

The balance between autonomy and paternalism in mental health care: harm minimisation and self-injury

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Abstract

My thesis considers the philosophical and legal issues associated with the use of harm minimisation techniques in supporting people who self-injure. This approach is controversial as it allows the individual to continue to self-injure and is contrasted with approaches that attempt to prevent self-injury. It is argued that this tension is an illustration of the balance that has to be maintained between autonomy and paternalism that is played out on a daily basis in mental health in-patient units. The philosophical analysis has three main elements. First, I argue that harm minimisation can be supported on the basis that by continuing to allow harm, the health professional respects the individual's autonomy and on balance, a net reduction in harm occurs. Second, I consider the objection that such an intervention represents a collusive relationship between the patient and the practitioner that supports a dysfunctional type of coping. This fails to deal with important underlying issues that are psychological in origin. This objection has both clinical and moral components. I argue on both clinical and ethical grounds that this argument fails. Third, I use the concept of epistemic injustice to develop an argument supporting harm minimisation based on the perspective of individuals with lived experience of self-injury. There are important moral reasons for recognising the validity of this perspective. Their narratives have challenged traditional ways of understanding self-injury. This has resulted in changes in clinical practice through the promotion of less restrictive forms of intervention. Harm minimisation is such an initiative and promotes individual autonomy.

On the other hand, health care professionals must work in a specific policy and legal context. I argue that this context is dominated by concerns about liability and accountability, which is characterised by a preoccupation with risk and blame. I consider how this has an impact on the use of harm minimisation approaches, as the risk of serious harm or death in a patient subject to a harm minimisation programme although unlikely, cannot be excluded as a possibility. I accept that for many health care professionals and the organisations that employ them, this means that harm minimisation may be a less attractive option. This may result in the balance moving towards more paternalistic and more restrictive forms of intervention. In my conclusion, I reflect on these issues and conclude that harm minimisation is sometimes an option that provides an ethical alternative to more restrictive forms of intervention. Although it will not always be an option, it should undoubtedly be a consideration, and sometimes it provides an appropriate intervention. It validates the views and perspectives of some, although, not all individuals who self-injure. In doing this, it respects the reasons why they self-injure and their right to use coping strategies that work for them. However, for interventions such as harm minimisation to be used more widely changes in both perspective and practice are required.

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Finally, I am thankful for the support of my family. During my period of study, my children have got married, and grandchildren have been born. They have endured my PhD journey and tolerated my failure to be involved in family activities as much as I would wish. A special thank you to my wife Tina, you have always been there and have always believed in me.

This thesis is dedicated to the memory of my father Peter, who died some years ago, and my mother Sylvia, who left us while I was completing my studies. They taught me that as long as you do your best nobody can ask for more. This thesis, with its inevitable faults and inconsistencies represents the best I can do, and all mistakes are my own.

The Author

Professional Background and Experience

My professional background is in mental health nursing, and I have worked in a number of clinical, professional leadership and managerial roles from the 1970s onwards. I am now semi-retired and although no longer registered as a nurse maintain a number of professional interests. I have in the past authored a number of peer-reviewed papers relating to mental health care policy and practice. In 2013 I completed the MA in Medical Ethics and Law at Keele University and commenced my PhD studies at the University of Manchester in January 2014.

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Diploma in Nursing (London) Cauldon College/ University of London 1989.
BSc (Hons). Health Sciences. (Awarded with first-class honours). Coventry Polytechnic. 1991.
MSoc.Sc. Health Care Policy and Management. (Awarded with distinction). University of Birmingham. 1995.
MA Medical Ethics and Law. (Awarded with Distinction). University of Keele. 2014.

Awards

Manchester Doctoral College Excellence Awards. Best outstanding output. Faculty of Humanities. University of Manchester. 2018.

Published Papers

Should healthcare professionals sometime allow harm? The case of self-injury. *Journal of Medical Ethics*. Vol. 43.p. 319-323. 2017.

Allowing harm because we care: Self-injury and harm minimisation. *Clinical Ethics*. Vol. 13. No. 2. p. 88-97. 2018.

Risk and responding to self-injury: is harm minimisation a step too far? *The Journal of Mental Health Training, Education and Practice*. Vol. 14 Issue1. p.1-11. 2019.

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Conference presentations

Binaries what role should they serve. 9th Postgraduate Bioethics Conference. University of Manchester. 2015.

Understanding self-injury as an epistemic injustice: a different perspective with therapeutic implications. Postgraduate Research Conference 2017. University of Manchester.

Harm minimisation and self-injury: a consideration of some of the ethical and legal issues. Postgraduate Research Conference. 2018. University of Manchester.

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Birch v UCL Hospital NHS Foundation Trust [2008] EWHC 2237 (QB)

Bawa-Garba v R [2016] EWCA Crim 1841

Bawa-Garba v General Medical Council (British Medical Association and others intervening) [2018] EWCA Civ 1879

Bolam v Friern Hospital Management Committee [1957] 1 WLR 582

Bolitho v City and Hackney Health Authority [1997] 4 All ER 771

Bonnington Castings Ltd v Wardlow [1956] AC 613

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Collins v Wilcock [1984] 3 All ER 374

Cork v Kirby Maclean Ltd [1952] 2 All ER 402

Dunn v South Tyneside AHA [2003] EWCA Civ 878

Defreitas v O'Brien and Another [1993] 4 Med LR 281

Lopes de Sousa Fernandes v Portugal [GC] 116

Donahue and Stevenson [1932] AC 562 (HL)

Dr Khoo James and Another v Gunapathy d/o Muniandy and another appeal [2002]

SGCA 25

F v West Berkshire Area Health Authority [1989] 2 All ER 545 (HL)

French v Thames Valley Strategic Health Authority [2005] EWHC 459 (QB)

General Medical Council v Bawa-Garba [2018] EWHC 76 (Admin)

JT (Adult Refusal of Medical Treatment) Re (1998)

Hucks v Cole (1968) [1993] 4 Med LR 393

Hyde v Tameside AHA [1986] PN 26

Hunter v Hanley [1955] SLT 213

Keenan v United Kingdom [2001] ECHR 27229/95

Kilinic v Turkey [2005] ECHR 40145/98

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Parkinson v HM Coroner for Kent, Dartford and Gravesend NHS Trust [2018] EWHC 1501 (Admin)

Pearce v United Bristol Healthcare NHS Trust [1999] PIQR 53

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Rose v R [2017] EWCA Crim 1168

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Selfe v Ilford and District HMC [1970] Times 26 November 1970

Sidaway v Bethlem Royal Hospital [1985] AC 871

Smiley v Home Office [2004] EWHC 240

T Re (Adult Refusal of Treatment) [1992] EWCA Civ 18

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Mental Capacity Act 2005 www.legislation.gov.uk

Human Rights Act 1998 www.legislation.gov.uk

European Material

European Convention on Human Rights and Fundamental Freedoms

Introduction

Self-injury is a complex phenomenon that is of increasing concern to health care professionals. It is a common occurrence in both hospital and community settings. Dealing with individuals who act in this way has posed clinical, ethical and legal challenges that have proved difficult to resolve. It is a complex clinical conundrum as although individuals may act in ways that are self-destructive and appear irrational, in other ways; they may present as rational and autonomous. This thesis is concerned with those individuals who self-injure while in-patients on mental health in-patient wards. As we will see the means of supporting such individuals can be a contentious issue.

The reasons such individuals are in hospital are not readily accommodated by traditional psychiatric diagnosis, and their needs are often not easily met by the application of standard approaches to treatment. Moreover, their actions may often be seen to challenge the professional authority of the professionals.¹ Issues of choice, power and control become central in considering ways to support individuals who behave in a way that many professionals find difficult to understand. Many individuals who self-injure argue their actions constitute an important means of coping with their distress. This may prove difficult to countenance in what can be a paternalistic environment designed to control such risks. Paternalistic intervention is a real phenomenon in mental health practice,² where enforced treatment is in some in-patient areas standard practice.³ It is impossible not to be struck by the tension between autonomy and paternalism that pervades both clinical practice and the organisational context in which services are provided. This constant tension means balancing the requirements for both care and control are played out on almost a daily basis.

¹ Middleton, H. (2015). The medical model: what is it, where did it come from and how long has it got. In Loewenthal, D. (ed). *Critical psychotherapy, psychoanalysis and counselling*. Basingstoke. Palgrave MacMillan. Chapter 2. p. 29-40.

²In 2017/18 NHS Digital reported 49,551 new detentions under the Mental Health Act. On 31 March 2018 21,439 individuals were subject to the Act. Over three quarters detained in hospital and the remainder subject to Community Treatment Orders. Source NHS Digital (2018). *Mental Health Act Statistics, Annual Figures. England, 2017-18*. NHS Digital.

³Rose, N. (2019). *Our Psychiatric Future*. Cambridge. Polity Press.

The treatment of self-injury involves a range of different approaches, but there is no accepted approach to intervention supported by a substantial body of evidence.⁴ This thesis concerns one approach to intervention that has developed based on the principle of harm minimisation. This is a public health framework, applied most consistently in the field of substance misuse.⁵ It involves interventions designed to reduce the potentially harmful consequences of engaging in high-risk behaviours rather than eliminating risk altogether. For example, in substance misuse, harm reduction provides an alternative to abstinence where this is considered an unrealistic goal.⁶ When used to support people who self-injure harm minimisation is controversial as it allows the individual to continue to inflict injury as part of the therapeutic process. Used in this way the application can be complex, challenging and controversial.

This thesis subjects this complicated clinical issue to ethical and legal analysis. In undertaking this task, I make use of various concepts and theories drawn from both bioethics and medical jurisprudence and apply them to this specific area of clinical practice. I argue that an ethical argument can be developed that promotes support for using harm minimisation approaches and although they would never be used routinely, a clinical case can be made for using the approach in specific circumstances. As the techniques discussed are controversial, the ethical arguments must be tempered by an appreciation of the challenges that implementing such measures entails. As we shall see, the actual uptake in clinical practice has been slow, and there are important legal and policy constraints that explain this situation.

These issues are considered in the articles that form the main body of this thesis. Before moving to these, it is important to consider the ethical and legal approaches that form the theoretical foundation for these papers. As a consequence, the thesis is constructed in two main parts. The first part aims to achieve two main objectives. First, to describe what is meant by self-injury and to describe the concept of harm

⁴National Collaborating Centre for Mental Health. (2004). *Self-Harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. National Institute for Health and Clinical Excellence. London. The British Psychological Society and The Royal College of Psychiatrists; National Collaborating Centre for Mental Health. (2012). *Self-harm. Longer-term management. National Clinical Guideline Number 133*. The British Psychological Society and the Royal College of Psychiatrists.

⁵Marlot, G.A. (2012). *Harm Reduction Pragmatic strategies for managing high-risk behaviours*. London. Guilford Press.

⁶Riley, D. Sawka, E. Conley, P. et al. (1999) Harm Reduction: Concepts and Practice. A Policy Discussion Paper. *Substance Use and Misuse*. Vol. 34 No. 1 .p. 11.

minimisation. This provides the clinical and empirical detail required to gain some understanding of the complex clinical issues. This information is provided in chapter 1. The chapter begins by outlining the scope of the problem, before defining self-injury and going on to consider its presentation and treatment, particularly in a hospital setting. Harm minimisation is then described and defined and its application to the problem of self-injury considered from a clinical perspective. The second objective is to articulate the conceptual underpinnings of approach taken and this is undertaken in the next three chapters. In chapter 2, the ethical and legal background to the research is outlined making use of the limited literature that is available from a philosophical and legal perspective. By drawing on the available literature regarding the ethical issues relating to the adoption of a harm minimisation approach, it is possible to outline a number of supportive arguments that have been used, while referring to the broader literature allows a counter-argument to be developed. The legal section of this chapter starts by drawing attention to the lack of case law available before going on to consider a number of arguments relating to the prevention of self-injury in a hospital setting and the complex issues that arise for professionals in relation to accountability and liability in the event of serious harm coming to the patient. A consideration of clinically based arguments is also incorporated into this part of the analysis. Chapter 3 considers the philosophical approach that underpins the thesis and the concepts of autonomy, paternalism, harm and epistemic injustice. These concepts are defined, and their application in a health care setting generally and self-injury specifically are considered. In chapter 4, the legal implications of autonomy are examined with particular reference to the importance of the individual consenting to a harm minimisation approach. The chapter then considers the role of the Mental Health Act before outlining the critical role that risk has taken on in a mental health setting. The final part of the chapter looks at the question of liability with specific reference to the civil and criminal law and the role of Article 2 of the European Convention on Human Rights. The second part of the thesis consists of five chapters, and these constitute the outputs of my research. In chapter 5, a summary of each of the papers is provided, and these papers are presented in the following four chapters. In chapter 10 a number of concluding comments are made.

Before going any further, I would like to make some brief comments by way of clarification. Throughout the text, I generally make use of the term self-injury and avoid the use of terms such as self-harm, self-mutilation and deliberate self-harm.

The only exception is when I am making direct reference to the literature, and this is the terminology used by the author. I use the term self-injury, as individuals with lived experience of this phenomenon generally prefer this.⁷ I also avoid the term patient except in circumstances where the context would suggest this is the most appropriate terminology. It is also important to be clear that when I refer to in-patient facilities, I use the term in its broadest sense. It may include, therefore, acute in-patient units, rehabilitation facilities, supported accommodation where there is intensive staff support, various forms of therapeutic community and secure accommodation. The context for my work is the United Kingdom, although I do make some use of international literature, particularly that from the United States, when this is appropriate. Finally, my thesis is based on a number of publications, which are either published or accepted for publication. This means that in chapters 6 to 9, there is some degree of repetition.

⁷ See Langden, E. and Proctor, G. (2012). A rationale for service response to self-injury. *Journal of Mental Health*. Vol. 21. No. 1. p. 15-22.

Chapter 1: The clinical issue described

1.1 Introduction

The aim of this chapter is to provide information about self-injury and harm minimisation. The chapter is structured in the following way. First, the scope of the problem is outlined. Second, self-injury is defined, and the type of self-injury referred to in this thesis is described. Third, some clinical and empirical information regarding self-injury is provided. Fourth, how patients who self-injure experience services is considered and traditional ways of dealing with self-injury in a hospital setting are outlined. Finally, harm minimisation is defined, and its application in working with people who self-injure is described.

1.2 Scope of the problem

Self-injury is an important public health issue, and research suggests that rates are high and appear to be increasing.⁸ It is difficult to be clear about the exact prevalence of different forms of self-injury, as estimates vary depending on the population studied, the assessment tools used and the different concepts in use.⁹ There is, however, no doubt that self-injury is a rapidly growing clinical issue.¹⁰ It is estimated that amongst the general population, the rate of self-injury is somewhere between 1% and 6%.¹¹ Reported rates are much higher amongst young people.¹² A

⁸ McManus, S. Hassiotis, A Jenkins, R. Dennis, M. Aznar, C. Appleby, L. (2016). Chapter 12: suicidal thoughts, suicide attempts and self-harm. In McManus, S. Bebbington, P. Jenkins, R. Brugha, T. (eds). *Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014*. Leeds. NHS Digital; Morgan, C. Carr, M.J. Kontopantellis, E. et al. (2017). Incidence, clinical management, and mortality risk following self-harm among children and adolescents cohort study in primary care. *British Medical Journal*. BMJ. DOI: 10.1136/bmj.j4351; McManus, S. Lubian, K. Bennett, C. Turley, C. Porter, L. Gill, V. with Gunnell, D. Welch, S. (2019). *Suicide and self-harm in Britain; researching risk and resilience using UK surveys*. NatCen. London.

⁹ Lingren, B.M., Oster, I. Astrom, S., Graneheim, U.H. (2011). 'They don't understand...you cut yourself in order to live.' Interpretive repertoires jointly constructing interactions between adult women who self-harm and professional caregivers. *International Journal of Qualitative Studies in Health and Well-Being*. Vol. 6. No. 3. p. 7254, DOI: 10.3402/qhw.v6i3.7254

¹⁰ Brown, T. B. and Kimball, T. (2013). Cutting to live: A phenomenology of self-harm. *Journal of Marital and Family Therapy*. Vol. 39. No. 2.p.195.

¹¹ Briere, J. and Gil, E. (1998). Self-mutilation in clinical and general population samples: prevalence, correlates, and functions. *American Journal of Orthopsychiatry*. Vol. 68. No. 4. p.609-29; Prinstein, M.J. (2008). Introduction to the special section on suicide and nonsuicidal self-injury: A review of unique challenges and important directions for self-injury. *Journal of Consulting and Clinical Psychology*. Vol. 76. No.1. p.1-8; Klonsky, E.D. (2011). Non-suicidal self –injury in United States adults: prevalence, sociodemographics, topography and functions. *Psychological Medicine*. Vol. 41. No. 9. p. 1981-6. McManus et al (2016). op. cit. n8; McManus et al (2019) op. cit. n8.

¹² See Whitlock, J. and Seleman, M.D. (2014). Nonsuicidal Self-Injury across the life span. In Nock, M.K. (ed). *The Oxford Handbook of Suicide and Self-injury*. Oxford. OUP; Morgan et al (2017) .Op.cit. n8; The Children's Society (2018). *The Good Childhood Report 2018*. London. Children's society.

North American review considered the prevalence in the nonclinical population and found overall prevalence was 17.2% in adolescence, 13.4% among young adults and 5.5% among adults.¹³ A recent study in the United Kingdom notes that the proportion of the population aged 16 to 74 reporting instances of self-harm rose from 2.4% in 2000 to 6.4% in 2014. This increase was found across both men and women.¹⁴ The prevalence in mental health in-patient units and prisons is much higher.¹⁵ A number of studies have found higher levels of self-injury amongst women, but this is contested.¹⁶ Given these figures, it is not surprising that considerable guidance has been made available to professionals.¹⁷

1.3 Defining Self-injury

Self-injury is a term that can cover a variety of actions, and it is important to be clear about terminology. The literature abounds with different terms, some referring to the same phenomenon. For example, Muehlencamp¹⁸ noted the use of 33 terms and no consensus over terminology and Millard commented on a “bewildering array of labels,”¹⁹ examples include; self-injury, self-harm, self-mutilation, deliberate self-harm, self-injurious behaviour.²⁰ The result is that confusion arises regarding what

¹³ Swannell, S.V. Martin, G.E. Page, A. Hasking, P. St.John. N.J. (2014). Prevalence of Nonsuicidal self-injury in nonclinical samples: Systematic review, meta-analysis and meta-regression. *Suicide and life-Threatening Behaviour*. Vol. 44. No. 3. p. 273-303.

