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Balancing costs and benefits: a clinical perspective does not support a harm minimization approach for self-injury outside of community settings

Hanna Pickard and Steve Pearce

Patrick Sullivan's emphasis on the importance of supporting autonomy and independence among vulnerable people who self-injure is fundamental to good clinical practice. Although people who self-injure typically experience overwhelming emotions and may be prone to impulsive behaviour, self-injury is nonetheless a choice and must accordingly be treated as such.¹ In addition, patients who self-injure when not acutely mentally ill typically retain decision-making capacity in relation to self-injury.² This is why some forms of harm minimization, such as encouraging reflection, responsibility, safe cutting and where appropriate self-aftercare, are uncontroversial and already widely practiced within community settings. The situation is different, however, with respect to both secure and non-secure inpatient settings. It is also different when we consider some of the other forms of harm minimization that Sullivan advocates, namely, the provision of self-harming instruments alongside education about anatomy and physiology.

Sullivan does not distinguish secure and non-secure settings, but it is crucial to do so. In secure (forensic) inpatient settings, it is neither practical nor ethical to provide implements that can be used as weapons to any patient, for any reason. This would be to severely compromise staff and patient safety.

In non-secure inpatient settings, patients are likely to be detained under the Mental Health Act. This raises the question of the grounds of detention. Typically, patients who self-injure are detained because they are judged to be currently at risk of life-endangering or life-changing injury. As Sullivan notes, it is not clinically or ethically appropriate to provide patients with the means to self-injure when they are in this state of mind. This means that the relevant inpatient population for which a harm minimization approach could even be considered is relatively small: those who have a standing pattern of self-injury and who are detained on non-secure units for reasons other than acute self-injury. This population is likely to be even further reduced, if one considers that the reasons for detention should not include acute mental illness which compromises the capacity for autonomous choice and decision-making, if a harm minimization approach is to be appropriate and genuinely viable.

Grant that there are some such patients, however few in number. Sullivan suggests that the long-term benefits of facilitating self-injury in such cases may outweigh the short-term costs. He notes that self-injury functions as a way of coping with psychological distress – which restrictions of liberty can heighten, for example, by increasing feelings of powerlessness – and suggests that harm minimization may improve therapeutic relationships with staff by decreasing confrontation and the use of restrictive measures, thereby potentially improving outcomes for patients over time. It is important to acknowledge that Sullivan does not advocate harm minimization as a stand-alone intervention, but only part of a broader clinical engagement designed to help patients develop healthier ways of coping with psychological distress in the long-term. However, the potential benefits of a harm minimization approach to a particular patient must be weighed – in clinical and ethical decision-making in a non-secure inpatient setting – not only against the potential costs to that patient, but also against the potential costs to staff and other patients. Let us consider these in reverse order.

With respect to costs to other patients, it is well-established that self-injury can be contagious.³ Patients who are admitted onto a ward without a history of self-injury may learn to self-injure if they see other patients doing it – this risk may be especially pronounced if self-injury is part of a therapeutic engagement with staff – and patients with a history of self-injury may learn new

means. Specialist inpatient units, including one at which SP worked in the 1990s, which have employed a harm minimization approach in the past have had difficulties with patients adopting techniques from one another and self-injury escalating.⁴ Put bluntly, witnessing or even just hearing about self-injury increases the chance that people try it themselves: people learn from their peers. This point has of course been well-documented outside of inpatient settings as well. Self-injury and similar behaviours can spread among friendship groups, as well as through media channels.^{5 6 7} The impact on other patients of facilitated self-injury on wards may be significant, and needs to be factored into any assessment of costs and benefits.

