services can work constructively with self-injury.

A Note About Language

We have thought carefully about the terms used in this guide to avoid stigmatising people who self-injure and reinforcing unhelpful myths and stereotypes. We prefer the term ‘people who self-injure’ rather than ‘self-harmers’ since the latter reduces a person to just one aspect of their behaviour, negating their broader personhood. We do not use the term ‘deliberate’ self-harm, as is sometimes seen because it implies unhelpful notions of willfulness that many people who self-injure do not report when self-injuring in dissociative states or when overwhelmed by powerful emotions for example. It is also unnecessary; after-all, non-deliberate self-injury is simply an accident. We also use the term ‘managing self-injury’. Here we mean actions taken by staff and service-users to work constructively in contexts where self-injury is occurring. We do not mean the ‘management of people who self-injure’, since we take the view that people who self-injure are not to be ‘managed’ but are to be cared for,
supported, informed, empowered and provided with appropriate services. How does the language that you use reflect your understanding and perceptions about self-injury?

SECTION TWO: LEARNING ABOUT SELF-INJURY

Definitions and Terms

One of the problems that can hinder understanding about self-injury is differing use of terminology and definitions. Why does it matter if staff use different terms? Because they may be using the same terms to mean different things; lack of precision can lead to confusion and misunderstanding. Box 1 shows just some of the terms that can be found in research to describe self-injury. Do you understand what all of these terms mean? Would they all be encompassed within your definition of self-injury? It is therefore important to have a working definition of self-injury that can be easily understood by service-users and everyone working with people who self-injure. It can be a helpful starting point for professionals as a group to identify a shared definition. If there isn’t an existing one that fits your circumstances, definitions can be modified. The important point is to have a clear working definition that can be easily explained and understood by staff and service-users alike.

It is important to include people who self-injure in your discussions. Some terms can be unhelpful: ‘parasuicide’ can reinforce links to suicide where none might exist. ‘Self-mutilation’ can be seen as stigmatising and sensationalist. If someone (especially a service-user) uses a term that is different to yours, do not seek to ‘correct’ them, ask them to explain, discuss the terms that you prefer to use and tell them why. In this guide we draw a distinction between ‘self-harm’, ‘self-injury’ and ‘suicide’, recognising the overlaps that may exist and the difficulties in drawing ‘neat’ distinctions.

**OUR WORKING DEFINITIONS**

- **Self-harm** – Any kind of action or behaviour that can be harmful to the body or mind e.g. drug use, excessive alcohol use, smoking.¹

- **Self-injury** - The destruction or alteration of one’s body tissue without conscious suicidal intent.⁶ We use this term to distinguish these actions from common socially accepted harmful behaviours such as drug use, smoking, excessive alcohol use. We exclude body modification for aesthetic purposes.

- **Suicide** - The act of taking one’s own life. This may be done in ways that leave no room for doubt about intent […] or tentatively, as attempted suicide, by an act that unless interdicted or interrupted would result in self-destruction.⁸
Behaviours and Methods

As well as thinking about the definition of self-injury, it is important to consider what behaviours constitute the definition. For example, some people would include overdosing on medication in the narrower definition of self-injury. Others would designate it as suicidal. Box 2 provides examples of just some of the sorts of self-injury that staff in secure mental health units may encounter. It is not an exhaustive list. Are there behaviours that you would add or remove from this list?

METHOD AND MOTIVATION

It is important to understand that there is no simple relationship between the behaviours that people use to harm themselves and whether the person is self-injuring or suicidal. Put another way, people can use highly lethal means to self-injure without intending to kill themselves and can use non-lethal methods even though they feel a desire to end their lives. It is not safe to make inferences about what a person intends through the method they choose to self-injure. There are several reasons for this. It is well-known from prison studies that a person may not understand how potentially lethal a method is, or might adapt their usual method of self-injury to the restrictions of the secure environment, perhaps switching from the less lethal method of skin wounding to tying ligatures because implements to cut with are unavailable. This leads to questions of understanding why people self-injure.

Why Do People Self-injure?

Understanding why people self-injure is, logically, an important part of trying to help them. However, there is no simple answer to this question: people self-injure for a very wide range of reasons. However, it has been noted that there are some key explanations and life-experiences that have been found to be significant. A model that many people find helpful in understanding self-injury is known as a bio-psycho-social model. As it suggests, it means that biological, psychological and social factors have been found helpful in understanding self-injury. It is not possible to give a fully comprehensive overview of these complex theories but some of the features of this model are outlined here.

BIOLOGICAL FACTORS

Researchers have suggested that some people are biologically predisposed to find emotional states of high arousal intolerable and to use self-injury to help avoid such states. Others have studied the brain chemistry of people who self-injure and found that they may have lower levels of chemicals such as serotonin or ‘exogenous opioids’ and that repetitive self-injury stimulates an elevation of these levels, which can produce a kind of addictive pattern of behaviour.

Box 1: Self-injury - Some Terms Used in Research

- Non-suicidal self-injury
- self-injurious behaviours
- self-mutilation
- autoaggression, symbolic wounding, self-attack,
- self-inflicted violence, self-abuse, attempted suicide,
- suiciation, suicidal gestures, parasuicide,
- antisuicide, wrist-cutting syndrome, wrist slashing,
- deliberate self cutting syndrome, self-assault,
- carving, indirect self-destructive behavior, and deliberate self-harm.