¹⁴ Mcmanus et al (2019). Op.cit. n8. p. 7.

¹⁵ Campbell, D. (2014). Self-harm by mental health patients in NHS has risen by 56%, figures show. *The Guardian* 27 August 2014; James, K. Stewart, D. Bowers, L. (2012). Self-harm and attempted suicide within in-patient psychiatric services. A review of the literature. *International Journal of Mental Health Nursing*. Vol. 21. No. 4. p. 301-309; Hawton, K. Linsell, L. Tunde, A. et al. (2014). Self-harm in Prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. *The Lancet*. Vol. 383. p.1147-1154; National Audit Office (2017). *Mental Health in prisons*. London. National Audit Office.

¹⁶ Bresin, K. Schoenlebar, M. (2015). Gender differences in the prevalence of self-injury. A meta-analysis. *Clinical Psychology Review*. Vol. 36. p. 55-64.

¹⁷ Examples would include the following; Royal College of Psychiatrists, (1994). *The General Hospital Management of Adult Deliberate Self-Harm. A consensus statement on Standards for Service Provision*. Council Report Number 32. London. Royal College of Psychiatrists; Royal College of Psychiatrists (2004). *Assessment following self-harm in adults*. London. Royal College of Psychiatrists; Royal College of Psychiatrists (2006). *Better services for people who self-harm. Quality standards for healthcare professionals*. London. Royal College of Psychiatrists. Royal College of Psychiatrists (2007). *Better services for people who self-harm. Service user Handbook*. London. Royal College of Psychiatrists; Royal College of Psychiatrists (2010). *Self-harm, suicide and risk: helping people who self-harm. Final Report of a Working Group*. London. Royal College of Psychiatrists; National Collaborating Centre for Mental Health (2004). Op.cit. n4. National Collaborating Centre for Mental Health (2012). Op.cit. n4.

¹⁸ Muehlenkamp, J.J. (2005). Self-Injurious Behaviour as a separate clinical syndrome. *American Journal of Orthopsychiatry*. Vol. 75. No. 2. p. 324.

¹⁹ Millard, C. (2012). Reinventing intention: “Self-Harm” and the “Cry for Help” in Post-War Britain. *Current Opinion in Psychiatry*. Vol. 25. No. 6. p. 503-7.

²⁰ See Caton, C (2018). *Developing a new model of understanding self-injury in secure settings: the role of risk, protective and attitude factors*. A Thesis submitted in partial fulfillment for the Degree of

actions and behaviours to include or exclude and this poses problems for anyone attempting to gain a proper understanding of the research.²¹ It is beyond the scope of this thesis to undertake an in-depth analysis of the terminological and definitional issues around self-injury, and this has been dealt with elsewhere.²² It is, however, important that the reader is clear about the type of behaviours to which I refer.

In his analysis of self-injury, Favazza differentiates between culturally sanctioned self-injury and what he terms deviant forms of self-injury often related to mental illness. He describes four different types of self-injury; major, stereotypic, compulsive and impulsive. Major injury includes enucleation, castration and limb amputation. It is highly uncommon and generally associated with severe psychosis. Stereotypic behaviour involves monotonous and repetitive acts such as head banging and is typically associated with severe learning disabilities or developmental disorders. Compulsive self-injury involves repetitive actions like skin scratching and nail-biting. Finally, impulsive self-injury includes actions such as skin cutting, burning, needle sticking, bone-breaking and interference with wound healing. Some individuals make use of multiple methods.²³ The actions are impulsive, as the individual cannot resist the impulse to self-injure,²⁴ Impulsive self-injury specifically cutting of the skin is the concern of this thesis. Favazza defines this type of self-injury in terms of immediate physical damage inflicted intentionally that is neither culturally sanctioned nor inflicted with the intention to cause death.

This conceptual perspective is repeated in a number of similar definitions.²⁵ The definition proposed by the International Society for the Study of Self-injury is illustrative and defines self-injury as;

Doctor of Philosophy. University of Central Lancashire. Chapter 2 for a detailed discussion. See p.8 and 9 particularly.

²¹ McShane, T. (2012). *Blades Blood and Bandages. The experiences of people who self-injure*. Basingstoke. Palgrave Macmillan.

²² See Muehlenkamp, J.J. (2005). Op.cit. n18.

²³ Whitlock, J. Muehlenkamp, J.J. Purington, A. et al (2011). Non-suicidal self-injury in a college population: general trends and sex differences. *Journal of the American College of Health*. Vol. 59. p. 691-698.

²⁴ Favazza. A. (2011). *Bodies under siege. Self-mutilation, nonsuicidal self-injury, and body modification in culture and psychiatry*. Baltimore. The Johns Hopkins University Press.

²⁵ Capriano, A. Cella, S. Cotruto, P. (2017). Nonsuicidal Self-Injury: A Systematic Review. *Frontiers in Psychology*. <https://doi.org/10.3389/fpsyg.2017.01946>; Klonsky, E.D. (2011). Non-suicidal self –injury in United States adults: prevalence, sociodemographics, topography and functions. *Psychological Medicine*. Vol. 41. No. 9. p. 1981-6.

*"The deliberate, direct, and self-inflicted destruction of body tissue resulting in immediate tissue damage, for purposes not socially sanctioned and without suicidal intent."*²⁶

This type of behaviour can be contrasted with a suicide attempt where the injury inflicted is undertaken with the intention to die, or a suicide gesture where the act is undertaken to lead others to believe that the intention is to make a suicide attempt.²⁷ These behaviours can overlap, an issue we will return to in due course.

1.4 Presentation and treatment

Self-injury tends to commence in individuals aged between 12 and 16 years.²⁸ It has been reported that 90% of individuals who self-injure would meet the criteria for a diagnosable mental disorder.²⁹ These individuals come from a diagnostically heterogeneous group and may present with various psychological co-morbidities.³⁰ Although self-injury is often associated with a borderline personality disorder, it is found in a number of other mental disorders such as posttraumatic stress disorder (PTSD), depression, anxiety and eating disorders.³¹ Some have argued that self-injury forms part of an identifiable psychiatric syndrome in its own right.³² It has recently been included, as a diagnostic condition, in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).³³

²⁶ International Society for the Study of Self-injury. (2007). *Definitional issues surrounding our understanding of self-injury*. Conference proceedings from the annual meeting. McGill University. Montreal.

²⁷ Nock, M.K. (2009). *Understanding nonsuicidal self-injury. Origins, Assessment and Treatment*. Washington. American Psychological Association.

²⁸ Muehlencamp, J. and Guttirez, P.M. (2007). Risk for suicide attempts among adolescents who engage in non-suicidal self-injury. *Archive of Suicide Research*, Vol. 11. p. 69-82; Nock, M.K. and Prinstein, M.J. (2004). A functional approach to the assessment of self-mutilative behaviour. *Journal of Clinical Consulting Psychology*. Vol. 72. p. 885-890; Whitlock, J. Eckenrode, J. Silverman, D. (2006). Self-injurious behaviour in a college population. *Pediatrics*. Vol. 117. p. 1939-1948.

²⁹ Haw, C. Hawton, K. Houston, K. Townsend, E. (2001). Psychiatric and personality disorders in deliberate self-harm patients. *The British Journal of Psychiatry*. Vol. 178. Issue 1. p. 480-54.

³⁰ Wills, K.A. (2012). What does recovery mean to adults who self-injure? An interpretive phenomenological analysis. *International Journal of Psychosocial Rehabilitation*. Vol. 17. No. 1. p. 93-116.

³¹ See Klonsky, E.D. and Olino, T.M. (2007). Identifying clinically distinct subgroups of self-injurers among young adults' latent class analysis. *Journal of Consulting and Clinical Psychology*. Vol. 76. No. 1. p. 22-27. Capriano, A. Cella, S. Cotruto, P. (2017) Op.cit. n25.

³² Kahan, J. and Pattison, E. M. (1984). Proposal for a distinctive diagnosis: the deliberate self-harm syndrome (DSH). *Suicide and Life-Threatening Behaviour*. Vol. 14. p. 17-35; Muehlencamp, J.J. (2005). Op.cit. n18.

³³ Selby, E.A. Kranzier, A. Fehling, K.B. Panza, E. (2015). Nonsuicidal self-injury disorder: The path to diagnostic validity and final obstacles. *Clinical Psychology Review*. Vol. 38. p. 79-91.

The reasons why people self-injure vary and Pickard³⁴ notes the following: affect regulation, self-punishment, communication, other punishment, control and a continuum with suicide. According to Adams et al,³⁵ self-injury, has three broad functions. First, it represents a form of coping to facilitate the reduction of tension. Second, it allows control over a threatening external environment. Third, it provides a means of validation, an external manifestation of internal pain. A recent review notes how work focused on the psychological reasons for self-injury has emphasised the role of emotional regulation and the reduction in tension.³⁶ As Sutton and Mattinson³⁷ put it, “paradoxically, damage is done to the body in an attempt to preserve the integrity of the mind.” Such psychologically orientated models perceive self-injury as a coping strategy, which works to release emotional tension.³⁸ Haines et al,³⁹ describe an almost stereotypical pattern of behaviour. First, prior to the self-injury, negative feelings occur. Second, a feeling of numbness, unreality and even depersonalisation is experienced. Third, the feelings become intolerable, and the person injures himself or herself. Fourth, the sight of blood appears significant; the act is almost therapeutic, leading to more manageable emotions and depersonalisation. This idea of self-injury as a form of coping to deal with overwhelming emotional distress provides one of the psychological reasons for why harm minimisation techniques may provide an appropriate means of support.

Specific treatment for self-injury tends to be eclectic, and there is no well-established treatment that is empirically supported.⁴⁰ Treatment of any underlying mental disorder is required, and reviews of the treatment options suggest that structured approaches to intervention are most effective. Interventions that focus on a collaborative therapeutic relationship that engages the person’s motivation to change in a way that directly addresses the self-injurious behaviour appear to be most successful. Interventions such as Dialectical Behaviour Therapy (DBT), Cognitive Behaviour Therapy (CBT), and Mentalisation Based Treatment (MBT) have been

³⁴ Pickard, H. (2015) Self-Harm as violence: When victim and perpetrator are one. In Widdows, H. Marway, H. (eds). *Women and violence. The Agency of victims and Perpetrators*. Basingstoke. Palgrave Macmillan. Chapter 4. p. 71-90.

³⁵ Adams, J. Rodham, K. Gavin, J. (2005). Investigating the “self” in Deliberate Self-Harm. *Qualitative Health Research*. Vol. 10. p. 1293-1309.

³⁶ Capriano, A. et al. (2017). Op.cit. n25.

³⁷ Sutton and Mattinson (2003) cited in Sutton, J. (2007). *Healing the hurt within. Understand self-injury and self-harm, and heal the emotional wounds*. Oxford. How to books. Kindle Edition.

³⁸ Haines, J. Williams, C.L. Brain, K.L. Wilson, G.V. (1995). The psychophysiology of self-mutilation. *Journal of Abnormal Psychology*. Vol. 104. No. 3. p. 471-489.

³⁹ Ibid.

⁴⁰ National Collaborating Centre for Mental Health (2004) Op.cit. n4; National Collaborating Centre for Mental Health (2012). Op.cit. n4.

used to this effect.⁴¹ Although there are no specific medications to treat self-injury, if it is associated with a specific mental disorder, then medicines may be prescribed to treat the disorder.⁴² In addition to treating any underlying disorder, the health care professional has to support the individual in attempts to deal with the harmful effects of self-injury. Cessation of the behaviour is the ideal scenario, but as will be argued, this can sometimes be unrealistic.

1.5 Self-injury and hospital care

In a hospital environment, the priority will be to treat the underlying cause of the self-injury. It will, however, also be necessary to deal with the actual behaviour itself. This refers to what Keywood⁴³ calls behaviour management, and these interventions are aimed at ensuring safety and the containment of risk. A focus on risk management and safety involves practices that are restrictive and frequently concerned with containment.⁴⁴ These include continuous observations, searches of rooms, removal of potentially harmful implements and no harm contracts. More restrictive interventions such as seclusion, sedation and physical restraint may occur if a person is physically prevented from injuring themselves and becomes aggressive towards staff. Recent research suggests that controlling strategies continue to be used to try and reduce self-injury.⁴⁵ For example, Sandy and Shaw note how some staff considered the use of restrictive practices to prevent self-injury was the standard approach to intervention.⁴⁶ The Care Quality Commission (CQC) has

⁴¹ See Prada, P. (2018). Strategies to deal with suicide and non-suicidal self-injury in borderline personality disorder, the case of DBT. *Frontiers in Psychology*. Doi; 10.3389/fpsyg.2018.02595; Hawton, K. Witt, K.G. Taylor Salisbury, T.L. Arensman, E. Gunnell, D. Hazel, P. Townsend, E. Van Heeringen, K. (2016). Psychosocial interventions for self-harm in adults (Review). *Cochrane Database of Systematic Reviews Issue 5*. No. CD012189; Rossouw, T.I. Fonagy, P. (2012). Metalization-based treatment for self-harm in adolescents: a randomized controlled trial. *Journal of Academic Child Adolescent Psychiatry*. Vol. 51. No. 12. p.1304-1313.

⁴² Turner, B.J. Austin, S.B. Chapman, A.L. (2014). Treating nonsuicidal self-injury: A systematic review of psychological and pharmacological interventions. *Canadian Journal of Psychiatry*. Vol. 59. No. 11. p. 576-585. et al 2014 p. 576.

⁴³ Keywood, K. (2005). Psychiatric Injustice? The therapeutic presumption of behaviour management in mental health law. *The Journal of Adult Protection*. Vol. 7. Issue 4. p. 25-31.

⁴⁴ Keywood (2005) focuses particularly on the use of techniques such as restraint, sedation and seclusion.

⁴⁵ Morrissey, J. Doyle, L. Higgins, A. (2018). Self-harm: from risk management to relational and recovery-orientated care. *The Journal of Mental Health Training, Education and Practice*. Vol. 13. Issue 1. p. 34-43; See also Thomas, R. (2019). Mental Health Matters: Punitive Practices. www.hsj.co. This paper provides a recent example of two patients' experiences in an Accident and Emergency Department following an incident of self-harm.

⁴⁶ Sandy, P.T. and Shaw, D.G. (2012). Attitudes of Mental Health Nurses to Self-Harm in Secure Forensic Settings: A multi-Method Phenomenological Investigation. *Online Journal of Medicine and Medical Science Research*. Vol. 1. Issue 4. p.72.

reported that the routine use of restrictive practices remains a problem across in-patient facilities in England.⁴⁷

Although the aim of these interventions is the welfare of the patient, he or she can perceive these approaches as highly intrusive.⁴⁸ They restrict choice, invade an individual's privacy and prevent freedom of movement.⁴⁹ Moreover, Individuals may feel it devalues their experiences and puts significant obstacles in the way of autonomy and self-determination.⁵⁰ As a result, the individual may experience the caring environment as unhelpful and oppressive.⁵¹ The decision to use some of these strategies is often reactive and rarely if ever involves the patient in the decision making process.⁵² It may compound an original trauma and impose additional harm.⁵³ It is not surprising, therefore, that many individuals who self-injure are dissatisfied with the care that they receive.⁵⁴

1.6 Harm Minimisation

Harm minimisation is a public health framework, applied most consistently in the field of substance misuse. In the literature, a number of other terms may be used, such as harm reduction, risk minimisation and risk reduction.⁵⁵ Harm minimisation approaches argues Foy, have the following characteristics.⁵⁶ First, the approach is pragmatic. It accepts that some people will not be able to change their current behaviour, and in these situations, efforts should be made to prevent harm. Second, harm minimisation techniques focus on harm and are designed to reduce the impact of the individual's risky behaviour. The actions of the individual are accepted, although not encouraged. Third, the approach aims to balance the costs and benefits

⁴⁷ Care Quality Commission (2019). *Monitoring the Mental Health Act in 2017/18*. London. Care Quality Commission.

⁴⁸ Chandler, A. (2016). *Self-Injury, Medicine and Society*. New York. Palgrave Macmillan. p. 152

⁴⁹ Hext, G. Clark, L. Xyrichis, A. (2018). Reducing restrictive practice in adult services: not only an issue for mental health professionals. *British Journal of Nursing*. Vol. 27. No. 9. p. 479-485.

⁵⁰ Campbell, P. (1992). 'A survivor's view of community psychiatry', *Journal of Mental Health*. No.1. Vol. 2. p.117.

⁵¹ Cresswell, M. (2005a). Self-Harm 'Survivors' and Psychiatry in England, 1988–1996. *Social Theory & Health*, Vol. 3, p. 259–285.

⁵² See Duperouzel, H. and Fish, R. (2007). Why Couldn't I stop her? Self –Injury: the views of staff and clients in a medium secure unit. *British Journal of Learning disabilities*. Vol. 36. p. 62.

⁵³ Cresswell, M. (2005b). Psychiatric "survivors" and testimonies of self-harm. *Social Science & Medicine*. Vol. 61 p. 1668–1677.

⁵⁴ Taylor, L. T. Keith Hawton, Sarah Fortune and Navneet Kapur. (2009). Attitudes towards clinical services among people who self-harm: systematic review. *British Journal of Psychiatry*. Vol. 194. p. 104-110.

⁵⁵ Riley, D et al (1999) Op.cit. n6.

⁵⁶ Foy, S. (2017). *Solution focused Harm Reduction, working effectively with people who misuse substances*. London. Palgrave Macmillan.

associated with the risky behaviour and those associated with implementing harm minimisation techniques. There is some evidence that this balance tips in favour of harm minimisation techniques in some areas of practice.⁵⁷ Finally, intervention is predicated on a hierarchy of clinical goals. Although focused on the risks in the here and now, the overall aim is to engage the individual in a therapeutic relationship designed to help facilitate change.

Harm minimisation approaches are based on the rationale that the risk of short-term harm may have longer-term therapeutic benefits. In addition, allowing people to make their own choices is psychologically positive, while removing control can be psychologically damaging. The issue of choice is crucial and cognitive and social psychological research supports the positive benefits of choice on both commitment and motivation.⁵⁸ The link between responsibility and adopting the least damaging option is important in understanding this debate. The patient takes responsibility for managing their own risk in a way that respects their autonomy.