With respect to the costs to staff, it is of course accepted that clinical work requires managing the psychological burden of treating challenging patients like many of those who self-injure. But facilitating self-injury through the provision of implements in non-secure inpatient settings would significantly increase this burden. Although Sullivan recognizes that staff may feel uncomfortable 'doing harm', he does not seem to appreciate the degree of psychological burden the measures that he is proposing would create. Risk assessment is not an exact science and mistakes will occur – especially, perhaps, in the current NHS context where wards are both overpopulated and understaffed. In addition, even if an assessment of risk is accurate when conducted, risk level in patients with a standing pattern of self-injury as a way of coping with psychological distress is dynamic and can fluctuate very quickly and unpredictably. Such patients are typically highly emotionally unstable and impulsive. Furthermore, events that from the outside appear insignificant can have devastating and immediate effects on mood. Indeed, this propensity may be heightened in inpatient settings where – as Sullivan notes – patients are likely to be detained and so must contend with general restrictions of liberty, increasing the likelihood that staff and services are experienced in line with early attachment figures with whom many patients will have had negative relationships. All of this contributes to volatility and risk and impacts on the ability for any risk assessment to be reliable. As a result, if staff provide implements to people to self-injure in inpatient settings, they not only bear the psychological cost of knowing they have facilitated – and in that sense sanctioned – the process of self-injury. There will also be occasions where patients accidentally or deliberately suffer life-changing injury as a result or indeed kill themselves. Staff will then be in a position of having provided the means to this devastating outcome. Obviously by far the most important cost in such a situation is to patients themselves. But the psychological burden of working with this risk – let alone dealing with its actual occurrence – and its potential impact on staff stress levels and burn-out will not be negligible, and again needs to be taken into account in any assessment of costs and benefits.

Finally, consider the potential costs to patients themselves. Sullivan is rightly moved by the stories of patients who feel they have suffered from measures restricting self-injury. We do not deny that it is extremely difficult for patients who have a standing pattern of using self-injury as a way of coping with psychological distress to have it curtailed. And we have no doubt that listening to patients, together with better awareness and attention to the impact of restrictions on their state of mind, would benefit care. But addressing this concern need not obviously involve providing permission and means for patients to self-injure: it could instead involve better psychological understanding and support for the underlying distress causing the desire to self-injure, as well as the further distress that is consequent upon having self-injury restricted. In our view, Sullivan does not seriously consider the potential costs to individual patients of a harm minimization approach. In this regard, it is important to appreciate the complicated psychology surrounding self-injury. People self-injure not only to manage psychological distress. Self-injury is also a potent communication to others as well as linked to low self-esteem, negative core beliefs, and emotions like shame and self-hatred.⁸ It can both express and reinforce a person's deeply held belief that they are bad, worthless, and deserving of punishment. This is part of its meaning. The impact of staff facilitating self-injury within a therapeutic relationship risks fuelling this mindset by implicitly sanctioning it. In other words, facilitated self-injury may give patients the message: 'We won't stop you from hurting yourself because you are not worth it'. This risk might be mitigated in contexts where staff are highly trained and skilled in offering complex psychological interventions with vulnerable patients – as well as expertly supported and supervised – but, again, this is not a realistic expectation on today's NHS wards.

Long-term self-injury is correlated with suicide.⁹ This is one of the main reasons why so much effort is made to address it across all mental health settings. Correlation is not causation, and

mechanisms are as yet unknown, but it is natural to speculate that one reason is that self-injury maintains a negative self-concept – a known risk factor for suicide. However, whatever the underlying mechanisms, the fact that long term self-injury is so strongly associated with completed suicide adds urgency to the task of helping patients find other ways of coping, and increases the burden of proof required to demonstrate that a shift in emphasis from prevention and rehabilitation to harm minimization is in fact ethical.

Even something as seemingly innocuous as education about anatomy and physiology carries risks that Sullivan does not acknowledge. In this respect, it is noteworthy that the medically trained population has higher suicide completion rates than the general population.¹⁰ Sullivan seems to presume that teaching someone about, for example, the important structures in the wrist, will enable them to cut with less risk. But we cannot assume knowledge is benign: rather than being used to self-injure more safely, it can, instead, be used to enable people to cut more dangerously and effectively.