Box 2: Self-injury – Some Behaviours

- Cutting, burning, scratching, hair pulling, inserting objects into the body, interfering with wound healing, biting, head-banging, ligature-tying, swallowing objects, ingesting poisonous chemicals or harmful substances, breaking bones.
PSYCHOLOGICAL FACTORS
There are many psychological theories as to why people self-injure. Significant among them are:

**Affect regulation theories** – these theories suggest that people self-injure in order to cope with powerful emotional states (anger, anxiety, tension, despair, depression, dissociation) that would otherwise be intolerable.\(^9,14-18\) Alleviating feelings of self-hatred and guilt and the need to self-punish are cited as reasons in some studies.\(^9,19,20\) Self-injury can also be used to release and avoid acting on emotional states such as anger or aggression toward others.\(^12,16\)

**To communicate profound distress** – these studies illustrate the way in which self-injury can be used to communicate to others profound and intolerable emotional pain so that the feelings are externalised on the body.\(^9,16,21\)

**In response to abuse, victimisation and trauma** – these theories suggest that people self-injure in response to early parental loss or neglect\(^13\) and/or sexual or physical abuse as children or adults, with childhood sexual abuse especially strongly implicated.\(^13,17,19,22,23\) This may be linked to feelings of self-blame and bodily shame with self-injury representing a form of on-going self-punishment or abuse.\(^13,24\) Post-traumatic stress disorder (PTSD) has been linked with self-injury because self-injury can be used to alleviate the distressing symptoms.\(^12,25\)

**To relieve a sense of compulsion** – these studies indicate that for some individuals, once begun, self-injury can become compulsive and repetitive.\(^15,16\) A ‘vicious cycle’ has been identified of overwhelming emotions, self-injury, negative reinforcement and repetition of the cycle in response to stressful feelings or situations.\(^12\)

**In relation to mental health problems** – these studies find an association between self-injury and diagnosable mental health problems: most notably depression, anxiety and psychotic illnesses, with individuals either engaging in self-injury as an attempt to express or relieve their distress or in response to certain symptoms instructing them to self-injure.\(^13,18,26,27\)

**In relation to personality disorders** – these studies find a relationship between self-injury and a range personality disorders.\(^28\) Self-injury is most commonly associated with Borderline Personality Disorder (BPD),\(^17,25\) however, it is important to note that the behaviour is one of the core diagnostic criteria for the condition.\(^13,18\) Some literature suggests that individuals may receive this diagnosis on the basis of this one behaviour after a brief assessment so may not necessarily present with other borderline traits.\(^29,30\) Staff should be aware that BPD is a
controversial and contested diagnosis and service-users may have valid reasons for rejecting it. Staff should also be prepared to ensure that unhelpful stereotypes and assumptions about people with BPD are not unduly affecting their practice when responding to self-injury.

In relation to substance misuse – some studies find a link between self-injury and drug and/or alcohol abuse problems. Studies with women prisoners suggest that the early incarceration and detoxification period can increase vulnerability due to the unpleasant physical and psychological effects of withdrawal and the removal of the coping strategy that substance misuse often represents.

SOCIAL AND ENVIRONMENTAL FACTORS

Socio-Economic Status - Self-injury has also been linked to social exclusion and lower socio-economic status. One study found that those most likely to have self-harmed were female, aged 16 to 34, single, living alone or with one parent, in social class 4 or unemployed and renting their accommodation. Homelessness and involvement in the state care system as a child have also been linked to self-injury.

As a response to detention – some people self-injure because they find coping with the demands of being detained intolerable, such as the loss of freedom, lack of autonomy and loss of contact with family and friends. Or there may be features of the detention environment that cause them significant distress such as poor relations with staff and other residents, boredom and segregation.

These are just some of the explanations that have been found for why people self-injure. It is very unlikely that any single explanation can account for all self-injury that occurs. The important principle is to be open-minded and receptive to developing professional understanding and listening to what people who self-injure say about it.

Who Self-injures?

Understandably, the question arises as to who is most likely to self-injure so that help can be targeted at those most in need. Research indicates that people in mental health inpatient settings show high rates of self-injury. As outlined above, people who have certain life-experiences also appear to be more vulnerable: abuse, mental health problems, social exclusion, substance misuse and being imprisoned are some examples. People in certain groups have also been found to be vulnerable, such as:

- Women and girls
- Younger people
- Lesbians, gay men, bisexual and transgendered people
- Young Asian women
- People with intellectual disabilities

Due to stereotypes about who self-injures, the experiences of boys and men have often been especially overlooked. But this is changing and studies are now documenting the needs of men and boys who self-injure. As these men explained, communicating pain and getting help were factors in their self-injury.

“I wanted to show people what they’ve done to me.”

“I had to do it to get through to someone that I wanted help.”

What opportunities are there in your workplace to find out from service-users about their reasons for self-injuring? Do you always clearly understand their motivations? What do you know about the reasons why people stop self-injuring? Do service-users who self-injure fit easily into a particular ‘profile’? What life experiences and vulnerabilities have you observed among patients who self-injure? How can staff be alerted to the ways that pre-conceived ideas about who self-injures might be influencing their practice?
In some cases, the picture is not straightforward and there is some ambiguity about the risks for certain groups (young Asian women for example) and the reasons for heightened risk may be complex. It is important to question assumptions and stereotypes about who self-injures. Potentially, any individual could self-injure and this cannot be inferred (or ruled out) because of that person’s characteristics: some people do not fall neatly into the categories of what may be thought ‘typical’ of people who self-injure. Having too narrow a view of who self-injures can restrict understanding and lead to self-injury among people who do not fit a ‘typical’ profile being overlooked. For example, the experience of men and boys is now being explored but had previously been overlooked (see Box 4). While it may help us to understand patterns and trends, the starting point in working with people who self-injure must always be the individual service-user. Box 5 asks you to think in depth about who in your workplace self-injures and why.