1.7 Harm Minimisation and self-injury

Harm minimisation is an alternative to the more prohibitive approaches described earlier. It accepts that some people may self-injure as a means of coping and may find immediate cessation of the behaviour difficult. The aim is to allow the person to continue to self-injure but to do so more safely.⁵⁹ It provides a means of coping until coping is possible through other means. There is no attempt to condone or encourage self-injury, but to ensure it occurs in a safe way.⁶⁰ Again it is important to be clear about terminology, as the literature uses a number of terms interchangeably. In addition to harm minimisation, the following terms are used; assisted self-harm, safer self-injury, supervised self-harm. When describing harm minimisation in this thesis, I am referring to what Shaw and Shaw⁶¹ describe as:

⁵⁷ Sumnall, H.R. Bates, G. Jones, L. (2017). *Evidence review summary: drug demand reduction, treatment and harm reduction*. European Monitoring Centre for Drugs and Drug Addiction

⁵⁸ Winnick, B.J. (1992). On Autonomy; Legal and Psychological Perspectives. *Villanova Law Review*. Vol. 37. Issue 6. p. 1705-1777.

⁵⁹ Shaw, C., & Shaw, T. (2009). *Harm-Ed Dublin Presentation*. Unpublished conference paper presented at New Ways of Understanding Self-Injury Trinity College Dublin, p.6.

⁶⁰ Pembroke, L.R. (2007). Harm Minimisation: Limiting the damage of self –injury. In Spandler, H. and Warner, S. (eds) *Beyond fear and control: Working with young people who self-harm*. Ch.11. p. 163-172. Ross-on-Wye: PCCS Books.

⁶¹ Shaw and Shaw (2009). Op.cit. n59.

"An alternative to preventative approaches which aim to prevent people from self-harming. Harm-minimisation approaches accept that someone may need to self-harm at a given point and focus, instead, on supporting that person to reduce the risk and the damage inherent in their self-harm".

Harm minimisation faces the reality that self-injury will occur anyway,⁶² and is designed to reduce risks of serious harm. The aim is to ensure that people are physically and emotionally safe while also exploring the reasons for their self-injury.⁶³ In addition to reducing the risk of serious injury, it promotes individual choice and control.⁶⁴ Moreover, it addresses the harms⁶⁵ that over-controlling and restrictive services may have on vulnerable and distressed people.⁶⁶ Harm minimisation is sometimes, but not always an option,⁶⁷ and decisions to use a harm minimisation approach are made on a case-by-case basis.

Using harm minimisation approaches with people whom self-injure has a number of critical components. First, reducing risk by supporting safer self-injury. This may include the provision of sterile blades to reduce the danger of infection, allowing a person to keep such implements for personal use, and education regarding safer ways of cutting. This reduces the chance of haemorrhage, permanent injury or death. In some cases, this is inappropriate, and items that mimic self-harm may also be used instead. For example, using elastic bands to snap against the skin or squeezing ice cubes have been suggested as possible alternatives.⁶⁸ Second, providing appropriate aftercare such as immediate access to relevant first aid measures and where possible supporting the person to dress the wound correctly.⁶⁹ Crisis plans and the use of advance directives are important in cases of more serious injury. Third, providing psychological support to help the person understand

⁶² Pembroke (2007). Op.cit. n60

⁶³ Inckle, K. (2017). *Safe with self-injury. A practical guide to understanding, responding and harm reduction*. Monmouth. PCCS Books. p. 159.

⁶⁴ *ibid.* p. 154.

⁶⁵ For example, interventions characterised by prevention and control limit an individual's movements and deny the fundamental right to privacy.

⁶⁶ Duperouzel, R. and Fish, R. (2010). Hurting No-One else's body but your own: People with intellectual disability who self-injure in a forensic setting. *Journal of Applied Research in Intellectual Disabilities*. Vol. 23. No. 6. p. 606-615.

⁶⁷ Sullivan, P.J. (2018a). Sometimes, not always, not never: a response to Pickard and Pearce. *Journal of Medical Ethics*. Vol. 44. p. 209-210.

⁶⁸ *Ibid.* For recent research challenging the effectiveness of these methods, see Wadman, R. Nielson, E. O'Raw, L. et al. (2019). "These things don't work". Young People's views on harm minimization Strategies as a Proxy for Self-Harm: A mixed Methods Approach. *Archives of Suicide Research*. DOI: 10.1080/13811118.2019.1624669.

⁶⁹ Pembroke, (2007). Op.cit. n60.

the reasons why they self-injure and to support change and the adoption of different coping strategies.⁷⁰ All or some of these initiatives may be used, and the combination depends on the individual patient and the type of environment in which the approach is used.⁷¹ Holley and Horton describe the essence of such programmes.⁷²

They describe the use of a harm minimisation approach with a woman who had self-injured for over twenty years. She cut her knees in a controlled way to deal with distressing thoughts and feelings. This was a coping mechanism, and at no time had she been assessed as being at a high risk of suicide. When admitted to hospital attempts had been made to prevent this behaviour. The risks escalated, and the individual used alternative means of causing injury, which were more dangerous. A further admission is described where the staff worked with the patient to develop a care plan that allowed some degree of controlled self-injury. Both staff and the patient were aware of what was agreed, and a consistent approach was implemented. This included a range of safeguards and contingency plans should the risk of harm increase.

It is important, at this point, to note that harm minimisation is not about the routine distribution of sterile blades with which people cut up their bodies.⁷³ Much debate focuses on this issue, and as Inckle points out, this is an urban myth and the essence of harm minimisation is understanding how the individual injures themselves, the risks involved, and how the person can be helped to reduce those risks.⁷⁴ Where the supply of blades may be appropriate is where the current means of self-injury is putting an individual at significant risk of infection. As Inckle argues, allowing a person to maintain a clean kit, which includes the provisions for self-injury and aftercare, is not the same as giving out clean blades and enabling an escalation of the behaviour. Clean kits are provided within a framework of comprehensive and meaningful support.⁷⁵

⁷⁰ Inckle, K. (2011). The first cut is the deepest: exploring a harm-reduction approach to self-injury. *Social work in Mental Health*. Vol. 9. No. 5. p. 364-378.

⁷¹ Hewitt, D. (2004). Assisting Self-Harm. Some Legal Considerations. In Duffy, D. and Ryan, T. (eds) *New Approaches to Preventing Suicide: A Manual for Practitioners*; London. Jessica Kingsley Publishers; Gutridge, K. (2010). Safer self-injury or assisted self-harm? *Theoretical Medicine and Bioethics*. Vol. 31. No. 1 p. 79-92; Sullivan, P.J. (2017). Should healthcare professionals sometimes allow harm? The case of self-injury. *Journal of Medical Ethics*. No. 43. Vol.5. p.319-323.

⁷² Holley, C. and Horton, R. (2007). The Safe self-injury Initiative. In Sutton, J. (Ed) *Healing the Hurt within. Understanding self-injury and self-harm and healing the emotional wounds*. Begbroke. Oxford.

⁷³ *ibid*

⁷⁴ Inckle, K. (2017). *Op.cit.* n63 p.158.

⁷⁵ Inckle, K. (2010). *Flesh Wounds? New ways of understanding self-injury*. Ross on Wye. PCCS

The NICE guidance does support harm minimisation approaches in working with individuals whose self-injury is repetitive and resistant to intervention, and there are a number of examples of how harm minimisation has been implemented in clinical practice.⁷⁶ This includes a number of in-patient facilities,⁷⁷ but the supporting literature is, however, limited to a small number of case studies, and these are often in specialist environments.⁷⁸ A recent research project completed by James et al (2017),⁷⁹ did not find a significant uptake of harm minimisation in a survey of in-patient units. In fact, Shaw⁸⁰ compares the use of harm minimisation as an option in other areas of practice and takes the view that this is not the case when working with people who self-injure. She argues that attempts to prevent or stop self-injury remain the principle upon which intervention is based. She argues that harm minimisation techniques remain marginal practices that are surrounded by controversy and continue to cause anxiety at an organisational and managerial level and are often resisted. This is an issue we return to in chapter 9.

1.8 Conclusion

This chapter has considered the clinical problem that forms the backdrop to the ethical and legal issues that are addressed in this thesis. By defining self-injury and describing its presentation and treatment, I have described the complex clinical matters associated with this phenomenon. In giving an account of how self-injury is

Books.

⁷⁶ National Collaborating Centre for Mental Health. (2004). Op.cit.n4; National Collaborating Centre for Mental Health. (2012). Op.cit. n4. Shaw, C. (2012). Harm Minimisation for Self-Harm. *Mental Health Today*. September/October 2012. p. 19-21.

⁷⁷ See for example Pengelly, N. Ford, B. Blenkinson, P. Reilly, S. (2008). Harm minimisation after repeated self-harm: development of a trust handbook. *Psychiatric Bulletin*. Vol. 32. Issue 2. p. 60-63; Birch, S. Cole, S. Hunt, K. et al (2011). Self-harm and the positive risk taking approach. Can being able to think about the possibility of harm reduce the frequency of actual harm? *Journal of Mental Health*. Vol. 20. Issue 3. p. 293-303; Holley, C. Horton, R. Cartmail, L. Bradley, E. Self-injury and Harm minimisation on acute wards. *Nursing Standard*. Vol. 26. No. 38. p. 51-56; Holley, C. and Horton, R. (2008) Op.cit. n72; Batty, D. (1998). Coping by cutting. *Nursing Standard*. No. 29. Vol. 12. p. 25-26. Fish, R. Woodward, S. Duperouzel, H. (2012). Change can only be a good thing: Staff views on the introduction of a harm minimisation policy in a learning disability service. *British Journal of Learning Disabilities*. Vol. 40. No. 1. p. 37-45.

⁷⁸ See, for example, Crowe, M. and Bunclark, J. (2000). Repeated self-injury and its management. *International Review of Psychiatry*. Vol. 12: Issue. 1. p. 48-53; Holley and Horton (2007). Op.cit. n72; Holley et al (2012) Op.cit. n77; Department of Health Self-Harm Reference Group (2012). *Safe and Secure. Working Constructively with people who self-injure – a guide for staff working in secure mental health units*. Department of Health Self-Harm Reference Group (SHERG).

⁷⁹ James, K. Samuels, I. Moran, Stewart, D. (2017). Harm Reduction as a strategy for supporting people who self-harm on mental health wards: the views and experiences of practitioners. *Journal of Affective disorders*. Vol. 214. p. 67-73.

⁸⁰ Shaw (2012). Op.cit. n76.

dealt with in a hospital setting, I have outlined the difficulties associated with clinical approaches that attempt to focus on the behaviour itself and to stop self-injury occurring. These preventative approaches have been contrasted with a more permissive model based on harm minimisation approaches. This approach has been described and its application when working with individuals who self-injure discussed. These approaches are controversial, and in the next chapter, the clinical case for and against these initiatives will be considered alongside the ethical and legal background to my research.

Chapter 2: Ethical and Legal Background

2.1 Introduction

This chapter examines the ethical and legal background of this thesis by focusing on the existing literature. This work provides a basis for the philosophical and legal approach developed in chapters 3 and 4. The chapter is structured in the following way. First, the clinical issues will be described, and the ethical and legal problem will be defined. I will use the perspective of the patient and the health professional as my starting point and go on to describe the tension between autonomy and paternalism that characterises the interaction between the professional and the patient in a mental health setting. A more detailed analysis of the concepts of autonomy and paternalism will come later in chapter 3. Second, I will describe the clinical case for and against supporting harm minimisation. This part of the analysis draws on my work and particularly the arguments that form the basis for chapter 6. In order to provide a balanced perspective, I also refer to literature that is critical of my particular perspective and the arguments on which it is based. Third, I will outline the ethical background to this complex issue. I draw on the available literature and in doing so, create the conceptual foundations for a more detailed examination of the issues in chapter 3. Finally, I will go on to consider the legal background to the practices under review. I again draw on the available literature, and the discussion prepares the way for a more detailed review of the issues in chapter 4.

2.2 The Ethical and legal problem defined

The clinical problem that forms the basis of this analysis is that an individual regularly engages in self-injurious behaviour. The health care professional has both a moral and legal duty to support this person. There is a moral and professional duty to intervene in some way, and although it may be self-evident that the prevention of harm is the right and proper thing to do, there are complex moral and legal arguments regarding the right type of intervention.

In trying to help this individual should we allow this person to continue with this behaviour and consider how we can limit the harm that their actions may produce, in doing so adhering to a harm minimisation approach? A participant in a study

completed by Duperouzel and Fish alludes to this problem.⁸¹ This individual exerts their right to autonomy and articulates a distinct challenge to health care professionals when stating that a person should be entitled to do what they want with their body as long as it is hurting no one else. It is worth using their words;

“I feel that I should be entitled to cut up as much as I want and when I want. I do feel there’s too many people laying the law down as far as I’m concerned with my self-injury”.

Alternatively, should we actively intervene to prevent such harm and attempt to stop the person acting in this way? There are health care professionals who take the view that more restrictive approaches to intervention that attempt to prevent the person from inflicting injury should be used.⁸² Moreover, some health care professionals do not support or feel skilled in working with harm minimisation approaches, and others fear this is a way of encouraging self-injury and leaving the practitioner open to complaint.⁸³ A health care professional cited in the research undertaken by Duperouzel and Fish⁸⁴ makes the following point;

“If we did allow self-harm and something went wrong, we’d be dead meat, for want of a better word. It could still be seen as neglect”.

These contrasting perspectives illustrate how the tension between autonomy and paternalism is ever-present in dealing with individuals who self-injure. There is always a trade-off between allowing so much freedom that harm results or such a level of restriction that people have too little control over their lives.⁸⁵ Healthcare professionals in a mental health care setting face this therapeutic conundrum regularly. If autonomy is to be respected, then the individual has the right to make his or her own decisions, and unless he or she lacks the capacity to make such decisions, then the choices associated with these decisions should be respected. However, where these choices are self-destructive, the tension between reconciling respect for individual choice with concern for their welfare comes into focus.

⁸¹ Duperouzel and Fish (2010) Op.cit. n66.

⁸² Sandy and Shaw (2012). Op.cit. n46.

⁸³ Pengally et al (2008). Op.cit. n77.

⁸⁴ Duperouzel, and Fish (2007). Op.cit. n 52 p.63.

⁸⁵ Coggan, J. Miola, J. (2011). *Autonomy, liberty, and medical decision making*. Cambridge Law Journal. Vol. 70. No. 3. p. 528.

Resolving the tension between these two perspectives can be difficult.⁸⁶ As Fennel has argued, respect for autonomy starts to lose its legitimacy when the decision respected will result in harm to the individual.⁸⁷ Others make the point that paternalistic interventions that ignore the will of the individual are “presumptively wrong” and constitute a moral problem.⁸⁸

Adjudicating between these different perspectives is challenging. It is not clear whether the act of self-injury is autonomous, or whether people could ever decide either to self-injure or refuse preventative interventions competently. This raises important questions about whether acts of self-injury per se indicate a lack of autonomy that may justify paternalistic intervention. Moreover, even if such actions are indicative of a lack of autonomy, this does not necessarily mean that the individual lacks the capacity to refuse certain forms of treatment or to consent to others. We will see in chapter 3 that a lack of autonomy or capacity to decide whether or not to self-injure is not the same as lack of autonomy or capacity to refuse or consent to treatment for self-injury. Besides, even where an individual lacks autonomy and decision-making capacity, there could still be a doubt as to whether preventative methods are in the patient’s best interests. Paternalistic interventions, it will be argued, can prove unhelpful in many situations. Paternalism is only justified if it is likely to be good for the patient.⁸⁹ These are issues I return to in chapter 3.

2.3 The Clinical literature: the case for and against harm minimisation

2.3.1 The Paradox of Prevention

In chapter 6, I make the case for harm minimisation and refer to what I term the paradox of prevention. This argument centres on the paradoxical situation whereby interventions designed to prevent self-injury may have the reverse effect. As Walsh⁹⁰ points out, “the mere process of ‘preventing’ self-injury can paradoxically produce it”,

⁸⁶ Harris cited in Fennell, P. (1991). Inscribing paternalism in the law: Consent to treatment and mental disorder. *Journal of Law and Society*. Vol. 17. No. 1. p. 29.

⁸⁷ Fennell, P. (1991). Inscribing paternalism in the law: Consent to treatment and mental disorder. *Journal of Law and Society*. Vol. 17. No. 1. p. 29- 51.

⁸⁸ Van Der Veer, D. (1986). *Paternalistic Intervention: The moral bounds on benevolence*. Princetown. Princeton University Press.

⁸⁹ I am indebted to Simona Giordano for drawing these three important points to my attention.

⁹⁰ Walsh. B. (2012). *Treating Self-Injury. A practical guide*. London. The Guildford Press.p.18.

in some cases leading to thoughts and feelings of suicide.⁹¹ This argument has four constituent parts.

The first argument relates to the fact that self-injury is for some individuals a form of coping. If this is accepted, then removing the coping mechanism will be counterproductive and intensify the need for it.⁹² Therefore allowing harm to continue in the short term may result in better long-term outcomes, while paradoxically reducing self-injury in the short term may worsen the longer-term situation.⁹³ For example, some patients have described how attempts to prevent their self-injury increased their distress and maintained their self-injury.⁹⁴ Writing from personal experience, Pembroke⁹⁵ makes the point that self-injury, for some people, is a means of survival until survival by other means is a possibility.⁹⁶ Thus challenging clinical approaches that promote the prevention of self-injury validates self-injury as a legitimate coping strategy.⁹⁷ Harm minimisation is an alternative that is both supportive and demonstrates empathy,⁹⁸ focussing on the cause rather than the symptom of the patient's distress.⁹⁹

The second argument relates to the problems that result from trying to prevent self-injury and has three components. First, if an individual's usual means of self-injury is removed, they will often try to find other ways to self-injure that may be more dangerous.¹⁰⁰ For example, there is anecdotal evidence that when in hospital, the behaviour of an individual who self-injures may escalate, and certainly the use of ligatures appears to be an increasing phenomenon. This type of behaviour is potentially life-threatening.¹⁰¹ Second, preventing self-injury may increase the level of distress experienced, and the individual may resort to more covert attempts to self-injure.¹⁰² They may use whatever method is available, and this may be more

⁹¹ Shaw, C. and Shaw, T. (2007). A dialogue of hope and survival. In Spandler, H. Warner, S. *Beyond fear and Control. Working with young people who self-harm*. Ross on Wye. PCCS Books. p. 30.

⁹² Inckle, K. (2017). Op.cit. n63 .p. 67.

⁹³ Babiker, G. and Arnold, L. (1998). *The Language of Injury. Comprehending Self-Mutilation*. Leicester. BPS Books. p. 93

⁹⁴ Duperouzel. and Fish (2010). Op.cit. n66.

⁹⁵ Pembroke, (2007). Op.cit. n60.

⁹⁶ See, for example, Holley. et al. Op.cit. n77; Holley and Horton (2008). Op.cit.n72.