This is one respect in which the analogy between harm minimization approaches to drug and alcohol misuse as compared with self-injury is not apt. Many drugs, including most notably alcohol, are widely used across society and are generally considered to have both intrinsic and instrumental value, so long as use is moderated so that it does not escalate and negative consequences ensue. The most obvious intrinsic value is pleasure; but well-known instrumental values include, among other things, improved social interaction, facilitated sexual interaction, heightened cognitive performance, and a way of coping with stress.¹¹ Quite generally, alcohol and some drug use in moderation is widely considered compatible with a life of flourishing; relatedly, those people who struggle with drug and alcohol problems do not typically use substances with the deliberate aim of causing self-damage. They may, of course, appreciate the negative consequences of use and consume nonetheless – although given the prominence of denial in many cases of drug and alcohol misuse, even this cannot simply be assumed.¹² But the key point for our purposes, which makes drug and alcohol harm minimization not analogous to self-injury harm minimization, is that most problematic substance use is not done with the express purpose of causing self-damage, but for other reasons. In other words, self-injury is an unintended by-product. As a result, it is reasonable to expect that education about how to consume safely in order to minimize risk of negative consequences is likely to be put to precisely that use, as opposed to being used to achieve the opposite result. Of course, there may be some exceptions, namely, when drug and alcohol problems overlap with or themselves function as a pattern of deliberate self-injury. But that is the point: where there is a standing pattern of self-injury, there is a reasonable risk that education aimed at promoting safety may have the opposite result, because in such cases there is a conscious and explicit intention to cause damage to the self by engaging in the behaviour in question.

Deliberate self-injury is rarely if ever part of a life of flourishing. It is high risk and serves to maintain a negative self-concept. In so far as it functions as a way of coping with psychological distress and so has that instrumental value, the clinical emphasis should be on supporting individuals to develop alternative means. In our view, the abstract principles of harm minimization are laudable, and in some contexts, such as drug and alcohol misuse, the benefits typically outweigh the costs – especially when part of a broader clinical engagement designed to help patients improve in the long-term. In addition, as we noted at the outset, some forms of community-based harm minimization for self-injury, such as encouraging reflection, responsibility, safe cutting and where appropriate self-aftercare, are uncontroversial and already widely practiced as part of good clinical practice. But this community-based practice is in keeping with the concerns we have outlined in relation to the potential costs to staff and patients alike of a harm minimization approach. Of course, in community settings, the possibility of actually preventing self-harm if a patient is committed to continuing with it is impractical, as well as of dubious clinical, ethical, and indeed legal status. But staff would never supply patients with the means to self-injure due to the risk of complicity in severe or fatal self-injury. Nor would they risk creating any impression that they endorse self-injury as a coping strategy due to the potential impact on the patient's self-concept. Patients with a standing pattern of self-injury need far better care, in the community and on secure and non-secure wards alike. But from a clinical and practical ethical perspective, the devil is always in the details. Of all the various measures that could in principle be adopted to help them, the forms of harm-minimization that Sullivan

advocates in inpatient settings do not strike us as the measures we ought to promote. For self-injuring patients themselves – let alone when we factor in the potential impact on other patients and staff – the balance between costs and benefits of these forms of harm-minimization for self-injury does not tip in their favour.

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⁵ Whitlock, JL, Powers, JL, and Eckenrode, J.(2006) The virtual cutting edge: the internet and adolescent self-injury. *Dev Psychol* 42(3):407.

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⁹ Zahl, DL, and Hawton K. (2004) Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11,583 patients. *Br J Psychiatry* 185:70-75.

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¹¹ Muller, C.P. and Schumann, G. (2011) Drugs as instruments: a new framework for non-addictive psychoactive substance use. *Behavioral and Brain Sciences* 34: 293-310.

¹² Pickard, H. (2016) Denial in addiction. *Mind and Language* 31: 277-299.