The Link Between Suicide and Self-injury

One important issue that many staff wish to understand more about is the link between self-injury and suicide. Historically, self-injury was often misidentified as a failed suicide attempt. It is true that people who have a history of self-injury are more likely to die by suicide. However, we are now coming to a more sophisticated understanding of the issue. Firstly, while people who self-injure may be at higher risk of suicide, it is important to remember that the majority of people who self-injure do not ultimately kill themselves. It is vital to be aware of what people who self-injure say about the issue. For many, their reasons for self-harming are not motivated by suicidal feelings. Indeed, in many cases, the coping strategy that self-injury represents can help them to manage situations and feelings that might otherwise drive them to suicide. See Box 6 where Sam’s poem explores the complex feelings associated with self-injury.

People’s motivations can also be mixed: on some occasions self-harm can be motivated by suicidal feelings but not on others (see Box 7). Individuals may even use different methods depending upon their intent - (e.g. cutting to ease psychological pain and drinking bleach to commit suicide) - although, as discussed above, there are dangers in making assumptions about what a person intends according to the method of self-harm. A clear understanding of intent, role and function of self-injury is an important and integral part of managing the risk. The best way to ascertain this is to encourage and enable the person self-harming to explore and understand their feelings and to share them with you. This means being open to thinking about and discussing complex, painful and taboo subjects: pain, grief, the body, risk, individual autonomy and death are just some examples. Above all, it requires being able to work in a supportive, constructive and
professional way with the person concerned, understanding that they may well have encountered negative responses from health professionals in the past, so that developing a trusting relationship where talking is possible may take time. 54-56
Section Three: Working constructively with self-injury

What Do We Know About ‘What Works’?
The National Institute for Health and Clinical Excellence (NICE) published guidance in 2011 on the longer term management of self-harm. This complements previously published guidance on the management of self-harm within the first 48 hours. The guidance sets out what is known about the most effective and appropriate ways for health and social care staff to respond to self-harm. In summary, it recommends that:

- Care should be based on general principles of trusting, supportive, non-judgemental relationships, where staff have an awareness of the stigma surrounding self-harm and seek to involve people who self-harm in decision-making, sharing information with others appropriately.
- Information is provided to the person who self-harms about the dangers, long-term health implications and interventions for self-harm.
- Integrated psychosocial assessment of needs and risks is conducted to include detailed clinical assessment of biological, social and psychological factors that are relevant to the individual and future risks.
- Integrated care and risk management plans are developed by multi-disciplinary staff teams in collaboration with the person who self-harms.
- Consideration is given to offering 3-12 sessions of a tailored psychological intervention that is specifically structured for people who self-harm, with the goal of reduction. This could include cognitive-behavioural, psychodynamic or problem-solving elements.
- Where stopping self-harm is unrealistic in the short term, strategies aimed at harm reduction are considered.
- Psychological, pharmacological and psychosocial interventions are provided for any associated mental health conditions (e.g. substance misuse, depression, schizophrenia, BPD, bi-polar disorder).
- Families, partners and carers are involved where the person who self-harms agrees.
- Transitions and the end of care is appropriately managed by planning this with the service-user, making contingency plans and providing additional support where needed.

It is essential that every member of staff responding to self-injury in secure mental health facilities is fully aware of the NICE guidance and its provisions. It should also underpin all organisational efforts to develop strategies and interventions.

Developing a Consistent and Coherent Approach
Unfortunately, there is not a strong evidence-base to draw upon to determine ‘what-works’ specifically in secure settings. However, the Guild Lodge Self-Injury Knowledge File, highlighted some important learning, summarised here.

- **Develop a consistent approach to managing self-injury behaviour** – multi-disciplinary care planning and good staff communication are essential tools in developing a consistent approach.
- **Systematically record all incidents of self-injury behaviour to determine any patterns** - note things like the injuries observed, the method of injury, the time and place that the injury occurred (and was reported), anything significant that the service-user says about the incident, any known precipitating stressors and the aftercare and treatment provided. This can be used to inform therapeutic processes, care management and service-user insight into their self-injury behaviour.
• **Avoid pressuring people not to self-injure** – it is understandable that staff will want the service-user to stop but it is not helpful to pressure people into this. This is because it may lead people to find ways to injure secretly and more dangerously; if the person has no other way of coping it may increase the risk of adverse outcomes, including suicide; it may undermine the relations of trust between the professional and the service-user; and it can become a way to demonstrate autonomy or anger towards staff.

• **Give attention and emotional support at times when the person is not self-harming** – this is important in conveying the message that the person does not need to self-injure in order to obtain care and support.

• **Encourage and facilitate engagement in psychological treatment** – this can enable a service-user who is self-injuring to gain further understanding of their self-injury behaviour.

• **Aim to instil a sense of hope** – people who self-injure often have low expectations about positive future events. A useful strategy in therapeutic processes can be to focus on the next step in recovery rather than long-term goals.

• **Aim to foster a sense of empowerment** – people who self-injure have often been deeply disempowered by their life experiences, which can engender feelings dealt with through self-injury. It is important that staff do not further disempower them; offering informed choice and control about treatments as far as possible and encouraging people who self-injure to take responsibility for themselves and their behaviour can be helpful.