⁹⁷ Babiker, and Arnold, (1998). Op.cit. n93.

⁹⁸ ibid.

⁹⁹ Inckle, K. (2017). Op.cit. n63.

¹⁰⁰ Sarker, J. (2011). Short-term management of repeated self-harm in secure institutions. *Advances in Psychiatric Treatment*. Vol. 17. Issue 6. p. 440.

¹⁰¹ Brausch, A.M. Decker, K.M. Hadley, A.G. (2011). Risk of suicidal ideation in adolescents with both self-asphyxial risk-taking behaviour and non-suicidal self-injury. *Suicide and Life-Threatening Behaviour*. Vol. 41. No. 4. p. 425.

¹⁰² See Fish et al (2012) n77. p. 38.

dangerous than their usual means of self-injury. Third, trying to prevent self-injury involves restrictive interventions that are rarely beneficial.¹⁰³ Based on a clinical example Sutton¹⁰⁴ makes this very point when she writes that, “her need to cut was so desperate, at this point, that her cutting was not controlled or safe. She, therefore, became ‘at risk’ because of a nursing protocol which was supposed to ensure (ironically) patient safety”.

The third component of this argument is that trying to prevent self-injury does not work. It is often associated with an increase in the frequency and the intensity of the self-injury and the level of distress accompanying it. This may result in physical and psychological harm.¹⁰⁵ In reality, there are very real practical difficulties in actually trying to remove the means or to prevent actual acts of self-injury. For example, even where research has indicated that staff actually support a more preventative approach to intervention, it has been conceded that achieving this can be very difficult.¹⁰⁶ In fact, James et al,¹⁰⁷ note that where they identified clinical teams making use of harm minimisation techniques, one of the reasons for adopting such measures had been that they had found it impossible to prevent some individuals from engaging in acts of self-injury.

Finally, attempts to prevent self-injury may be counter-productive as they may have a detrimental effect on the therapeutic relationship. The person's choices and autonomy are not respected, and this may lead to a reduction in trust between the patient and the health professional and result in a “hostile stalemate.”¹⁰⁸ As Gallup¹⁰⁹ has argued, time and energy spent trying to prevent self-injury can mean that efforts are no longer made to understand the reasons why the person acts in this way and the act of self-injury itself becomes the focus. Declining therapeutic relationships may result in what has been described as malignant alienation, which may increase

¹⁰³ Hanna. (2011). Paternalism and Impairment. *Social Theory and Practice*. Vol. 37. No. 3. p. 434-460.

¹⁰⁴ Sutton, J. (2007). *Healing the hurt within. Understand self-injury and heal emotional wounds*. Oxford. howtobooks.

¹⁰⁵ Inckle, K. (2017). Op.cit. n63. p.154.

¹⁰⁶ James et al (2017). Op.cit. n79 p. 70

¹⁰⁷ ibid p. 71.

¹⁰⁸ Cremin et al (1995). The efficacy of a nursing challenge to patients: testing a new intervention to decrease self-harm behaviour in severe personality disorder. *Journal of Psychiatric and Mental Health Nursing*. Vol. 2.p. 237.

¹⁰⁹ Gallup, R. (2002). Failure of the capacity for self-soothing in women who have a history of abuse and self-harm. *Journal of the American Psychiatric Nurses Association*. Vol. 8. Issue 1. P. 20-26. p. 25.

the risk of suicide.¹¹⁰ Alternatively, therapeutic approaches that place less emphasis on coercion and promote engagement through mutually agreed frameworks that support the individuals involvement and consent might improve the therapeutic relationship.¹¹¹ Writing from the perspective of someone with lived experience of self-injury, Pembroke¹¹² has described how adopting harm minimisation techniques both engages with a person's distress but also allows the person to move from being managed by professionals to being able to manage their distress. Less coercive forms of intervention result in higher levels of therapeutic engagement. If this occurs, then the prospect of an improvement in the person's health and wellbeing is possible and can be measured through their engagement and response to psychological intervention.

Not everyone would accept these supportive arguments, and the literature reflects this. In the interests of a balanced perspective, it is important to consider these concerns, and I will focus on two, in particular, those of Pickard and Pearce¹¹³ and Scanlon and Adlam.¹¹⁴ The former focus their attention on the use of harm minimisation approaches in in-patient facilities, the latter on the therapeutic implications of such approaches. My research involves some debate with these perspectives and the controversies this debate addresses will be outlined briefly.

2.3.2 A clinical perspective does not support a harm minimisation approach for self-injury outside of community settings: the debate with Pickard and Pearce.¹¹⁵

¹¹⁰ See Morgan, H.G. (1979). *Death Wishes? The understanding and management of Deliberate Self Harm*. Chichester, Wiley; Watts, D. and Morgan, G. (1994). Malignant Alienation. Dangers for patients who are hard to like. *British Journal of Psychiatry*. Vol. 164. p. 11-15. Morgan, H.G. and Priest, P. (1984). Assessment of Suicide Risk in Psychiatric in-patients. *British Journal of Psychiatry*. Vol. 156. p. 467-469; Whittle, M. (1997). Malignant Alienation. *The Journal of Forensic Psychiatry*. Vol. 8. No. 1. p. 5-10.

¹¹¹ See Zlodre, J. Yiend, Y. Burns, T. Fazel, S. (2016). Coercion, competence, and consent in offenders with personality disorder. *Psychology Crime and Law*. Vol. 22. No. 4. p. 315-330.

¹¹² Pembroke (2007). Op.cit. n60.

¹¹³ Pickard, H. and Pearce, S. (2017). Balancing costs and benefits: a clinical perspective does not support a harm minimisation approach for self-injury outside of community settings. *Journal of Medical Ethics*. Vol. 43. No. 5. p. 324-326.

¹¹⁴ Scanlon, C. and Adlam, J. (2009). "Why do you treat me this way? "Reciprocal violence and the mythology of 'deliberate self harm'. In Motz, A. (ed). *Managing Self-harm. Psychological Perspectives*. Hove. Routledge. Chapter 3. p. 54-81.

¹¹⁵ Pickard and Pearce (2017). Op.cit. n113 provided an invited response to my paper published in the *Journal of Medical Ethics*. See Sullivan (2017). Op.cit. n71. I wrote a response to Pickard and Pearce's paper. See Sullivan (2018a). Op.cit. n67. This debate is summarised in this section of the thesis.

In a response to the paper that forms the content of chapter 6, Pickard and Pearce¹¹⁶ develop a coherent set of arguments against the view that harm minimisation is a suitable intervention within an in-patient facility. They argue that clinical decision-making regarding harm minimisation must consider the potential benefits of the approach in relation to the impact on the patient, other patients and staff. Based on their analysis, they conclude that harm minimisation is only an option in community settings. I will consider the main elements of their argument and provide a brief response.

First, Pickard and Pearce argue that there are significant risks involved in the use of two particular techniques associated with harm minimisation and mentioned in my paper. The first is allowing patients to access sterile implements for their own use to reduce the chances of infection. The second is the provision of information about safer self-injury and particularly details of the dangers of cutting in certain ways and in specific places. They argue that the provision of sterile blades cannot be countenanced in an in-patient facility, as they constitute a significant risk to self and others. Moreover, while education regarding the impact on a person's health in the context of substance misuse may be helpful, education about self-injury is not benign, and knowledge may, therefore, result in increased risk particularly given the link between self-injury and suicide.¹¹⁷

In my response to Pickard and Pearce's paper, I accepted that although these arguments cannot be dismissed easily, there is an alternative perspective.¹¹⁸ I argue that the provision of implements to self-injure is the most controversial element of the harm minimisation approach, and there are some very difficult ethical and legal issues associated with such practices. However, I take the view that Pickard and Pearce misunderstood my arguments. My position is that if the danger of sepsis, through the use of dirty instruments is a real risk, then allowing the patient to obtain more sterile implements should be supported. I also made the point that there are also alternatives to such practice and cite the example of snapping elastic bands against the skin or squeezing ice cubes. Also, the patient does not necessarily possess the implements; it is the ability to self-injure in a safe and controlled environment that is important. In this respect, there are precedents for dangerous

¹¹⁶ Pickard H, Pearce S. (2017). Op.cit. n113.

¹¹⁷ See Chapters 4,9 and 10 for a more detailed consideration of these issues.

¹¹⁸ Sullivan (2018a). Op.cit. n67.

items to be used under supervision in some in-patient facilities.¹¹⁹ The important point is that there is no proposal for the routine distribution of dangerous items to patients who are acutely ill or detained in secure units, an argument that a cursory reading of Pickard and Pearce's paper would indicate was my position. This is not a position I could support.

In responding to Pickard and Pearce's paper, I also considered comments made in relation to the education of patients about safer self-injury. I took the view that this argument is difficult to sustain, as many types of knowledge are used for both negative as well as positive purposes. Therefore, a position that at least implicitly appears to advocate the restriction of certain information would appear problematic in most situations. Particularly as this information is easily accessible on the Internet and patients have both a moral and in some circumstances, a legal right to information related to their care and treatment.¹²⁰ An Individual has a right to understand the damage they are doing to themselves set against the damage they may do to themselves with increased knowledge. The important point is how the information is relayed, the assessment of the potential for suicidal intent and the therapeutic context in which education takes place.

The second area of concern addressed by Pickard and Pearce relates to the effect of such programmes of care on other patients. They argue that the impact of allowing patients to harm themselves within an in-patient environment will have detrimental effects upon other patients on the ward. There is a significant danger that self-injurious behaviour will increase as a result of the process of contagion, resulting in increased self-injury as other patients on the ward copy the behaviour. There is certainly empirical support for this argument,¹²¹ and one of the authors noted his experience of these phenomena in a ward using harm minimisation techniques in the 1990s. I argued that although this is an important point, the studies of contagion and self-injury within in-patient units are generally completed in units where harm minimisation is not used, and the approach is likely to be based on containment of

¹¹⁹ The example of a diabetic patient using insulin is an example provided in the paper.

¹²⁰ *Montgomery (Appellant) v Lanarkshire Health Board (Respondent)* [2015]. Scotland, UKSC 11.

¹²¹ See Jarvi, S. Jackson, B. Swenson, L. et al. (2013). The impact of social contagion on non-suicidal self-injury: a review of the literature. *Archives of Suicide Research*. Vol. 17. p.1-19; Taiminen, T.J. Kallio-Soukainen, K. Nokso-Koivisto, H. et al. (1998). Contagion of deliberate self-harm among adolescent in-patients. *Journal of the American Academy of Child and Adolescent Psychiatry*. Vol. 37. p. 211-217; Cawthorpe, D. Somers, D. Wilkes, T. (2003). Behavioural contagion reconsidered: self harm among adolescent psychiatric in-patients: A five-year study. *The Canadian Child and Adolescent Review*. Vol. 12. No. 4. p. 103-6 – They provide a different perspective on this issue.

the behaviour. Furthermore, in my experience of such facilities dating back to the 1970s, the issue of contagion is also problematic in environments where harm minimisation is not a therapeutic option. The point being that contagion will occur where incidents of self-injury occur per se, and there are examples of in-patient facilities where self-injury is almost endemic, and yet the approach to intervention is based on restricting self-injury and trying to stop it happening.¹²² As a result, any therapeutic means for addressing such a problem may reduce the risks described.

The impact on staff is also considered by Pickard and Pearce, they argue that the psychological burden of allowing harm to come to the patient will lead to considerable psychological distress amongst staff, particularly should an untoward incident result. This position resonates with some clinical staff, who feel unsure about their competence to implement a harm minimisation approach and who are concerned that it could be construed as encouraging self-injury and would, therefore, put them in breach of their duty of care.¹²³ This is a genuine concern for staff and is raised elsewhere in this thesis.¹²⁴ The potential for stress and burnout cannot be ruled out, but again I am not convinced that this argument refers only to areas where a harm minimisation approach is applied. This is a difficulty in any clinical area where high rates of self-injury are observed regardless of the type of intervention. In these units, serious harm and even death may occur, and the effects on staff are well documented.¹²⁵

Finally, Pickard and Pearce challenge the use of harm minimisation within an in-patient facility on therapeutic grounds. They argue that there is a danger that rather than providing a positive therapeutic message to the patient, the practice of harm minimisation could create the reverse scenario. First, it may communicate to the patient that this is an effective means of coping with distress and in doing so may support the habitual use of self-injury in the longer term. Second, and perhaps more significantly, it may give the patient the impression that he or she lacks worth and this may have a negative impact on their self-esteem.¹²⁶ Pickard and Pearce¹²⁷ make

¹²² Sullivan, (2018a). Op.cit. n67.

¹²³ Pengelly, et al (2008). Op.cit. n77.

¹²⁴ See Chapters 4 and 9.

¹²⁵ Johnson, S. Wood, S. Pau, M. et al (2011). *In-patient Mental Health Staff Morale: a national investigation*. NHIR Service Delivery and Organisation Programme. National Institute for Health Research.

¹²⁶ Edwards, S. and Hewitt, J. (2011). Can supervising self-harm be part of ethical nursing practice? *Nursing Ethics*. Vol. 18. p. 209-210.

¹²⁷ Pickard and Pearce (2017). Op.cit. n113

this very point when they argue that the clinical team risk supporting a patient's deeply held belief that they are "bad, worthless and deserving of punishment."¹²⁸ It provides a message that "we won't stop you from hurting yourself because you are not worth it."¹²⁹ These are important issues and must always be addressed with the individual patient. The problem is, however, that more traditional means of working with the patient may involve practices that the patient perceives as restrictive and coercive. In such an environment, they may also receive the message that no one understands or even cares. Unfortunately, by restricting basic liberties to try and stop the behaviour, the health care professional may inadvertently give the message that "we know you really need to do this, but we are going to stop you because we don't really care what you think."¹³⁰

2.3.3 Active collusion; Scanlon and Adlam's objection to harm minimisation¹³¹

A significant critique of harm minimisation from a clinical perspective is to be found in the work of Scanlon and Adlam.¹³² I will consider their arguments in more detail in chapter 7 but make some preliminary comments here. The critique is developed within the academic field of inquiry associated with psychosocial studies, which considers the way that an individual's experience is interwoven with their broader social life. Both psychological issues and subjective experiences, it is argued, cannot be abstracted from societal, cultural and historical contexts. Psychosocial studies is an interdisciplinary approach to research that emphasises individual and social change. The approach has strong links with other fields of practice such as psychotherapy, psychoanalysis and group analysis.¹³³

Both Scanlon and Adlam are practising psychotherapists whose background is in psychodynamic psychotherapy. This is a particular model of working focused on revealing the unconscious content of the patient's psyche, which aims to resolve psychological tension and distress. The process is highly dependant upon the

¹²⁸ *ibid.* p. 325.

¹²⁹ *Ibid.*

¹³⁰ Sullivan (2018a). *Op.cit.* n67.p210.

¹³¹ Chapter 7 and Sullivan, P.J (2018b). Allowing harm because we care: Self-Injury and harm minimisation. *Clinical Ethics*. Vol. 13. No. 2. p. 88-97. These provide a response to Scanlon and Adlams perspective.

¹³² Scanlon, C.and Adlam, J. (2009). *Op.cit.* n114.

¹³³ This information is taken from the website of the Association for Psychosocial studies. www.psychosocial-studies-association.org.

interpersonal relationship between the patient and the therapist. It also provides a very specific understanding of self-injury, as psychodynamic understandings of self-injury focus on the unconscious meanings and functions of the individual's actions. Acts of self-injury are then seen as having unconscious meanings, a means of communicating repressed thoughts and feelings that cannot be allowed into the individual's conscious awareness, and these may often relate to childhood trauma. ¹³⁴ Adshead,¹³⁵ for example, has described self-injury in terms of a bodily communication of internal dynamics of the relationships with the self and others. Yakerley and Burbridge-James explain the importance of seeing the person's actions within the psychodynamics of their experiences over time, and the need to deal with their unmanageable feelings through the safety of a therapeutic relationship.¹³⁶

It is this psychodynamic model of intervention that informs the thinking of Scanlon and Adlam. They argue that harm minimisation is nothing more than a mechanism for avoiding thinking about the psychological issues that need to be addressed in working with people who self-injure. By allowing the person to continue to self-injure the health care professional merely reinforces a dysfunctional pattern of behaviour and effectively supports the perpetuation of self-injury. This approach suggests Scanlon and Adlam, is reflective of a failure to deal with important and underlying issues that are causing the self-injury. This results in a situation where the patient and the clinical team become stuck in patterns of behaviour that merely perpetuate the status quo and make further change unlikely. It is a form of therapeutic collusion. In chapter 7, the critique developed by Scanlon and Adlam is considered in some detail, and I respond to their concerns.

2.4 The ethical background

2.4.1 The work of Guttridge and Hewitt and Edwards

The literature approaching harm minimisation from a philosophical perspective is limited to the analysis completed by Guttridge,¹³⁷ and Hewitt and Edwards.¹³⁸ The

¹³⁴ Yakerley, J. and Burbridge-James, W. (2018). Psychodynamic approaches to suicide and self-harm. *British Journal of Psychiatry. Advances*. Vol. 24. p. 37-45.

¹³⁵ Adshead, G. (2016). Written on the body; deliberate self-harm and violence. In Weldon, E. and Van Velsen, C. (eds). *A practical guide to forensic psychotherapy*. London. Jessica Kingsley publishers. p. 110-114.

¹³⁶ Yakerley and Burbridge-James. (2018). Op.cit. n134 p.44.

¹³⁷ Guttridge (2010). Op.cit. n7.

¹³⁸ Edwards and Hewitt (2011). Op.cit. n126.

first supports harm minimisation based on its therapeutic benefits, even though she takes the view that self-injury is not fully autonomous. The second argues that given the options available to healthcare professionals harm minimisation is the most appropriate form of intervention. As I point out in chapter 6, I build on this work in developing my perspective. It is, therefore, important to be clear about their contribution to the literature.

In her work, Guttridge takes a supportive position in relation to harm minimisation, and there are four components to her argument.¹³⁹ First, the healthcare professional “assists” with the act of self-injury and contributes to the harm that occurs. Thus, they must accept some responsibility for their action. This raises important questions as health care professionals have a duty of care and a prima facie obligation to reduce the harms associated with self-injury. If the health care professionals actions or omissions reduce harm, then the actions taken can be justified. If, however, the harm is increased, then the acts or omissions of the health care professional could be seen as careless or even reckless.