• **Facilitate the development of interpersonal and problem-solving skills** – People who self-injure have been found to evidence difficulties with interpersonal and problem-solving skills. Helping people to identify alternatives and appropriate solutions to their problems are important goals.

### Developing Professional Skills
Staff in secure facilities will bring their own experience of helping people in distress to their encounters, with many skills being relevant to working with people who self-injure. Providing opportunities to discuss the subject and to be heard and supported are essential in managing self-injury. Here we have sought to highlight ways that these skills can be constructively applied.

• Never dismiss self-injury as unimportant, attention-seeking or time-wasting even if wounds appear superficial – there is often no relation between the type of injury engaged in and the depth of feeling motivating the behaviour.

• Even if self-injury appears to be a strategy for changing a person’s circumstances or getting emotional needs met, this still indicates a significant need for help: it may be more helpful to think of such actions as ‘attention needing’ rather than attention seeking.  

• Listen to the person’s experience without being critical, judgemental or blaming. Try not to panic or overreact; a calm, empathic approach works best.

• Give the person the space and time to talk about their feelings but recognise that they may not be able to (or not able at that moment). Remember, self-injury can be a response to an inability to use words to articulate feelings. Try to encourage the person to talk at their own pace in a place of their choosing.

• It is not unprofessional to be honest if you find it difficult to hear what the person is saying – conveyed in an appropriate way, this may be perceived as a more authentic response, leading to the building of genuine rapport. However, it is important not to convey incomprehension, disgust, revulsion or rejection.
• Don’t just focus on the injuries – try to convey to the person an attitude of professional care for the whole person. Try to emphasise the person’s inherent value to help develop and support their own sense of self-worth.

• Never assume that a person who self-injures repeatedly will always maintain the same pattern. People can and do change their behaviour – each episode needs to be considered in its own right.

• Wherever possible, try to involve the person in dialogue about approaches to managing the self-injury and their care. Participation in such a dialogue may be an important act of empowerment leading to positive change.

‘Self-help for self-injury’ contains a wealth of useful information and advice, which may be appropriate to share with service-users. It includes a form to help people record their feelings around the urge to self-injure, which can be a helpful tool in facilitating communication and understanding. You can find further details in the ‘useful publications’ section.

**Practical Strategies and Approaches**

One of the most important strategies to address self-injury is to provide interesting and enjoyable activities to minimise boredom and reduce the likelihood for negative and painful feelings to dominate. Some practitioners believe that ‘rumination’ (dwelling on or revisiting negative or self-critical thoughts) plays an important part in self-injury. For people who are ready to try to stop self-injuring, finding alternative ways to manage the feelings motivating self-injury can be useful. This means helping the person to identify the feelings (e.g. anger, sadness, unhappiness, depression, low self-esteem, lacking control, emptiness, numbness, craving sensation associated with self-injury) and seeking alternative actions that might bring about their alleviation. For example, if the person needs to see visible proof of their distress, they might want to experiment with art materials or draw on their skin. It may be helpful to offer suggestions that other people have found useful as set out in Box 8. However, neither you nor the service-user should feel ‘let down’ if these approaches don’t alleviate the need to self-injure. It will not be the right approach for everyone or it may be a process of experimentation that takes time to yield results.

**What Isn’t Helpful**

Again, the principle applies that each person who self-injures needs to receive individualised care – what one person finds counter-productive may be helpful for another. However, here are some suggestions of things that people who self-injure tend not to find helpful:

- Being treated as rebellious/a time-waster/a hypochondriac/an attention seeker.

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**Box 8: Alternatives to self-injury**

- Exercise.
- Draw on yourself with washable red pen.
- Scribble on paper.
- Write – stories, poems, letters.
- Play an instrument, sing, dance.
- Flick rubber bands on your skin.
- Pillow fight, scream into your pillow.
- Pop bubble wrap.
- Cry.
- Play computer games.
- Do some housework or cleaning.
- Be with others.
- Think about not wanting more scars.
- Paint your nails.
- Sleep.
- Have a hot (or cold) bath.
- Pamper yourself.
- Put all your books/CDs/DVDs in alphabetical order.
- Memorize song lyrics or book passages.
- Curl up under a blanket.
- List positive things about yourself.
- Do something to help someone else.
- Make a wish list of things you would like to buy.
- Throw socks around.
- Draw fake tattoos.
- Make words out of the letters of your name.
- Count backwards from 100.
- Say the alphabet backwards.
- Play a card game.
- Bite into a lemon.
- Focus on breathing.
- Rip up paper.
• Bargains or contracts to stop.
• Expecting them to stop immediately.
• Assuming that taking away implements for self-injury means that they can’t – people can be highly adaptive and resourceful in finding the means to self-injure.
• Getting into a ‘battle of wills’ about the issue – this can only heighten tensions and frustrations so that no-one wins.

**What Do People Who Self-injure Say?**

One of the best ways of understanding what is required in responding constructively to self-injury is feedback from service-users about those occasions when professionals ‘get it right’ (or ‘get it wrong’). Box 9 describes what a group of service-users in one study had to say about mental health professionals. If service-users were asked about how you respond to self-injury, what do you think they would say? In what ways does your service go about collecting information from people who self-injure? Could you do more to enable people to feed back their views and experiences?

**Service-user Advocacy**

Advocacy can be defined as: “an individual being supported to express views, communicate choices and receive services or participation as a result.” From April 2009, some service-users subject to the Mental Health Act 1983 have a statutory right to access an Independent Mental Health Advocate (IMHA). This includes people who are detained under the Act (including when on leave of absence from hospital), people subject to guardianship and people subject to Community Treatment Orders. An article by Stevens and Symington gives a useful overview of the role of IMHAs. Box 10 outlines the approach taken by one IMHA they spoke with.

If you don’t already know, find out about your local IMHA service. The Advocacy Resource Exchange can help you to find information about your local area (see the Sources of Further Information). Think about how you could usefully involve them in your work with people who self-injure. How might they help to empower service-users to express their concerns, needs and experiences?

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**Box 9: Getting It Right - What do Emma, Vicky and Kirsty think?**

I was very lucky with my first psychiatrist. She was lovely...She was absolutely wonderful. She was so caring. She really did seem to give a s**t and she didn’t label me. She just talked to me and tried to help me through it (Emma).

She’s understanding. She listens to you. She’ll not just shove you out of the room. I see her every time. I don’t see her understudy... because that’s what I couldn’t cope with. You go into the room and there’s somebody different again, and you feel like they don’t even know you (Vicky).

[Seeing a psychologist] has been very very useful because there are lots of things that I never really talked about that happened in my past that I’d never been able to face before, and we’re actually in the process of starting to work through those things, which I never thought I’d be able to do. So it’s obviously doing something. If we’d been having this interview a couple of years ago, I’d have been sat here and really defensive, and the only way I felt emotion was through self-harming. I’d just have been thinking ‘what does she want?’. Really like, attitude. Just so angry and so different than what I am now (Kirsty).
Box 10: Advocates in Action
As an advocate, when I am working with an individual I always encourage them to do some aspects of the advocacy. When I first suggest this, they often back off, saying that they don’t feel able to do anything. I explain that I am not asking them to act on their own and I will support them. Then they are more open to sharing the task. Recently, I spent time with Jay, preparing for her CPA meeting. We wrote down a list of questions and in the meeting she read out the questions and I took notes. She told me that she was very nervous to start with but once she got into it she got more confident and was glad to actively participate in the meeting.
SECTION FOUR: EVOLVING APPROACHES AND DEBATES

One of the challenging aspects of working with people who self-injure is that it can require us to consider our own values and beliefs about mental wellbeing, healthcare, the role of helping professions and human rights. Examples of questions this might raise are:

- To what extent should people be allowed complete autonomy over their body, even the right to injure it? Does the fact that a person has mental health problems influence this?
- What takes precedence, the service-user’s autonomy or the professional’s duty of care to keep the self-injuring person safe?
- What is the proper role of mental health and other professionals in supporting people engaged in seemingly self-destructive behaviour?
- How can the needs of people self-injuring be balanced with those of staff and other service-users who may be distressed by the fact that self-injury is occurring?

These are just some of the value judgements that lead to a consideration of the paradigm that informs our thinking about the issue (our underlying philosophical and theoretical framework) and the implications this might have for practice and care.

Paradigm Shifts

It is often the case in healthcare that orthodox and mainstream approaches are debated and challenged, leading to a change in thinking and practice. We call this a paradigm shift. One familiar example might be the debates over abstinence and harm minimisation models in relation to drug misuse.61

Historically, the paradigm for understanding self-injury was that it is pathological and self-destructive behaviour and that the priority in working with people who self-injure is to encourage them to stop.50 There are those who, after careful consideration, maintain this view (see Box 11).

However, service-users and practitioners are developing new ways to think about the issue and a paradigm shift may be occurring. The development of harm minimisation approaches for self-injury would appear to be evidence of this. Guidance from the Department of Health and National Institute for Clinical Excellence makes it clear that harm minimisation approaches can legitimately be included in strategies to address self-injury (see Box 12).

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**Box 11: Advocating abstinence**

“For supplying individuals who self-harm with blades cannot be good for them. Nurses should not be supporting patients to self-harm…By giving self-harmers the tools they need, the nurses could be seen as encouraging individuals to harm themselves. We should be doing something to discourage this behaviour.” Katherine Murphy, Patients Association, 2006.2

**Box 12: Harm minimization - NHS Policy**

Guidance from the Department of Health

[Mental health trusts, primary care services, social services and accident and emergency departments should] consider a ‘harm minimisation’ approach rather than an exclusive ‘prevention’ model approach (p.57).7

Guidance from NICE

Advice regarding self-management of superficial injuries, harm minimisation techniques, alternative coping strategies and how best to deal with scarring should be considered for people who repeatedly self-injure (p. 64).8
What is harm minimisation?
It is important that all staff have a clear understanding of what harm minimisation is (and is not). The Department of Health has set out some useful principles on harm minimisation in its strategy on women’s mental health. The principles are equally applicable to work with men.

The aims of a ‘harm minimisation’ approach are to:

- Adopt a non-judgemental and non-punitive attitude to understanding the reasons why women self-harm based on listening and hearing what women have to say.
- Actively support and encourage individuals to take steps to contain their self-harm within reasonable limits while working with them to replace self-harming with other, more positive, means of coping and expressing themselves, which are primarily ‘user-led’.
- Provide the means by which individuals can address the underlying causes of their self-harm.
- Recognise and provide the level of support staff require when working with women who self-harm.
- Advise and support service-users in taking care of their own injuries except in instances where hospital treatment is required.
- Clarify the instances in which staff’s responsibility to protect should override the responsibility resting with the individual i.e. when the severity of self-harm may become dangerous/life threatening even though there may be no suicidal intent.
- Provide a structure in which individuals can retain their autonomy, dignity and responsibility wherever possible.