Second, Guttridge emphasises autonomy and voluntariness as key philosophical concepts to support her argument, and in this sense, her work is influenced by that of Feinberg.¹⁴⁰ The act of self-injury, she argues, is neither voluntary nor fully autonomous. Self-injury it is claimed is not “maximally voluntary, but it also may not be completely non-voluntary.”¹⁴¹ Furthermore, self-injury is not a fully autonomous act, and a procedural/hierarchical model of autonomy informs Guttridge’s view.¹⁴²

Third, Guttridge turns her attention to the health professional’s obligation to reduce harm. Fundamental to Guttridge’s argument is the view that the health professional has a prima facie obligation rather than an absolute obligation not to cause harm.¹⁴³ She considers whether prohibiting or allowing self-injury is the most effective means of removing an individual from a harmed condition.¹⁴⁴ In attempting to answer this question, Guttridge contrasts subjective harm, as the person perceives it, and objective harm as measured independently of the person. She takes the view that

¹³⁹ Guttridge (2010). Op.cit. n71. p.79.

¹⁴⁰ Feinberg, J. (1986). *Harm to self. The moral limits of the criminal law. Volume 3.* Oxford. Oxford University Press.

¹⁴¹ Guttridge (2010). Op.cit. n71 p.80.

¹⁴² See Chapter 3 for more detail regarding the different models of autonomy.

¹⁴³ Feinberg cited in Guttridge (2010). Op.cit. n71. p.90.

¹⁴⁴ Guttridge (2010). Op.cit. n71. p. 89.

self-injury does not cause “relative harm” as subjectively defined by the individual. However, self-injury does maintain a state of “objective harm “when harm is measured independently.¹⁴⁵

Finally, Guttridge argues that the healthcare professional has a moral obligation to remove the individual from harm. Paradoxically reducing harm, she argues, may depend on allowing the individual to continue to self-injure in the short term. This position is based on two supportive arguments. First, although self-injury is a form of objective harm, “allowing self-injury does not appear to cause relative harm.”¹⁴⁶ Second, allowing harm in the short term may enhance the person’s autonomy. This is through the individual’s engagement with appropriate psychotherapeutic intervention, which will increase the individual’s capacity to make different choices and change may occur.¹⁴⁷ On this basis, Guttridge concludes, “health care practitioners are justified in allowing self-injury if they ensure relative harm does not occur and they work towards enhancing the patient’s capacity to undertake voluntary choices.”¹⁴⁸

In their analysis, Edwards and Hewitt,¹⁴⁹ address the question of whether supervising self-harm can be part of ethical nursing practice. At the start of the paper, they make two important points. First, that the normal approach to dealing with self-injury has taken “prevention to be a prima facie duty.”¹⁵⁰ Second, that harm minimisation appears to challenge the view that self-injury is “indisputably harmful.”¹⁵¹ Having made these points, they proceed to make a number of comments about the ethical issues that harm minimisation raises. These include asking whether it can be compatible with professional ethics for harm to be allowed to come to the patient. Edwards and Hewitt point out that the idea of harming oneself to enhance coping is paradoxical. They suggest that intuitively it would seem that not harming oneself or protecting oneself from harm would be the more obvious strategy.¹⁵² Questions are raised, they argue, about both the nature and the quantification of harm.

¹⁴⁵ Ibid.p.80.

¹⁴⁶ ibid. p.90.

¹⁴⁷ Ibid.

¹⁴⁸ ibid. p.90.

¹⁴⁹ Edwards and Hewitt (2011). Op.cit. n126.

¹⁵⁰ ibid. p.79.

¹⁵¹ ibid p.80.

¹⁵² ibid p. 80.

After dealing with these preliminary issues, Edwards and Hewitt consider three competing responses to self-injury. They evaluate each from an ethical perspective. The first is to prevent self-injury from occurring through interventions such as enhanced observation or the removal of implements that could be used to inflict self-injury.¹⁵³ The second is to allow self-injury to continue and to make no active attempt to prevent self-injury. The third is to make provisions for some form of supervised self-injury. This, they argue, is a compromise position between the two extremes described previously.¹⁵⁴ The advantages and disadvantages of adopting each of these positions are examined in some detail.

The issues considered in the course of this analysis include the most effective means of preventing harm, the importance of the therapeutic relationship, the need to balance harms and benefits, the link to suicide, the impact on staff and respect for autonomy. Moreover, during the course of the paper reference is made to a number of ethical theories or perspectives and these include the ethics of care, consequentialism, Kantian ethics, moral realism and the four principles approach. These are not examined or applied in any detail, and there is no overall ethical framework employed by Edwards and Hewitt in completing their analysis. After reviewing each of the alternative ways of dealing with self-injury, they conclude that supervised self-injury is the preferred option. They argue that this approach promotes both the continued use of coping strategies required by the patient and ensures that their autonomy is not compromised. Furthermore, the choices of the individual are respected, and the patient maintains control in a way that demonstrates moral concern and enhanced trust. This has a positive impact on the therapeutic relationship and the potential for improved clinical outcomes.

2.4.2 A counter-argument: the work of Schramme and Cudd

There is no specific counter-argument developed in the philosophical literature that deals directly with harm minimisation and self-injury and that argues against its use. Edwards and Hewitt¹⁵⁵ make the point that a Kantian perspective would be likely to oppose harm minimisation on the basis that an individual whom self-harms does not show themselves respect as a moral agent. They do not pursue this critique in any

¹⁵³ Ibid p.81.

¹⁵⁴Ibid. p. 84.

¹⁵⁵ Ibid p. 80.

detail, but it does constitute the basis of a different perspective. The theoretical work discussed so far considers the concept of autonomy as an essential constituent of the argument, and this is an underlying theme in the current thesis. However, it could be argued that harm minimisation does not support autonomy, as self-injury is both irrational and abnormal. Therefore, it would be contrary to our rationality and inimical to autonomy properly understood. Although Kant was critical of paternalism, in these situations, a preventative approach to intervention could be supported. Both Schramme¹⁵⁶ and Cudd¹⁵⁷ take this position, the former in the context of extreme body modification and the latter in the context of drug misuse.

A Kantian perspective, argues Schramme, would perceive “self-maiming” as a violation of a duty to oneself as it contravenes self-preservation. This is a necessary condition of morality. The wish to self-injure is in Kantian terms; therefore, a desire that cannot be rationally held.¹⁵⁸ These actions do not represent an autonomous choice and respecting autonomy in these circumstances may require some form of paternalistic intervention to support the person in making a rational, autonomous decision.¹⁵⁹ This is a form of beneficence, and it supports the individual’s status as a pursuer of ends.¹⁶⁰ Self-mutilation is, therefore, argues Schramme,¹⁶¹ an instance of harm that is severe enough to justify its prevention to protect and enhance the individual’s autonomy. In these circumstances, it is ethically required to try and prevent self-injury, and preventative strategies designed to stop risky behaviours occurring are broadly based on deontological ethics.¹⁶²

In her work on drug abuse, Cudd¹⁶³ also makes use of a Kantian type analysis in providing a counter-argument to the view that self-injury serves a positive function for some individuals. She argues that it is feasible to argue that there are certain desires, which a person cannot rationally hold. Although her paper relates to

¹⁵⁶ Schramme, T. (2008). Should we prevent non-therapeutic mutilation and extreme body modification? *Bioethics*. Vol. 22. No.1. p.8-15.

¹⁵⁷ Cudd, A.E. (1990). Taking drugs seriously: liberal paternalism and the rationality of preferences. *Public Affairs Quarterly*. Vol. 4. No. 1. p. 17-31.

¹⁵⁸ Ibid.

¹⁵⁹ Hinkley, A.E. (2012). Two rival understandings of autonomy, paternalism and bioethical principlism. In Engelhart Jr, H.T. (ed). *Bioethics Critically Reconsidered. Having second thoughts*. London. Springer. Chapter 5. p. 93.

¹⁶⁰ Kong, C. (2017). *Mental Capacity in relationship: Decision making, dialogue, and autonomy*. Cambridge. CUP. p. 173.

¹⁶¹ Schramme. (2008). Op.cit. n156.

¹⁶² Christie A, T. Groarke, L. and Sweet, W. (2008). Virtue ethics as an alternative to deontological and consequential reasoning in the harm reduction debate. *International Journal of Drug Policy*. Vol. 19. No. 1. p. 54.

¹⁶³ Cudd, (1990). Op.cit. n157. p.19.

substance abuse, she uses self-injury as an example. The argument she develops has two components. First, it cannot be rational to hurt oneself as to do so will reduce an individual's utility now and in the future. This resonates with the view that there can sometimes be a danger that we fail to appreciate the serious nature of self-injury and understand the considerable distress that accompanies it.¹⁶⁴ In effect, we attribute autonomy to individuals in the most inappropriate of circumstances.¹⁶⁵ Second, if it is agreed that injuring oneself is irrational, it would then be legitimate to take action to prevent it. This would be based on the view that the actions of the person are irrational. They may not represent their actual wishes and preferences and be part of their underlying identity. Paternalistic intervention is then justified in terms of helping the person to become more autonomous.¹⁶⁶

The essence of the arguments provided by both Schramme and Cudd is that some actions cannot be respected, as they are by their very nature, not autonomous. Action to prevent such actions is, therefore justified. Applied to self-injury, the argument could run as follows. Self-injury is not a rational decision, and we are mistaken in assuming that by adopting a harm minimisation approach, we respect the person's autonomy. In fact, what we are doing is denying them the care they require, and some form of paternalistic intervention can be justified or even required, in order to prevent harm if the harm is not autonomously pursued,¹⁶⁷ Stopping the self-injury and imposing treatment is justified as a means of enhancing the individual's autonomy.¹⁶⁸ We return to these issues in the next chapter but first some consideration of the relevant legal background.

2.5 The legal background to harm minimisation

In a health care setting, it has been argued that the law is primarily concerned with the relationship between the health care professional, the patient and the institutional setting in which care is provided.¹⁶⁹ The law influences health care as certain actions performed by the health care professional may be required or prohibited by the

¹⁶⁴ Babiker and Arnold (1997). Op.cit. n93. p.19.

¹⁶⁵ Jeffrey, S. (2000). 'Body Art' and social status: Cutting, tattooing and piercing from a feminist perspective. *Feminism and Psychology*. Vol. 10. p. 411.

¹⁶⁶ Matthews, E. (2003). Autonomy and the Psychiatric patient. *Journal of Applied Philosophy*. Vol. 17. No. 1. p. 67.

¹⁶⁷ Verkerk, M. (1999) A Care perspective on coercion and autonomy. *Bioethics*. Vol. 13. p. 358-368.

¹⁶⁸ Matthews (2003) Op.cit. n166. p. 67.

¹⁶⁹ Kennedy, I. and Grubb, A (2000). *Medical Law*. London. Butterworths.p. 5. It is important to note that this perspective has been criticised for being too narrow. See for example Herring, J. (2012). *Medical Law and Ethics*. Oxford. OUP.

law.¹⁷⁰ Health care is practised in an environment characterised by legal regulation, and we have seen a more interventionist stance in the twenty-first century. A failure to comply with the law can result in a civil or criminal action.¹⁷¹ As Brazier and Cave point out, health care cases are a regular feature of the law reports and practitioners can find themselves in the legal spotlight. Concerning doctors particularly, they make the point that; “at every level of medical practice, law plays a role. Doctors cannot escape the reach of the law.”¹⁷² This point has broader implications for other health care professionals.

In this environment, it is not surprising that practitioners are concerned about the implications of using a harm minimisation approach. Research indicates that they are concerned about the legal and professional implications involved. In a study of the views of staff within a forensic learning disability service, Fish et al,¹⁷³ found that in spite of support for harm minimisation, staff were concerned about their duty of care and their potential culpability. In a more recent research study,¹⁷⁴ James et al point out that the legal implications are unclear but that there is certainly a possibility of legal challenges such as claims of negligence. These are legitimate fears in an environment where the public is increasingly concerned with holding professionals to account if an adverse event occurs.¹⁷⁵

In addressing these concerns, we are beset by two problems. First, the work of Warner and Feery¹⁷⁶ and Hewitt¹⁷⁷ are the only publications that appear to consider harm minimisation from a legal perspective.¹⁷⁸ These are now both quite dated, and the issues they address need to be reconsidered, and this task is undertaken in chapter 4. This said, much of what they say still has currency and their views will, therefore, be examined in some detail. Warner and Feery look at how the law may support interventions that aim to prevent self-injury. Hewitt examines the

¹⁷⁰ Hoppe, N. and Miola, J. (2014). *Medical law and Medical Ethics*. Cambridge. CUP. p. 4.

¹⁷¹ *Ibid.* p. 9.

¹⁷² Brazier, M. and Cave, E. (2016). *Medicine, patients and the Law*. Manchester. MUP. p. XVII.

¹⁷³ Fish et al (2012). *Op.cit.* n77.

¹⁷⁴ James, K. Stewart, D. and Bowers, L. (2012) Self-harm and attempted suicide within in-patient psychiatric services: A review of the Literature. *International Journal of Mental Health Nursing*. Vol. 21. p.301–309.

¹⁷⁵ See Laurie, G.T. Harmon, S.H.E. Porter, G. (2016). *Mason and McCall Smith's Law and Medical Ethics*. Oxford. OUP. p. 129.

¹⁷⁶ Warner, S. Feery, D. (2007). Self-Harm and the law: What choices do we really have? In Spandler, H. Warner, S. (eds). *Beyond Fear and control. Working with young People who self-harm*. Ross on Wye. PCCS Books

¹⁷⁷ Hewitt (2004). *Op.cit.* n71.

¹⁷⁸ *Ibid.*

circumstances under which a practitioner may be held accountable should serious harm or death occur in a patient subject to a harm minimisation approach. The second problem, as Hewitt has argued,¹⁷⁹ is that harm minimisation functions in a legal and policy vacuum. There is no primary or secondary legislation or case law providing an effective legal framework.¹⁸⁰ Therefore, It is not possible to apply a traditional form of legal analysis based on the principle of statutory interpretation or precedent.¹⁸¹ There is one minor exception which we deal with below.

2.5.1 The Watkins case

In 2005 a prisoner named Jeffrey Watkins made an application for judicial review. A case reported in the literature¹⁸² and the media¹⁸³ but not formally reported in the law reports. This application appears to be the only case involving harm minimisation to have been subject to legal consideration in a judicial setting. Mr Watkins's counsel argued that he was an individual who had self-injured for some years. It was reported that medical experts agreed that cutting did lift his mood by releasing endorphins into his system. Therefore the risk of suicide was reduced.¹⁸⁴ The prisoner had requested sterile blades to self-injure in a hygienic manner. Mr Justice Newman refused permission for Mr Watkins to pursue judicial review. He is quoted as stating that "it is offensive to the individual, it is offensive to the (prison) staff and to the prison service and flies in the face of what we regard as civilised standards."¹⁸⁵ He took the view that the case was "unarguable."¹⁸⁶ It, therefore, failed to progress.

In discussing this case, Warner and Feery argue that this decision has wider implications because it can be used as a landmark case that sets a precedent.¹⁸⁷ Although this is unlikely, as the case never actually got beyond the preliminary stages of an application for judicial review, the case does raise some interesting issues. At one level, the Judge's reasoning could undoubtedly be challenged. First, he could be criticised for putting the abstract interests of the prison over the concrete

¹⁷⁹ Ibid.

¹⁸⁰ Ibid p. 148.

¹⁸¹ Ibid p. 148.

¹⁸² See Gutridge, K. (2013). *Self harm. The philosophical, Ethical and policy issues*. Kindle Edition; Warner and Feery, (2007). Op.cit. n176.p.136-148.

¹⁸³ See, The Journal – Prisoner's plea for razor is refused. 7 April 2007; BBC News 6 April 2005; Coventry Live – Suicide watch prisoner fails in razor blade claim.

¹⁸⁴ BBC News 6 April 2005.

¹⁸⁵ Ibid.

¹⁸⁶ Ibid.

¹⁸⁷ Warner and Feery (2007). Op.cit. n176. p. 137.

interest of the individual. Second, in developing his arguments, he appeals to the notion that the proposal is “offensive” and yet it is not clear exactly why it is offensive in either a moral or judicial sense. This immediately raises the question of whether the fact that someone takes ‘offence’ should override the interests of the individual. Moreover, it raises the strong possibility that the judge’s reasoning was based on an instinctive abhorrence against self-injury and a proposal that appeared to encourage it. Unfortunately, this sort of attitude could be an issue in any future case and is one of the critical issues that undermine the wider adoption of harm minimisation approaches in practice.¹⁸⁸ In spite of this, rejection of the application appears to be reasonable based on other reasons.

Watkins had a diagnosis of bipolar disorder associated with serious suicide attempts. Furthermore, he proposed that he had the right to cut through to the muscle, thus causing serious injury, and this has the potential for permanent damage and the development of life-threatening infections. Moreover, in circumstances where there is a risk of serious harm or suicide a harm minimisation approach would not be clinically indicated. In addition, the provision of razor blades to an individual within a prison setting constitutes a significant risk to others, and Watkins appears to have had a history of violence. Add to this that such an initiative is contrary to prison rules, and there is unlikely to be the level of specialist mental health expertise available to support the proposal. Then despite the autonomy-based arguments proposed by Watkins, the balance of costs and benefits are unlikely to come out in favour of a harm minimisation approach. In fact, as we shall see the requirements of Article 2 of the European Convention on Human Rights could mitigate against this proposal.¹⁸⁹

2.5.2 Warner and Feery: restricting self-injury

It is the view of Warner and Feery that the law restricts a person’s choice to self-injure as a form of coping.¹⁹⁰ The analysis starts from the position that self-injury is usually a private matter. However, when individuals who self-injure come into contact with professionals then private decisions are mediated by the professional decisions of others. In this situation, respecting the individual’s choices must be balanced against professional responsibilities and possible accusations of negligence. A moral

¹⁸⁸ I am indebted to Nicola Glover Thomas and Simona Giordano for informing my analysis on this issue. See also Chapter 7 and 10 which comments further on these issues.

¹⁸⁹ See chapter 4 and 9 for a consideration of the issues associated with Article 2.

¹⁹⁰ Warner and Feery, (2007). Op.cit. n176. p.136.

decision about respecting choices is then transformed into a legal decision relating to the responsibilities of both the professional and the state.¹⁹¹

In developing their analysis, Warner and Feery consider the impact of the Mental Health Act 1983 amended 2007¹⁹² and the Human Rights Act 1998.¹⁹³ They argue that a person who self-injures may be detained under the Mental Health Act. This would not be as a direct result of the self-injury but because the behaviour was seen to be the result of a mental disorder that was associated with a risk to self. Detention in hospital will lead to infringements on the person's liberty, which will be curtailed for the purpose of assessment and/or treatment.¹⁹⁴ This, they argue, will lead to a more preventative approach to dealing with the individual's self-injury as the hospital authorities must comply with the Mental Health Act Code of Practice. At the time, this stated that an individual must be protected from themselves if their self-injury was due to a mental disorder.¹⁹⁵ The Code now refers to the need to protect patients who are at risk of self-harm,¹⁹⁶ and although less explicit the essence remains the same. Warner and Feery also make the point that although a person may be detained under the Mental Health Act, it is wrong to assume that they also lack the capacity to make decisions,¹⁹⁷ an issue that I will return to shortly.