As with our discussion about definitions of self-injury, there are many definitions of harm minimisation in use and there has been unhelpful confusion resulting from a lack of precision about terminology. We would like to introduce a more nuanced definition into the debate. We like the definition of one service-user, which sees ‘safer self-injury’ as a sub-category of harm minimisation.

“Harm minimisation describes a wider theoretical and ethical as well as practical approach. Safer self-injury describes the practical implications; it is more focused and less holistic.”

These are our working definitions.

**HARM MINIMISATION & SAFER SELF-INJURY**

Harm minimisation is a broad concept that means enabling the individual to address the urge to self-injure with as little risk and damage as possible.

‘Safer self-injury’ is a sub category of harm minimisation and means enabling people who are self-injuring to modify their behaviour to reduce physical damage.

Some practical examples can help to illustrate the subtle distinction.

Harm minimisation approaches:

- Making service-users feel safe so that they can tell staff when they feel the need to self-injure and ask for help and extra support.
- Enabling service-users to understand their need to self-injure by giving access to good quality information and helping them to identify the underlying feelings motivating self-injury.
- For service-users who are ready, enabling them to experiment with alternatives to manage the feelings motivating self-injury. Examples include snapping an elastic band on the wrist, using marker pen to simulate cuts, the use of ice-cubes or ‘Deep Heat’ on the skin to create strong physical sensation (see Box 8).

Safer self-injury:
- Educating service-users about anatomy to reduce the risk of serious injury when cutting.
- Working with service-users to reduce risk of infection (including consideration of providing sterile blades).
- Facilitating post-injury care by providing service-users with advice and access to dressings etc.

It is somewhat obvious but ‘safer self-injury’ would not be applicable to all types of self-harm. Overdosing and ligature tying are potentially so risky that attempts to render them safer are not considered feasible. Blood-letting to a potentially lethal level would be another example.

It is also important to understand what harm minimisation is not. It does not mean:
- Condoning, encouraging or ignoring self-injury.
- An admission that staff have ‘failed’ or lost control of the situation – indeed, it can be a way to pro-
- actively manage the situation.
- That care-givers and service-users cannot work towards the ultimate goal of stopping – it is a way to manage self-injury until stopping becomes a realistic goal.

Supervised Self-injury - A Thought Experiment
How can staff teams examine whether and to what extent harm minimisation approaches might be integrated into their practice? The obvious answer is to review the options and potential consequences carefully.

Two ethicists, Steven Edwards and Jeanette Hewitt examined the ethics of supervised self-injury by nurses. Their paper represents a kind of ‘thought-experiment’ where the pros and cons of three different logical approaches are explored: (1) prevent self-injury; (2) do not prevent self-injury; (3) permit supervised self-injury. Summarised below are some of the arguments they explore. How many of the issues they raise are already familiar to you?

<table>
<thead>
<tr>
<th>1) Prevent self-injury</th>
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<tbody>
<tr>
<td><strong>Pros</strong></td>
<td><strong>Cons</strong></td>
</tr>
<tr>
<td>If successful, physical injury is prevented.</td>
<td>Prevention efforts can increase the risk of suicide because it removes from service-users a vital coping strategy.</td>
</tr>
<tr>
<td>Prevention communicates to service-users that staff care about them and they matter enough for staff to take steps to protect them, potentially enhancing service-user’s self-esteem.</td>
<td>Preventing self-injury can drive service-users to be more secretive about it and take more drastic steps to self-injure if they become desperate.</td>
</tr>
<tr>
<td>Preventing service-users from doing something they would otherwise do may erode a service-user’s already fragile sense of autonomy and control over their</td>
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• Prevention strategies (such as the removal of self-harm implements, observation and segregation techniques) can be experienced as restrictive, punishing and humiliating, undermining trust between professional and service-user and the potential for therapeutic alliances.

Conclusion: Edwards and Hewitt reject the prevention approach because in practice the oppressive nature of the prevention strategies required mean that service-users do not experience this as caring. Harms are not prevented because the risk of suicide is potentially increased.

<table>
<thead>
<tr>
<th>2) Do not prevent self-injury</th>
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</thead>
<tbody>
<tr>
<td><strong>Pros</strong></td>
<td><strong>Cons</strong></td>
</tr>
<tr>
<td>• Service-users are allowed to continue to use a strategy that enables them to cope.</td>
<td>• When people self-injure there is a risk that the person will do more damage than they intended, perhaps acquiring infections or even killing themselves – service-users may not fully understand or anticipate the risks.</td>
</tr>
<tr>
<td></td>
<td>• Similarly, service-users may not understand the long-term implications of their actions (e.g. life-long scarring), which may be stigmatising and a source of shame.</td>
</tr>
<tr>
<td></td>
<td>• Repetitive self-injury may enable people to become habituated to harming the body and they may need to increase the severity of injury to achieve similar effects, thus increasing the risk of suicide.</td>
</tr>
<tr>
<td></td>
<td>• The fact that care-givers do not attempt to prevent self-injury may increase a person’s feelings of worthlessness. Also, if self-injury is a communication strategy, failing to intervene may be perceived as abandonment.</td>
</tr>
<tr>
<td></td>
<td>• There is a risk that staff will become brutalised, de-sensitised and callous as a result of overriding their instinctive response to intervene to prevent self-injury.</td>
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</tbody>
</table>

Conclusion: Edwards and Hewitt reject the permissive approach because although it respects service-user autonomy, it risks unforeseen harms, potentially increases suicide risk, may lower service-users’ self-esteem, and risks brutalisation of staff.