The analysis by Warner and Feery also considers the impact of Article 2 of the European Convention on Human Rights.¹⁹⁸ This is incorporated into English law through the Human Rights Act 1998.¹⁹⁹ This deals with the requirement of the State to protect the right to life of the individual, and it is argued that if self-injury were seen to imply a risk of suicide, then a failure to take preventative action may mean that clinical judgements are overridden by legal considerations. Article 2 like the Mental Health Act, is for Warner and Feery an example of a legal framework, which may increase the propensity for health professionals to make use of more restrictive

¹⁹¹ Ibid.

¹⁹² Mental Health Act 1983 amended 2007 Chapter 20. Available at <http://legislation.gov.uk>

¹⁹³ Human Rights Act 1998 Chapter 42. Available at <http://legislation.gov.uk>

¹⁹⁴ Ibid. p. 138.

¹⁹⁵ Department of Health and Welsh Office. (1999). *Code of Practice: The Mental Health Act 1983*. London. Stationary Office.

¹⁹⁶ Department of Health (2015). *Mental Health Act Code of Practice*. Norwich. TSO. p. 72.

¹⁹⁷ Warner and Feery (2007). Op.cit. n176. p.141.

¹⁹⁸ Convention for the Protection of Human rights and Freedoms. European Convention on Human Rights, as amended. ECHR Article 2

¹⁹⁹ Warner and Feery (2007). Op.cit. n176.

forms of intervention to “cover their backs.”²⁰⁰ In chapter 4, I deal with these issues in more detail.

2.5.3 Hewitt: accountability and liability in supporting self-injury

The analysis by Hewitt is broader in scope and although published in 2004 continues to have some resonance today.²⁰¹ He starts by making two important arguments regarding the Mental Health Act 1983 amended 2007.²⁰² First, he asks whether there is a legal basis for the use of harm minimisation approaches. If this is not the case, then health care professionals could be acting unlawfully should they adopt such practices. He dismisses this concern through a brief analysis of the legal basis for medical treatment, which makes use of the jurisprudence around the Mental Health Act. The Act adopts an expansive definition of medical treatments, and on this basis, Hewitt concludes that at least some forms of harm minimisation could be seen to constitute medical treatment.²⁰³ A more recent analysis²⁰⁴ and subsequent case law²⁰⁵ would confirm this position. Second, he argues that although harm minimisation could be conceived as a medical treatment under the Act, it cannot be enforced and is dependent upon the person’s ability to provide valid and reliable consent. The direct role of the Mental Health Act in relation to harm minimisation is therefore limited.²⁰⁶

The review then goes on to consider a number of potential challenges to harm minimisation from a legal perspective. Hewitt spends some time focused on the possibility of a civil claim or criminal charges. Concerning clinical negligence, he notes that given that harm minimisation is still far from established as a clinical intervention the application of the *Bolam* test²⁰⁷ would require an expert witness to have to justify the very existence of the intervention. He argues that this would be unusual as in most cases of negligence, the actual treatment is accepted as

²⁰⁰ibid.p. 140.

²⁰¹ Hewitt (2004). Op.cit. n71.

²⁰² Ibid.

²⁰³ Hewitt (2004).Op.cit.n71. p. 148.

²⁰⁴ Laing, J. (2015). Doctors’ orders? Analysing appropriate medical treatment in mental health law. In Forvargue, S. and Mullock, A. (eds). *The legitimacy of medical treatment: What role for the medical exception*. Chapter 10. P. 160-182.

²⁰⁵ *MD V Nottinghamshire Healthcare NHS Trust* [2010] UKUT 59 (AAC); *Reid v Secretary of State for Scotland* [1998] UKHL 43; *Hutchison Reid v The United Kingdom*. Application [2003] no.50272/99.

²⁰⁶ ibid p. 156.

²⁰⁷ *Bolam V Friern Hospital Management Committee* [1957] 1 WLR 582. The case is considered in more detail in chapter 4.

standard practice, and it is the application of the treatment that is open to question. Thus, such a justificatory process would not arise. It is argued that identifying a body of responsible professional opinion may be difficult and the application of the *Bolitho* test,²⁰⁸ whereby evidence presented in court must be able to withstand logical analysis may present challenges. Several possible sources of evidence are considered, and Hewitt argues it remains an open question whether the court would accept such evidence. Based on his analysis, Hewitt argues that a civil claim is likely to prove problematic. I examine this argument in more detail in chapter 4.

The analysis then moves on to consider the possible implications of the criminal law through a charge of manslaughter. The overall analysis developed by Hewitt focused on the complex issues around the supply and administration of illicit drugs to a consenting adult.²⁰⁹ He considered how case law dealing with this issue could be relevant, as the actions under scrutiny involved an individual assisting a person to inject themselves and hence cause harm. The case law he considered has now been superseded by more recent judgements and makes his original arguments less persuasive, although his overall judgement could still stand. He states that where a health care practitioner makes use of one of the more risky techniques associated with harm minimisation, and in these cases he appears to be referring to the provision of sterile blades to the patient, then “it is neither fanciful nor alarmist to suggest that the practitioner might be charged with manslaughter.”²¹⁰ The most likely scenario would be a charge of gross negligence manslaughter. This is a criminal offence that applies when death results from an act or omission that is considered to be grossly negligent in a situation where the defendant owes a duty of care.²¹¹ Again, I subject this argument to more detailed analysis in chapter 4.

²⁰⁸ *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771. See chapter 4 for a more detailed discussion.

²⁰⁹ Hewitt’s analysis is focused on the case of *R v Rogers* [2003] EWCA Crim 945, the case was subsequently superseded by *R v Kennedy* [2007] UKHL 38

²¹⁰ Hewitt (2004). Op.cit. n71 p. 163.

²¹¹ *R v Adomako* [1994]. Op.cit. n209; *R v Rose* [2017] EWCA Crim 1168.

Based on his analysis, Hewitt draws a number of conclusions of which the following are relevant. First, in some circumstances, it may be lawful to assist a capable patient to self-harm, and this may be seen to constitute medical treatment. Second, a patient is highly unlikely to be in a position where this type of intervention could be compelled, so it sits outside the statutory framework provided by the Mental Health Act. Therefore, the patient must be capable of consenting to treatment, and it would be important to be clear that the patient was not subject to any undue pressure to consent. Third, both civil and criminal actions cannot be excluded, particularly in those situations where the more risky techniques associated with harm minimisation are applied, and serious harm or death occurred. Fourth, given the above, health professionals and the organisations that employ them must ensure that any approach used must meet the requirements of the *Bolam* and *Bolitho* tests. I return to these issues in chapter 4 and chapter 9.

2.6 Conclusion

In his chapter, I have built on the clinical discussions undertaken in the previous chapter. I have provided an overview of the ethical and legal background that applies to the use of harm minimisation approaches when applied to self-injury. I have defined the research problem and have contrasted preventative and permissive approaches to intervention in terms of the on-going tension between autonomy and paternalism that pervades clinical practice in a mental health setting. The clinical case for and against harm minimisation was then presented, and this was followed by a review of the literature that deals with the ethical issues involved. This work is limited and generally supportive. I drew on the wider literature to demonstrate how a counter argument could be developed. I went on to consider the legal background, and a number of issues came to the fore. When an individual is admitted to hospital, their personal choices may come into conflict with the professional and legal responsibilities of the health care professional. They are bound by legal and professional rules that are subject to scrutiny by both the courts and regulatory bodies. Add to this a litigious environment in which civil actions and criminal prosecutions are a legitimate concern,²¹² then the risk of serious harm or even death, however remote, will bring questions of liability and culpability to the fore. In the next two chapters, I consider in more detail the philosophical and legal approaches that

²¹² Hewitt (2004). Op.cit.n71.

provide the theoretical underpinnings for the analysis that is developed in chapters 6 to 9 and my analysis builds upon the work described in this chapter.

Chapter 3 : Philosophical Approach

3.1 Introduction

The purpose of this chapter is to consider the philosophical approach that directs the analysis. It builds on the content of chapter 2 with a more detailed examination of autonomy, paternalism and harm, paying particular attention to the role they play in the development of the first two papers. The chapter also introduces a new perspective into the analysis in the form of the conceptual framework of epistemic injustice, which facilitates the development of a perspective based on the views of individuals with lived experience of self-injury which informs chapter 8.

This chapter will be structured in three parts. First, I will consider the concept of autonomy in a way that informs the theoretical arguments developed in chapter 6. I will describe the challenges associated with defining autonomy and then go on to apply the concept in a healthcare context. I will note the presence of a conceptual core that describes the essence of the concept but will note the different models of autonomy to be found in the literature and the various conceptual distinctions that characterise any analysis of the concept. I will then describe how this has practical implications in a healthcare setting. Second, I will consider the concept of paternalism, beginning by describing the standard definition of the term and going on to consider some of the conceptual distinctions found in the literature. I pay particular attention to the distinction between soft and hard paternalism and will then argue that the inherent tension between autonomy and paternalism can give rise to four different clinical scenarios. Third, I consider the theoretical challenges associated with understanding the concept of harm. This is important given that a central question running throughout the thesis is whether harm should be allowed as part of the therapeutic process. This forms part of the argument developed in chapter 6 but more specifically, in chapter 7. I will begin by providing a definition of harm and the associated notion of benefit. I will briefly outline why this is clinically relevant and refer to the notion of first do no harm, which is considered a primary imperative in a health care setting. I will then go on to differentiate between the idea of pro tanto and overall harm before completing this section of the thesis with a discussion of Feinberg's analysis of harm, which prepares the way for the arguments developed in

subsequent chapters. Finally, I will consider the concept of epistemic injustice, which provides the theoretical background for chapter 8. I will draw on the theoretical literature to describe the different types of epistemic injustice and then to explain why these concepts are relevant to healthcare, mental healthcare and particularly the study of self-injury.

3.2 Autonomy

The word autonomy is derived from the Greek “autos” meaning “self” and “nomos” meaning “rule, governance or law.” It originally referred to the self-rule of independent city states.²¹³ The concept has been considered from a range of perspectives and has ethical importance in a number of different areas such as medical ethics and the law.²¹⁴ Feinberg²¹⁵ has noted that the term ‘autonomy’ is typically used in four different ways. First, it may refer to a capacity to govern oneself, that is the ability to make rational choices and to act and choose independently. Second, autonomy may be seen as a condition, and in this sense, it refers to how individuals govern themselves.²¹⁶ Third, it may be understood as a sovereign authority where it refers to the entitlement to certain rights. Finally, it may be viewed as an ideal, which refers to a goal the individual may aspire to, whereby the individual’s choices are fully authentic, and the individual realises their potential as a person.²¹⁷

These “varieties of autonomy”²¹⁸ mean it is not always clear what autonomy refers to, and Dworkin has argued that the only common features that the different accounts of autonomy possess are that it is a “feature of persons and a desirable

²¹³ Beauchamp, T.L. and Childress, J.F. (2013). *Principles of Biomedical Ethics*. Oxford. Oxford University Press. p. 101.

²¹⁴ O’Neil, O. (2002). *Autonomy and Trust in bioethics*. Cambridge. Cambridge University Press.

²¹⁵ Feinberg (1986). Op.cit. n 140.

²¹⁶ *ibid.* p.31.

²¹⁷ Christman, J. (2018). Autonomy in moral and political philosophy. The Stanford Encyclopedia of Philosophy. In E. N. Zalta (ed),

URL=<https://plato.stanford.edu/archives/spr2018/entries/autonomy-moral/>

²¹⁸ O’Neil (2002). Op.cit. n214.

quality to have".^{219 220} In spite of this, Christman²²¹ has argued that there is a conceptual core that can be identified. More recently, he argues that the fundamental idea of autonomy refers to the capacity to be one's own person and to live life according to one's own reasons and motives. These reasons and motives should not be the product of manipulative or distorting external forces.²²² On this basis, as Feinberg argues, individuals should be respected and be free to make their own choices and to shape and plan their lives without interference from others.²²³ In spite of this core, there are a number of different accounts of autonomy, and in a review of the literature Ashley²²⁴ describes three different models. These are the procedural, substantive and relational.

3.2.1 Different models of autonomy

Procedural approaches to autonomy focus on the nature of the decision-making process rather than the content of the decision made. Under this perspective, autonomy is content-neutral, and there are no actions or choices, which are by their very nature non-autonomous. The critical issue is whether the individual has followed the most appropriate procedure in coming to his or her decision.²²⁵ The decision-maker rather than the decision is the important factor, and as long as the decision-maker is competent and has undertaken an evaluative procedure, which involves rationally considering and endorsing the values, desires and preferences on which the decision is made, then the individual's choice is autonomous.²²⁶ The nature of the values, desires and preferences is of secondary importance or not important at

²¹⁹ Dworkin, G. (1988). *The theory and practice of autonomy*. Cambridge. Cambridge University Press. p. 6.

²²⁰ For a further discussion of this issue, see; Dworkin, G. (1988). Op.cit. n217; Arpaly, N. (2003). *Unprincipled virtue. An Inquiry into moral agency*. Oxford. Oxford University Press. Chapter 4.

²²¹ Christman, J. (1989). Introduction. In Christman, J. (ed). *The Inner Citadel. Essays on individual autonomy*. Oxford. Oxford University Press. p.6.

²²² Christman (2018). Op.cit.n217.

²²³ Feinberg (1986) n140.

²²⁴ Ashley, V. (2012). *Philosophical models of personal autonomy*. Essex Autonomy Project. University of Essex.

²²⁵ Charles, S. (2010). How should feminist theorists respond to the problem of internalized oppression. *Social Theory and Practice*. Vol. 36. No. 3. p. 409.

²²⁶ Sperry, E. (2013). Dupes of patriarchy: Feminist strong substantive autonomy's epistemological weakness. *Hypatia*. Vol. 28. No. 4. p. 888.

all. Examples of procedural approaches to autonomy are found in the work of Frankfurt,²²⁷ Dworkin²²⁸ and Christman.²²⁹

Procedural approaches are typically contrasted with substantive approaches to autonomy. In contrast to procedural models, substantive theorists argue that certain preferences and values cannot be compatible with autonomy based on their content.²³⁰ The focus thus turns from the process of decision-making to the nature of the decision made. These approaches are, in turn differentiated as weakly substantive,²³¹ or strongly substantive.^{232 233} In weakly substantive models of autonomy, a decision is autonomous only if certain “supplemental’ requirements are in place.²³⁴ This means that certain choices are not inherently non-autonomous, but they do require that the individual possesses certain attitudes and characteristics such as self-respect and self-esteem for their actions to be autonomous.²³⁵ These character traits militate against factors that will undermine the individual’s autonomy and allow the individual to take ownership of their actions and choices.²³⁶ A choice is not good or bad, but the individual must possess certain attitudes in order to make it. Examples of weakly substantive models of autonomy include the work of Benson²³⁷ and Westlund.²³⁸

²²⁷ Frankfurt, H. (1971). Freedom of the will and the concept of a person. *Journal of Philosophy*;

²²⁸ Dworkin, (1988). Op.cit. n219.

²²⁹ Christman, J. (2009). *The politics of persons. Individual autonomy and socio-historical selves*. Cambridge. Cambridge University Press

²³⁰ Stoljar, N. (2018). Feminist perspectives on autonomy. *The Stanford Encyclopedia of Philosophy*. (Winter 2018), Edward N. Zalta (ed), URL=<https://plato.stanford.edu/archives/win2018/entries/feminism-autonomy/>>.

²³¹ See Benson, P. (2005). Taking Ownership: Authority and voice in autonomous agency. In Christman, J. and Anderson, J. (eds). *Autonomy and the challenges to liberalism*. New Essays. Cambridge. Cambridge University Press. Chapter 5. p. 101-126; Kristinsson, S. (2000). The limits of neutrality towards a weakly substantive account of autonomy. *Canadian Journal of Philosophy*. Vol. 30. No. 2. p. 257-286.

²³² See, for example, Oshana, M.A.L. (2006). *Personal autonomy in society*. London Routledge.

²³³ See Oshana, M. (2015). Personal Autonomy and Social Oppression. *Philosophical Perspectives*. London. Routledge; Veltman, A. and Piper, M. (2014). *Autonomy, Oppression, and Gender*. Oxford. Oxford University Press. For recent edited volumes associated with the complex issues surrounding substantive autonomy.

²³⁴ Charles (2010). Op.cit. n225 p. 410.

²³⁵ Sperry, E. (2013). Op.cit. n226; Benson (2005). Op.cit. n231.

²³⁶ Benson (2005). Op.cit. n231; Dillon, R. (1992). Toward a feminist conception of self-respect. *Hypatia*. Vol. 7. No.1. p. 52-69; Govier, T. (1993). Self-trust, autonomy and self-esteem. *Hypatia*. Vol. 8. No. 1. p. 99-120.

²³⁷ Benson (2005). Op.cit. n231.

²³⁸ Westlund, A. (2003). Selflessness and responsibility for self: is deference compatible with autonomy? *The Philosophical Review*. Vol. 112. No. 4. p. 483-523.

In strongly substantive models of autonomy, some choices will by their very nature be considered non-autonomous.²³⁹ For example, Stoljar²⁴⁰ argues that preferences, which develop in the context of oppressive norms, cannot be autonomous. Thus, specific criteria external to the individual are important.²⁴¹ This means that certain ways of living or certain decisions cannot be autonomous. Oshana's socio-relational account of autonomy is an example of a strongly substantive model of autonomy.²⁴² Strongly substantive models can be quite demanding, and actions that would be seen as autonomous at an intuitive level may fail to meet the requirements of autonomy described in these models.²⁴³

Procedural, weakly substantive and some strongly substantive models of autonomy have been criticised as being overly individualistic. A focus on the individual's ability to make rational choices may ignore the fact that decisions are not taken in isolation from others. Relational models provide an alternative to such approaches and developed in response to their perceived deficiencies.²⁴⁴ Under a relational model, autonomy can only be defined in a social context.²⁴⁵ These approaches are based on the view that an individual forms their values, desires and preferences in the context of social relationships. Identities cannot be separated from such relationships, and social determinants such as race, class, gender and ethnicity have a formative influence.²⁴⁶ The importance of relationships is that they impact on an individual's ability to develop autonomy and where these relationships are oppressive, they may damage the development of the competencies and capacity necessary for autonomy.²⁴⁷ Like individualistic models of autonomy, relational models may also be procedural or substantive.²⁴⁸

²³⁹ Stoljar, N. (2000). Autonomy and the feminist intuition. In Mackenzie, C. and Stoljar, N. (eds). *Relational Autonomy Feminist Perspectives on Autonomy, Agency and the Social Self*. Oxford. Oxford University Press. p. 109.