<table>
<thead>
<tr>
<th>3) Permit supervised self-injury</th>
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</thead>
<tbody>
<tr>
<td><strong>Pros</strong></td>
<td><strong>Cons</strong></td>
</tr>
</tbody>
</table>


As noted above, service-users continue to have access to an important coping strategy and their autonomy and sense of personal control is respected – factors which have been found to be very important to service-users.

There is an opportunity to increase trust between professional and service-user by agreeing the strategy being employed and its intended outcomes.

The presence of a member of staff while self-injury is taking place demonstrates care and concern for the person’s distress, providing opportunities for therapeutic engagement about the self-injury while it is taking place.

There is an opportunity to change the nature of the relationship between service-user and caregiver from that of surveillance agent to one of befriending. Where the role of staff is not to prevent self-injury but to care and engage during and after episodes, feelings of frustration and failure may be lessened.

Staff can be present to comfort service-users during episodes and to help guard against unintended harms.

Brutalisation of care-givers may be heightened because supervised self-injury requires staff to be physically present rather than simply aware that it is happening.

Supervised self-injury sends a message to service-users and staff that self-injury is an effective way of responding to emotional distress.

Conclusions: Edwards and Hewitt accept the supervised self-injury approach. They counter-argue against the cons by suggesting that caregivers have to manage emotional responses that may cause them distress in other contexts (e.g. tranquillising a psychotic service-user, dressing a wound that causes pain to the service-user). Also, they point out that many people do in fact find self-injury an effective way to cope with distress that helps them to maintain life. Edwards and Hewitt add an important caveat that supervised self-injury should include strategies to reduce the behaviour in order to lessen the risk that the person will become habituated to self-injury.

Box 13: Safer Self-injury – Thinking it through

What do you think about Edwards’ and Hewitt’s consideration of the issues? Think about each of the arguments in turn? Do you support them or oppose them? Does your view change depending on the type of self-injury (e.g. cutting vs. ligature tying). Repeat the exercise with a group of colleagues – does this change or reinforce your view?

Conduct your own thought experiment in relation to the following question: Should staff give sterile blades and dressing packs to people who are cutting using found or improvised implements (e.g. broken glass, broken plastic)?

To conduct your own thought experiments: 1) define the issue or problem, 2) set out the logical options for responding, 3) set out the pros and cons for each option 4) decide whether to accept or reject each option. 5) come to an ultimate conclusion.
Edwards and Hewitt’s paper provides a useful example of how staff teams can come to a reasoned decision about harm minimisation approaches by thinking them through. Their analysis considered just one approach to harm minimisation: supervised self-injury. This may be a challenging and perhaps extreme idea for many staff in secure units but it has been debated as a serious proposition (see Box 14). The important point to remember is that ‘safer self-injury’ is just one aspect of harm minimisation and there are many other less controversial strategies that can be deployed.

**Duty of care**

Thinking about the theoretical and philosophical implications of changing practice around harm minimisation is important. However, staff will want to be clear about their duties of care and their responsibilities in this. Indeed, balancing the duty of care with the autonomy of service-users is one of the most challenging aspects of responding constructively to self-injury, arousing strong feelings in service-users who self-injure and staff (see Box 15). Therefore, every member of staff coming into contact with service-users should know the legal, ethical and practical duties of care that are owed to service-users with regards to self-injury.

Key questions:

- What is the position of your professional association/regulating body?
- What is the position of the Mental Health Trust/organisation within which you work?
- What is the policy and practice of the secure unit within which you work?

If the answers to these questions are not clear take steps to get clarification: 1) email the policy units of your professional association/regulating body and Mental Health Trust, 2) initiate a discussion with your unit’s clinical manager, your line manager and colleagues.

**Initiating Harm Reduction Approaches**

In the context of secure units, broader harm minimisation strategies can be employed with little risk (e.g. encouraging a service-user to use red marker pen instead of cutting). However, staff must **never** be in the position of independently implementing ‘safer self-injury’ strategies such as the provision of sterile blades etc. These approaches need to be based on a carefully considered and formulated policy, with organisational support, taking into account the views and needs of service-users and staff. As a minimum, this should include:

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**Box 14: Supervised Self-injury – A viable proposition?**

“We should give patients clean blades and a clean environment to self-harm and then access to good-quality dressings...My instinct is that it is better to sit with the patient and talk to them while they are self-harming. We should definitely give advice on safer parts of the body to cut. It could get to the stage where we could have a discussion with the patient about how deep the cuts were going to be and how many.” Jeremy Bore, Vice-Chairman of the RCN’s Prison Forum, 2006.
- A clear written policy covering the approach to be used, endorsed by the secure unit and the Mental Health Trust/Organisation in which it is located and in accordance with NHS guidance.
- A robust risk assessment of the policy.
- A clear understanding of the legal and duty of care requirements.
- Consultation with service-users and staff.
- Guidance, supervision, education and training for staff.
- Education and accessible written information about the policy for staff, service-users, families, partners and carers.
- Regular and timely review of the policy and opportunities for reflective practice.

This should be underpinned by:

- Individualised care plans for each service-user developed by a multi-disciplinary staff team – these should be regularly independently reviewed.
- A clear approach to risk assessing service-users to be included within care planning.
- Effective multi-disciplinary team working, with clear individual and collective responsibility.
- Good documentation with appropriate information sharing.

**No Undue Pressure**

It is also important to state that there should be no pressure put upon staff to participate in ‘safer self-injury’ initiatives. The most productive approach is for staff to come to a carefully reasoned decision following access to information and a detailed and comprehensive assessment and understanding of the individual’s self-injury, undertaken with their involvement. There should also be an opportunity to reflect and take guidance. In units where ‘safer self-injury’ is implemented, provision must be made for staff who feel that to participate would be in contravention of their professional ethics.

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**Box 15: Duty of care – divergent views**

Services place a greater priority on litigation, bureaucracy and insurance risks than they do on the dignity, distress, humanity and human rights of the individual they seek to serve. Compassion and care do not feature. Duty of care = licence to bully (Service-User).

It is difficult for employees of an organisation to witness self-harm without acting assertively to prevent the act. I find people are placed on enhanced observations while an in-patient, to prevent self-harming behaviour, which is not an effective strategy but to fail to act would appear negligent. It would take a skilled and confident professional to devise a treatment plan advocating a minimal reaction to continued self-harm (Staff Member).
SECTION FIVE: PROFESSIONAL SUPPORT AND DEVELOPMENT

Undoubtedly, responding to self-injury can be emotionally taxing for staff. In one study with staff working with people with learning disabilities in medium secure units, the staff talked about some of the difficulties they experienced around self-injury (see Box 16). Frustration, personal guilt, feelings of failure, worries that by talking about self-injury they might trigger incidents, feeling out of their depth and a culture of blame were some of the issues reported. The important point to acknowledge is that these experiences are not uncommon; there is nothing to be gained by downplaying the challenges that working with self-injury can bring. However, by recognising the challenges and putting strategies in place there are ways to empower staff to respond constructively.

No More Blame

One of the most important points to reinforce is the need for a no-blame culture. Of course, staff have professional accountabilities and a duty of care to service-users but if we understand that incidents of self-injury do not automatically mean that staff have ‘failed’, we can reject the notion of blame. By working to empower service-users and share the responsibility for managing self-injury, within a harm minimisation approach if appropriate, it is possible to change the culture of blame to one of increasing personal control and shared accountability. A clear policy on responding to self-injury and effective multi-disciplinary working can facilitate a collective organisational response, so that no individual is left to ‘shoulder the blame’.

Professional Development

Training is instrumental in enabling staff to develop the attitudes, skills and confidence needed to work constructively with self-injury. Training needs identified in one study were understanding and communication skills in relation to self-injury, counselling skills and knowledge of practical responses. But training is only one aspect of professional development. Here we suggest some other approaches that may be useful.

- On-going knowledge development – via professional journals and publications, self-help books, user group websites and online support forums.
- Promoting reflective practice – via supervision and significant event audit examining self-injury incidents.

It is also important to emphasise that staff have a right to safeguard their own emotional wellbeing and to seek support from line-managers.

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Box 16: Working with self-injury – Tensions and frustrations

I suppose it’s just like beating your head against a brick wall…You’re trying to help her and sort her through and sort her life out and she basically just throws it back in your face. That’s how it seems; she’s throwing it back in your face (Staff Member).

So there was a lot of guilt… there was a lot of guilt initially – a lot of frustration and wanting to blame somebody. If you blame somebody, it’s not your fault is it? (Staff Member).

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Box 17: What do I need?

We cannot always know in advance what we will find difficult or challenging about working with self-injury but one way to feel better equipped to respond is to be prepared for it. Think about what you will do if you encounter an issue in relation to self-injury that you find frustrating, disturbing or frightening. Complete this sentence by listing three actions that you will do if you need support. “If I am upset, worried or need support about an issue relating to self-injury I will…”
and colleagues (see Box 17). It is especially important if you are a manager to play your part in creating a no-blame culture and being ready to support your staff when needed. Responding to and balancing the needs of staff and service-users in relation to self-injury can be a challenging task. What do you need to do to develop your management skills in this respect?

Although working with self-injury can be challenging, it is also important to acknowledge that it can be professionally rewarding. We have suggested that it is not helpful to judge the effectiveness of responses to self-injury solely in terms of whether or not it is prevented: managing and reducing the risk are also significant achievements. However, by working constructively, staff can also play a central role in helping people to find alternative ways to cope and hope of recovery (see Box 18).

Box 18: Goals to aim for

I had my psychologist at the time help me and talking to me and saying what’s this about? What’s that about? And generally talking to me, and counselling through that way, and then with great help from [ward staff]. I think they give you aspects of life to think about, like what could be out there for you once you leave here, giving you goals to aim for. There are better ways (Service-User).
SECTION SIX: SOURCES OF FURTHER INFORMATION

Policy and Practice Guidelines


Practical Strategies and Self Help

Websites
Basement Project - http://www.basementproject.co.uk/
Bristol Crisis Service for Women - http://www.selfinjurysupport.org.uk/
Mental Health Foundation - http://www.mentalhealth.org.uk/
National Self-Harm Network - http://www.nshn.co.uk/

Helplines
National Self-Harm Network
0800 622 6000 7pm-11pm daily

The Samaritans
08457 90 90 90. 24 hours

MIND Infoline
0300 123 3393 9am-6pm Monday-Friday
REFERENCES