²⁴⁰ Ibid. p.94-111.

²⁴¹ Charles (2010). Op.cit. n225. p.411.

²⁴² Oshana. (2006). Op.cit. n 232.

²⁴³ Quante, M. (2011). In defence of personal autonomy. *Journal of Medical Ethics*. Vol. 10. p. 599.

²⁴⁴ See Nedalsky, J. (1989). Reconceiving Autonomy: Sources, Thoughts and Possibilities. *Yale Journal of Law and Feminism*. Vol. 1. p. 10; Jennings, B. (2016). Reconceptualising Autonomy: A relational turn in bioethics. *Hastings Center Report*. Vol. 46. No. 3. p. 11-16.

²⁴⁵ McLeod C, Sherwin, S. (2000). Relational autonomy, self-trust and health care for patients who are oppressed. In Mackenzie and Stoljar (200). Op.cit.n239. p.259–260.

²⁴⁶ Ibid. p. 4.

²⁴⁷ Ibid.

²⁴⁸ Kong (2018). Op.cit.n160.

3.2.2 Some further conceptual distinctions

Another distinction is between basic and ideal versions of autonomy. At its most basic level, autonomy refers to an all-or-nothing concept that identifies the minimal capability required to undertake a specific task or to make a certain choice. This reflects the understanding of capacity described in the Mental Capacity Act.²⁴⁹ The majority of individuals will reach this threshold, and it has applications in the healthcare setting through the rules regarding consent to treatment. Autonomy as an ideal is something different and is much more demanding. It requires a much higher level of functioning and is something that we should aspire to, Christman and Anderson describe it in terms of a regulative idea.²⁵⁰ It refers to a set of values and competencies that not everyone will achieve and the more demanding the ideal, the smaller the number of people who would be described as autonomous.

A further distinction is also made between what Oshana²⁵¹ terms local or global autonomy. The former involves acting autonomously in relation to a specific act or decision in the present. The latter describes the idea of being able to govern one's life as a whole. Other characterisations of this dichotomy are found in the literature. Young,²⁵² for example, has differentiated between occurrent and dispositional autonomy, Sneddon has distinguished between shallow and deep autonomy,²⁵³ Meyers²⁵⁴ between the episodic and the programmatic autonomy. Although the terms used are different, all these authors refer to a distinction between a particular occasion in which a choice needs to be made and choices made over a lifetime. Local autonomy is focused on how an autonomous decision is made, and global autonomy concerns the nature of an autonomous life.

²⁴⁹ Feinberg (1986). Op.cit. n140. p. 28.

²⁵⁰ Christman, J. and Anderson, J. (2005). *Autonomy and the challenges to liberalism. New Essays*. Cambridge. Cambridge University Press.p. 2.

²⁵¹ Oshana, M.A.L. (2002). The misguided marriage of responsibility and autonomy. *The Journal of Ethics*. Vol. 6. p. 261-280.

²⁵² Young, R. (1986). *Personal autonomy. Beyond negative and positive liberty*. London. Routledge.

²⁵³ Sneddon, A. (2001). Advertising and deep autonomy. *Journal of Business Ethics*. Vol. 33. No. 1. p.15-28.

²⁵⁴ Meyers, D.T. (1987). *Self, Society, and Personal Choice*. New York. Columbia University Press.

This distinction between an autonomous choice and an autonomous person is important and draws attention to the importance of considering both competency and authenticity conditions of autonomy. Competency conditions refer to autonomous decisions and whether an individual has the skills and capacities required for decision-making.²⁵⁵ Authenticity conditions require engagement with more metaphysical questions about autonomous persons. They are concerned with the person's capacity for self-governance and whether the choices made are authentic. This means that they are made on the basis of reasons and values that reflect the person's identity as it has developed over time.²⁵⁶ The individual must be in a position to make a decision based on his or her desires and preferences. This includes the capacity to reflect upon and support a particular perspective in a way that is not influenced by illness or any form of coercion, however subtle the latter may be. The Individual's decisions are their own, and they take responsibility for how they live.

3.2.3 Autonomy in a healthcare context

The idea that individuals should make their own decisions about healthcare issues is a central concept in medical ethics.²⁵⁷ What this brief overview illustrates is that this can be difficult, as identifying a theoretical account of autonomy that can do the heavy lifting required in a clinical context has proved challenging. As we have seen, it can be difficult to reconcile different understandings of autonomy and choices that would be regarded as autonomous in one model may not be regarded as autonomous under another. The solution to this problem in a medical context has been to adopt models of autonomy that have a predominantly procedural and individualistic focus, and this has been subject to criticism, and this is an issue to which we shall return. However, before this, there is a further level of complexity that requires attention. In a healthcare context, other values must be taken into account. For example, respect for autonomy must always be balanced with the need to protect the individual from the consequences of choices and actions that could result

²⁵⁵ Christman and Anderson (2005). Op.cit. n250.

²⁵⁶ Mackenzie, C. (2014). Three dimensions of autonomy: A relational analysis. In Veltman and Piper. Op.cit. n233. Chapter 2. p. 15-41; Sjostrand, M. Eriksson, S. Juth, N. Helgesson, G. (2013). Paternalism in the name of autonomy. *Journal of Medicine and Philosophy*. Vol. 38. No. 6. P. 710-24.

²⁵⁷ Taylor, J.S. (2018). Introduction: Autonomy in Healthcare. *HEC Forum* Vol. 30. p. 187-189.

in serious harm or even death. In these circumstances, the need to promote the individual's welfare raises ethical considerations that engage the concept of paternalism. The justification for paternalism in health care is based on the beneficence principle, whereby any healthcare intervention aims to benefit the patient.²⁵⁸ The fact that they must also respect the patient's autonomy means that tensions between what the patient wants and what the health care professional feels he or she needs may conflict. Paternalism arises when autonomy is overridden.²⁵⁹

3.3. Paternalism

There is a significant literature considering the concept of paternalism.²⁶⁰ The basic idea is articulated in what Scoccia describes as the "standard definition."²⁶¹ Scoccia argues that such a definition is proposed by Dworkin,²⁶² and incorporates three key components. First, there is some form of coercive interference to prevent a person from acting in a particular way. Second, this interference is associated with an absence of consent and is therefore against the person's will. Third, the intervention is supported on the basis that it is for the good of the individual and is justified in terms of their wellbeing. In the literature, it is often although not exclusively argued that paternalistic actions are presumptively wrong unless there are morally relevant considerations that justify them.²⁶³ Scoccia has summarised the main objections to paternalism as follows.²⁶⁴ First, paternalistic intervention is rarely of benefit as the individual is the best judge of their interests.²⁶⁵ Second, even if the paternalist does

²⁵⁸ Beauchamp and Chidress (2013). Op.cit. n213. Chapter 2. p.202-248.

²⁵⁹ Groll, D. (2014). Medical Paternalism-Part 2. *Philosophical Compass*. Vol. 9. Issue 3. p.195-197.

²⁶⁰ See Coons, C. and Weber, M. (2013). *Paternalism. Theory and Practice*. Cambridge. Cambridge University Press; Grill, K. and Hanna, J. (2018). *The Routledge Handbook of the Philosophy of Paternalism*. London. Routledge. These edited volumes provide an overview of the issues.

²⁶¹ Scoccia, D. (2018). The concept of paternalism. In and Grill and Hanna (2018) Op.cit. n260. Chapter 1.

²⁶² See Dworkin, G. (1972). Paternalism. *The Monist*. Vol. 56. No.1. p. 64-85. Dworkin defines paternalism as "the interference with the person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced" (p. 65); Dworkin, G. (2017). Paternalism. *The Stanford Encyclopedia of Philosophy* (winter 2017 Edition). Edward Zalta (ed), URL=<https://plato.stanford.edu/archives/win2017/entries/paternalism/>.

²⁶³ Van Der Veer. (1986). Op.cit. n88.

²⁶⁴ Scoccia, D. (2013). The right to autonomy and the justification of hard paternalism. In Coons and Weber (2013). Op.cit. n260. Chapter 4. P. 74-92.

²⁶⁵ See, for example, Cornell, N. (2015). A third theory of paternalism. *Michigan Law Review*. Vol.113. p.1295-1336. Who argues that paternalism is questionable because it implies the other person cannot decide for herself.

know best, the use of force outweighs the benefits of any form of intervention. Finally, such intervention violates the individual's right to autonomy.²⁶⁶ The presence of coercion and the absence of consent mean that the concept is often used pejoratively.²⁶⁷

3.3.1 Soft and hard paternalism

According to Feinberg,²⁶⁸ paternalism comes in two forms: soft and hard paternalism. Soft paternalism refers to paternalistic interventions undertaken when the person's actions are not autonomous or more specifically, not voluntary. Intervention may also be required to establish whether the individual's actions are autonomous and voluntary. Hard paternalism refers to paternalistic interventions that aim to prevent harm to a competent and therefore autonomous individual. Soft and hard paternalism reflect two contrasting ethical positions.

The first suggests that autonomy is the paramount value, and unless autonomy is lacking, then the person's choices and actions must be respected. Christman makes this point,²⁶⁹ when he argues that a lack of autonomy opens the door to intervention to improve a person's wellbeing, whereas the presence of autonomy closes such a door. The origins of soft paternalism may be traced back to Mill. He argued that the only ground for interferences with a person's choices is the requirement to prevent harm to others.²⁷⁰ The only exception to this is that the choice is not autonomous. The concept of autonomy, therefore, plays a vital role in the debate regarding the ethics of paternalistic intervention.²⁷¹

²⁶⁶ In his analysis, Scoccia describes the position in terms of three principles; the best judge, force and sovereignty principles. When applied together, the argument is that the person knows their best interests, force always causes harm and rarely produces benefits, and although a paternalistic intervention may benefit it wrongs as it violates the right of autonomy. See Scoccia (2013). Op.cit. n264. p. 74.

²⁶⁷ A point illustrated by the etymology of the term, which originates in the Latin "pater" and translates as to act like a father, and therefore by implication to treat like a child.

²⁶⁸ See Feinberg (1986). Op.cit. n140.

²⁶⁹ Christman, J. (2014). Relational autonomy and the social dynamics of paternalism. *Ethical Theory and Moral Practice*. Vol. 17. No. 3. p. 369-382.

²⁷⁰ Mill, J.S. (1859). *On Liberty*. London. Penguin; Feinberg, J. (1984). *Moral Limits of the criminal law*. Volume 1: harm to others. Oxford. Oxford University Press.

²⁷¹ Schone-Seifert, B. (2015). Paternalism: its ethical justification in medicine and psychiatry. In Schramme, T. (ed). *New perspectives on paternalism and health care*. London. Springer. Chapter 10. P. 145-162.

The second position takes the view that welfare considerations can legitimately override autonomy, and intervention can be justified based on its outcomes. It is argued that the idea of autonomy is not inviolable and can be overridden if this benefits the individual. In fact, it is often morally right or even obligatory to intervene to change behaviour.²⁷² For example, Conly has argued,²⁷³ that by allowing individuals to cause themselves harm, we do not respect human value. On this basis, she develops an argument for what she terms coercive paternalism. She argues that where individuals act in ways that “undercuts their own chances of happiness” then paternalism, even if not welcome, is necessary.²⁷⁴

The contrast between soft and hard paternalism reflects a tension between autonomy on the one hand and wellbeing on the other. This is, argues Sneddon, an intransigent problem as the former is a deontological argument while the latter takes a consequentialist position. He summarises the difficulty this presents in the following way, “since we have no generally agreed upon way of adjudicating conflict between consequentialist and deontological values, paternalism turns out to be a resilient problem”.²⁷⁵ Nowhere is this resilience more apparent than in the treatment of self-injury.

3.4. Autonomy and paternalism: Clinical implications

The concepts of autonomy and paternalism raise important issues when applied in the context of self-injury and harm minimisation. At the outset, it is important not to conflate an individual’s autonomy to decide on whether or not to self-injure with their autonomy to make decisions about consent to treatment. Although there are questions about whether the act of self-injury can be considered autonomous, there are very different questions about whether an individual possesses a sufficient level

²⁷² Graylin, W. Jennings, B. (2003). *The perversion of Autonomy*. Georgetown. Georgetown University Press; Conly, S. (2013). *Against autonomy*. Cambridge. Cambridge University Press.

²⁷³ Conly, (2013). Op.cit.n272.

²⁷⁴ *ibid* p. 349.

²⁷⁵ Sneddon, A. (2006). Equality, Justice, and Paternalism: Recentering debate about physician-assisted suicide. *Journal of Applied Philosophy*. Vol. 23. No. 4. p. 395.

of autonomy to choose to participate in a therapeutic programme involving harm minimisation approaches. Add to this the fact that some would argue that the issue of autonomy is irrelevant, and the very nature of self-injury means that action should be taken to prevent it; we are faced with four possible scenarios.

First, harm minimisation can be supported where the act of self-injury and the individual's ability to consent to treatment are both autonomous. Second, even if the act of self-injury is not autonomous, the individual may still have sufficient autonomy to consent to treatment and harm minimisation may be an option. Third, if the level of illness and pathology mean that the self-injury is not autonomous and in addition, the individual fails to meet the required competency to make a decision about treatment then harm minimisation is not an option. Finally, it could be argued that irrespective of the individual's autonomy, we should not respect an individual's right to self-injure and regardless of his or her capacity to consent to treatment, preventative forms of intervention would need to be pursued. Let us say something about each of these.

3.4.1 An autonomous decision

As I will argue in further detail in chapter 6, self-injury can be an autonomous decision, as individuals may be highly functioning in many ways and understand the implications of their actions. In these cases, it is not unreasonable to see self-injury as an autonomous decision in the same way as decisions about other potentially self-destructive and high-risk behaviours such as smoking or drinking. Some would object that these other self-destructive behaviours are also not autonomous.²⁷⁶ They may be determined by addiction, trauma or some form of genetic predisposition. However, whereas these behaviours may incorporate factors that undermine the person's autonomy, an addiction to a particular substance, for example, such considerations are less clearly evident in cases of self-injury. For instance, it may be difficult to ascertain whether the act of self-injury is driven by mental illness, or whether people who self-injure are regarded as mentally ill because they self-injure.

²⁷⁶ See, for example, Craigie, J. and Davies, A. (2018). Problems of control; alcohol dependence, anorexia nervosa, and the flexible interpretation of mental incapacity tests. *Medical Law Review*. Vol. 27. No. 2. p. 215-241.

The answer to the question of whether choices and actions are autonomous, as we saw earlier, depends on the model of autonomy applied. For example, procedural accounts provide a broader concept of autonomy that captures a wider range of choices that could be seen as autonomous, while substantive approaches have a more limited perspective about what can and cannot be seen as an autonomous choice.²⁷⁷ In many cases, the application of substantive models of autonomy could suggest a lack of autonomy, but even then it is not clear how valuable substantive models of autonomy are if applied to clinical practice.²⁷⁸ The difficulty is that such models tend to reflect an ideal as opposed to a basic model of autonomy. This can be difficult to translate into the practicalities of the healthcare setting. As Sperry²⁷⁹ argues, procedural and weakly substantive accounts of autonomy provide a more suitable basis for assessing an individual's autonomy in relation to decision-making. However, even if self-injury is not autonomous and the decision to act in this way should not be respected or valued, it does not follow that the individual lacks the capacity to participate in a harm minimisation programme.²⁸⁰

3.4.2 Capacity to decide in the absence of autonomy

Although we may be unable to agree on whether the person who self-injures is autonomous, some of these individuals may be able to understand the consequences of their actions and be able to consent to involvement in a harm minimisation programme, which is ultimately attempting to reduce this type of behaviour. A lack of autonomy to self-injure does not imply a lack of autonomy to refuse particular types of treatment or to make clinical decisions. Draper has made this very point about anorexia nervosa.²⁸¹ She argues that a small number of individuals whose anorexia is treatment-resistant should be able to refuse life-saving treatment. The argument Draper makes is that while people with anorexia nervosa

²⁷⁷ Freyenhagen, F. (2017). Autonomy's Substance. *Journal of Applied Philosophy*. Vol. 34. No. 1. p. 115.

²⁷⁸ See, for example, Ahlin, J. (2018). The impossibility of reliably determining the authenticity of desires: implications of informed consent. *Medicine, Health Care and Philosophy*. Vol. 21. Issue 1. p. 43-50.

²⁷⁹ Sperry, E. (2013). *Op.cit.* n226.

²⁸⁰ Consent in this sense is predominantly a legal concept, and I return to this issue in the next chapter.

²⁸¹ Draper, H. (2000). Anorexia nervosa and respecting a refusal of life-prolonging therapy. A limited justification. *Bioethics*. Vol. 14. No. 2. p. 120-133.

may lack the capacity to make decisions concerning food, a decision about refusing nasogastric feeding may for some be a decision about their quality of life after years of interventions that have failed to work. Draper makes the point as follows, “ whilst it is likely to be the case that someone who is autonomous is also competent to make a specific medical decision, it need not be the case that someone who is competent to make a specific medical decision is also autonomous.”²⁸² The important point is that discussions around decision-making capacity and the ability to consent to treatment do not usually require a detailed consideration of the complex philosophical arguments around what constitutes an autonomous person.²⁸³

It could be objected that this reflects the use, in a clinical context, of conceptually inadequate models of autonomy.²⁸⁴ A focus on the autonomy of the decision-making process rather than autonomy of the individual²⁸⁵ invites the criticism that an individual may be competent to make decisions. However, these decisions may not be authentic in the sense of the more demanding models of autonomy developed in the wider philosophical literature.²⁸⁶ Furthermore, it ignores that fact that healthcare professionals are not always faced with simple choices about whether the individual is competent, rational and capable of informed decision making. As relational and substantive approaches to autonomy argue, the reality is often more complex and must account for social relationships where issues of care and dependency occur within complex hierarchies of power and knowledge.²⁸⁷ These may also be associated with abusive or oppressive relationships.²⁸⁸ This may restrict the opportunities an individual has to develop and use autonomy skills.²⁸⁹

²⁸² Ibid. p. 283.

²⁸³ Schone-Seifert, B. (2015). Op.cit. n271. p. 151.

²⁸⁴ Walker, R. L. (2008). Medical ethics needs a new view of autonomy. *Journal of Medicine and Philosophy*. Vol. 33. No. 6. p. 594-608.

²⁸⁵ Schone-Seifert, B. (2015). Op.cit. n271. p. 151. Martens, A. (2015). Paternalism in psychiatry: Anorexia nervosa, decision-making capacity, and compulsory treatment. In Schramme, T. (2015). *New perspectives on paternalism and health care*. London. Springer.p. 184.

²⁸⁶ Walker (2008). Op.cit.n284.

²⁸⁷ Macdonald, C. (2002). Relational professional autonomy. *Cambridge Quarterly of Healthcare Ethics*. Vol. 11. p. 282-289.

²⁸⁸ Sherwin, S. (1998). A relational approach to autonomy in health care. In: Sherwin, S. (Ed) *The politics of women's health: exploring agency and autonomy*. Philadelphia, PA: Temple University Press. p. 19-47; Donchin, A. (1995). Reworking autonomy: toward a feminist perspective. *Cambridge Quarterly Health Care Ethics*. Vol. 4. p. 19-47; Mackenzie, C. (2008) Relational Autonomy, Normative Authority and Perfectionism. *Journal of Social Philosophy*. Vol. 39. No. 4. p. 512-533.

²⁸⁹ McLeod and Sherwin. (2000). Op.cit. n245.

In responding to such a criticism, it is important to move beyond the question of consent and to consider how harm minimisation supports autonomy and promotes independence in a wider sense. By engaging the individual in such a therapeutic programme, we help them in the here and now, by supporting them to make competent decisions and to act in more positive ways. In this way, we support what Oshana²⁹⁰ terms 'local' autonomy. However, when we engage the individual in psychological therapy, we focus on developing autonomy in a more global sense. This engages therapeutically with the theoretical idea of authenticity in a way that has therapeutic implications.²⁹¹ One of the aims of psychological therapy is to move beyond relationships of care and dependency and address issues of power and knowledge.²⁹² By focusing on the resolution of complex underlying issues associated with self-injury, it is possible to help people understand why they behave in certain ways and to challenge self-perceptions that may not be justified. A combination of harm reduction techniques and more intensive psychological support and therapy serves to respect autonomy at both a local and global level. It not only respects a person's autonomous ability to choose,²⁹³ it helps them to develop autonomy competencies.²⁹⁴ This helps individuals to develop their voice and be empowered to lead their lives in their own way.²⁹⁵

3.4.3 An absence of autonomy and capacity

Harm minimisation supports autonomy at several different levels, but what about situations where autonomy is not present? Take, for example, a case where an individual is acting in a way that does not reflect their normal personality or behaviour. They may be delusional or suffering from an acute psychotic episode. As a result, they are inflicting serious injuries on their person and are not able to stop. They cannot reflect on their behaviour or engage in clinical decisions about their treatment. In these situations, it is ethically right to prevent harm, and this is an

²⁹⁰ Oshana, (2002). Op.cit. n251.

²⁹¹ Eler, A. and Hope, T. (2014). Mental disorder and the concept of authenticity. *Philosophy, Psychiatry and Psychology*. Vol. 21. No. 3. p. 222.

²⁹² MacDonald. C. (2002). Nurse Autonomy as relational. *Nursing Ethics*. Vol. 9. No. 2. p. 194 – 201.

²⁹³ See, for example, Meyers (1987) Op.cit. n254.

²⁹⁴ Meyers cited in Oshana, M.A.L. (2015). Is social-relational autonomy a plausible ideal? In Oshana, M.A.L. (ed). *Personal Autonomy and Social Oppression. Philosophical perspectives*. p. 32.

²⁹⁵ Meyers (1987). Op.cit. n254.

example of soft paternalism. However, not all cases of self-injury are like this. In fact, in most cases, people who self-injure do not suffer delusions and are not inflicting injury in the course of an acute psychotic episode. But even in those clear situations in which self-injury is, by most accounts, not autonomous, it is not always clear that preventative approaches may be beneficial. This is an issue we return to in chapter 6.

Making a judgment on whether self-injury is autonomous is not always straightforward, and this means that the differentiation between soft and hard paternalism may become blurred.²⁹⁶ If we take the view, as some substantive accounts of autonomy would, that an individual couldn't by definition autonomously self-injure then a preventative strategy that may involve some forms of restraint or strict surveillance will be seen as a form of soft paternalism and as such ethically justified. If however, one takes the view that it is not clear that those individuals are less autonomous than many of us who engage in activities that cause harm to ourselves, or even that individuals can self-injure autonomously, then restrictive interventions that try to stop self-injury are a form of hard paternalism and are more difficult to justify.²⁹⁷ After all, many individuals engage in risky and self-harming activities, and their freedom of action is not restricted.

Even in situations where an intervention is, at least in principle, justified because the person lacks autonomy, the situation can be ethically complex. Paternalistic intervention may not represent a violation of the individual's right to exercise their autonomy if autonomy is not present. However, the individual concerned may experience such intervention as coercive. This may then erode the therapeutic alliance and make future intervention difficult. It must always be remembered that even in the absence of autonomy, paternalistic intervention is only justified if it benefits the individual. Thus, in some cases, more restrictive interventions may do more harm than good and become difficult to justify. The general rule is that the least restrictive option is always the most desirable form of intervention, and that

²⁹⁶ See Hanna, J. (2018). Hard and soft paternalism. In Grill and Hanna (2018). *Op.cit.* n260. Chapter 2.

²⁹⁷ For a defence of hard paternalism, see Lindley (1986). *Op.cit.* n252; Kleinig, J. (1983). *Paternalism*. Manchester. University of Manchester Press.

intervention should also aim at restoring the patient's autonomy.²⁹⁸ Even in cases of clear autonomy deficits, the prevention of serious harm must be balanced with the danger of eroding the therapeutic alliance and failing to enhance the patient's autonomy.²⁹⁹ It is not always the case that, because someone lacks autonomy, others are justified in taking whatever action they deem appropriate to prevent harm.

Thus, even in cases where there is an evident lack of autonomy, it may be difficult to decide what is the clinically and ethically best action to take. The situation must be considered on a case-by-case basis. Where paternalism appears to be the best option, it can only be justified on beneficence grounds. Both soft and hard paternalistic action has to be beneficial. If preventative methods are not beneficial, then they lose legitimacy regardless of whether individuals are autonomous. We then need to consider carefully what benefits are sought in each case, and how interference with a person's freedom to self-injure may benefit them in the short and long term.

3.4.4 An argument against autonomy

If however, it is accepted that autonomy is not the only relevant consideration, then there is a consequentialist argument, which could be used to justify hard paternalism in cases of self-injury.³⁰⁰ As Conly argues,³⁰¹ autonomy has less importance than it is sometimes credited with, and it is entirely reasonable to force people to refrain from certain activities and to engage in others.³⁰² She advocates a form of "coercive paternalism" whereby an individual's choices can be limited as long as this will have long term benefits.³⁰³ In a similar vein, Hanna has defended a "pro-paternalistic" perspective based on the view that it is legitimate to interfere to promote a person's interests.³⁰⁴ It is not the individual's autonomy that is most important but the nature of

²⁹⁸ See, for example, Department of Health (2015). Op.cit. n196 p. 22.

²⁹⁹ Grill, K. (2006). *Anti-paternalism*. Theses in philosophy from the Royal Institute of Technology. Stockholm. Sweden.

³⁰⁰ Szerletics, A. (2010). *The moral foundations of legal paternalism*. <http://hdl.handle.net/1854/LU-4333749> p. 488.

³⁰¹ Conly, S. (2013). Op.cit. n272. Conly, S. (2018). Consequentialism, paternalism, and the value of liberty. In Grill and Hanna (2018). Op.cit. n260. Chapter 7.

³⁰² Conly (2013). Op.cit. n260.

³⁰³ Ibid.

³⁰⁴ Hanna, J. (2018). *In our best interest: A defense of Paternalism*. Oxford. Oxford University Press.

the choice the person is making and as de Marneffe points out, some choices are so “ill-considered, irreversible and self-destructive” that a rejection of interference would appear unreasonable.³⁰⁵ As a result, if an individual acts in a self-destructive way, then there is a threshold beyond which it becomes necessary to intervene.³⁰⁶ Therefore, in the case of self-injury, it can be argued that the individual’s actions cannot be supported and the threat of harm can be so bad that some form of paternalistic intervention is justified regardless of considerations around autonomy.³⁰⁷

There are philosophical objections to this argument, both on deontological and on utilitarian grounds. On deontological grounds, at least based on one interpretation of Kantian ethics, any form of paternalistic intervention is wrong unless it can be justified on the basis that the person is not autonomous.³⁰⁸ On utilitarian grounds, as Riley has argued,³⁰⁹ if an individual is competent, then they are the best judges of what constitutes their own good. Their choices may not be prudent, but they should be permitted unless they will result in harm to others.³¹⁰ It is arrogant to believe that we can judge what is right for another person, and this perspective underpins the Millian argument that paternalistic interference interferes wrongly and in the wrong place.³¹¹ Under this perspective, if force is used to impose certain benefits, it is possible that we may be mistaken about those benefits. In these situations, we prevent the individual from exercising their capacity for choice and fail to respect their autonomy. Moreover, our interventions may fail to optimise their wellbeing on any measure of wellbeing that incorporates an element of subjective assessment.

³⁰⁵ de Marneffe, P. (2013). Self-sovereignty and paternalism. In Coons and Weber (2013). Op.cit. n260.p72.

³⁰⁶ Ibid.

³⁰⁷ Szerletics (2010). Op.cit. n488; Husak, D.N. (1981). Paternalism and autonomy. *Philosophy and Public Affairs*. Vol. 10. No. 1. p. 27.

³⁰⁸ Seynor-Fahy, M. (2018). Kantian perspectives on paternalism. In Grill and Hanna (2018). Op.cit. n257. Chapter 8; Husak (1981). Op.cit. n260. p. 27.

³⁰⁹ Riley, J. (2018). Mill’s absolute ban on autonomy. In Grill and Hanna (2018). Op.cit. n260. Chapter 13.

³¹⁰ Riley terms this the “provisional epistemic argument” which can be traced back to Mill and his analysis is an exploration of Mill’s perspective. See Riley, J. (2018) *ibid*.

³¹¹ Mill cited in Wilson, J. (2011). Why it’s time to stop worrying about paternalism in health policy. *Public Health Ethics*. Vol. 4. No. 3. p. 274.

On this basis, I am not convinced that such hard paternalistic intervention is justified in the routine treatment of self-injury. Such interventions may be justified in some circumstances when autonomy is absent, although even then questions about effectiveness remain, and thought would need to be given to exactly what the benefits would be. It would, therefore, need to be justified in the specific case in question. However, more generally, the use of restrictive interventions to try and prevent self-injury may be problematic for three reasons. First, they fail to respect the individual's autonomy. Second, they may fail to benefit the person. Third, as we have also seen, they may be ineffective. On this basis, the argument that constraints on a person's liberty and autonomy can be justified to reduce the overall level of harm then fails.³¹² Set against this, if harm minimisation techniques are employed, there are important questions about regarding the level of risk to which the individual is exposed.³¹³ A risk of harm is only worth taking if it can be justified in terms of both respecting the autonomy of the person, and there is a reasonable expectation that an overall reduction in harm is in the person's interests.³¹⁴ It is to the complex issue of harm that I now turn.

3.5. Harm

3.5.1 Harm: conceptual and ethical problems and definitions

One of the first imperatives in clinical practice is *primum non nocere*, first do no harm. In virtually all moral codes, there is a presumptive duty to prevent harm and not to harm others. The fact that an action involves doing harm will weigh against performing it.³¹⁵ Furthermore, considerations of whether harm has or has not occurred are an important factor in considering whether a particular course of action is ethically permissible.³¹⁶ On this basis, if harm minimisation results in harm, then that would be a strong argument against it. It would seem to violate the very first

³¹² Sullivan (2017). Op.cit. n71. p. 320.

³¹³ Oberdiek, J. (2009). Towards a right against risking. *Law and Philosophy*. Vol. 28. No. 4. p. 367-392.

³¹⁴ Finkelstein, C. (2003). "Is risking a harm". *University of Pennsylvania* Vol. 151. p. 963-1001.

³¹⁵ Kagan, S. (1998). *Normative Ethics*. Oxford. Westview Press. p. 84.

³¹⁶ Pursehouse, C. (2016). A defence of the counterfactual account of harm. *Bioethics*. Vol. 30. Issue. 4. p. 251-259.

imperative of clinical practice that finds its expression in the principle of nonmaleficence. Chapters 6 and 7 will discuss this concern in detail.

In addressing these issues, the first difficulty we face is developing a clear understanding of precisely what is meant by harm. The concept of harm has a range of ordinary language usages that would be difficult to accommodate in any single account of the concept.³¹⁷ This complexity needs to be acknowledged and finding an appropriate definition is difficult.³¹⁸ As Wilkinson³¹⁹ points out, it is “messy and moralised.” This makes understanding and applying the concept challenging. In fact, Bradley argues that attempts to define harm are so problematic that the concept should be dropped.³²⁰ A detailed consideration of the conceptual difficulties associated with defining harm is not required for current purposes, but some discussion is required to provide a foundation for the arguments developed in the first two papers.

The term harm is much used in medical ethics, and it could be argued that a simple definition suffices to meet the requirements of this imperative. As Harman has argued,³²¹ pain, early death and bodily injury are examples of harm and no complex analysis is required to come to this conclusion. At one level, this definition would suffice as self-injury, is when viewed from this perspective, undoubtedly an example of harm. However, in order to support the current analysis, a little more is required. In what follows, I also refer to an interest-based account of harm, particularly that articulated in Feinberg’s work. He develops an account of harm that occurs when an individual is made worse off due to an adverse effect on one of their interests.

³¹⁷ Shiffrin, S. (2012). Harm and its moral significance. *Legal Theory*. Vol. 18. p. 357-98.

³¹⁸ Feinberg, J. (1983). Noncoercive exploitation. In Sartorius, R. (ed). *Paternalism*. Minneapolis. University of Minnesota Press. p. 214.

³¹⁹ Wilkinson, S. (2003) *Bodies for sale: Ethics and exploitation in the human body trade*. London. Routledge.p. 40.

³²⁰ Bradley, B. (2012). Doing away with harm. *Philosophy and phenomenological research*. Vol. 85. Issue. 2.p. 390-412.

³²¹ Harman, E. (2004). Can we harm and benefit in creating? *Philosophical Perspectives*. Vol. 18. Issue 1. p.92.

Feinberg defines harm as “the thwarting, setting back, or defeating of an interest”.³²²

There are different forms of interests, and I am particularly concerned with what Feinberg terms welfare interests, and this would include the interests associated with health. In this sense, harm minimisation would result in harm if the individual's health were in a worse position than it would have been had the intervention not taken place.

The concept of harm is closely related to the idea of benefit. This is also defined in terms of the individual's interests. While harms impact negatively, a benefit will impact positively. Using Feinberg's analytical framework, if harm minimisation results in decline in the person's overall welfare, in this sense his or her health, then they are harmed, if their health improves then they are benefited. I consider Feinberg's conceptual framework in more detail below.

A consideration of harms and benefits is important in healthcare as decision-making in this context involves the assessment of harms and benefits. The success or otherwise of an intervention involving a harm minimisation approach would be judged on whether the individual's health and wellbeing were improved or adversely affected. Whether the intervention is appropriate in a particular situation is based on an assessment of the potential harms and benefits given the specific needs of the

³²² Feinberg, J. (1984). *Harm to Others. The Moral Limits of the Criminal Law Volume 1*. Oxford. Oxford University Press. As noted elsewhere in this thesis, Feinberg's approach is a comparative model of harm, and it is also important to note the presence of alternative models in the literature. For example, Shiffrin and Harris argue that harm is concerned with causing an individual to be in a bad state or suffer injury rather than making them worse off. What Shiffrin refers to as absolute non-comparative conditions. See Shiffrin, S. (1999). *Wrongful life, procreative responsibility, and the significance of harm*. *Legal theory*. Vol. 5. p. 117-148; Shiffrin, S. (2012). *Harm and its moral significance*. *Legal Theory*. Vol. 18. P. 357-98. Harris, J. (1998). *Clones, Genes and Immortality*. Oxford. Oxford University Press. p. 110

individual in question. In undertaking such an assessment, the views and perspective of the individual are of ethical and clinical importance. These ideas are examined in more detail below.

3.5.2 First do no harm?

It is within the framework of harms and benefits that the idea that health care professionals should do no harm must be considered. The aim of any healthcare intervention is that it benefits the patient and certainly does nothing to harm them. It is commonly accepted that a therapeutic intervention must maximise benefit and minimise harm.

This forms an essential component of the professional requirement to practice in accordance with an accepted standard of care, an issue we return to in chapter 4. Certainly, it would be uncontroversial to argue that most patients would not wish to participate in a therapeutic process that resulted in harm due to an adverse effect on their interests. Equally, it would be fair to say that most health professionals would accept that on occasions their actions could result in more harm than good and practitioners contemplating the use of harm minimisation approach must always be aware of this possibility.

In addition, even when there is some agreement on what is meant by harm, in this case adopting an interest-based perspective, there remains an added difficulty. This is because there are different ways of categorising harm which have different moral implications, and these are important to note. For example, there are stronger moral constraints against doing harm as opposed to allowing harm. Harming an individual

as opposed to failing to prevent harm is seen as more ethically problematic. Likewise, a failure to provide a benefit is less problematic than allowing harm.³²³ Moreover, first do no harm, cannot literally mean do not harm or do not allow harm at all, if it were to do so then the practice of medicine could not exist, as there are circumstances in which harm can be justified. In reviewing the origins and use of the idea of "primum non nocere," Smith³²⁴ makes this very point when he notes that the actions of health care professionals almost invariably have the potential for harm and some therapeutic interventions do result in harm. In some cases, the best that can be done is to minimise harm or to choose the least harmful solution. In fact, in some situations, harm can be justified.³²⁵

3.5.3 Pro tanto and overall harm

The above can sound almost counterintuitive and requires some exploration. The perspective taken is dependent upon whether it is pro tanto or overall harm that is considered. The former looks at harm in the short-term and other considerations may come to outweigh the importance of harm in this particular instance. So, for example, an individual may self-injure, and this constitutes harm on a pro tanto basis, while the fact that they self-injure to reduce distress may count as a benefit also on a pro tanto basis. Overall harm, however, takes a longer-term perspective, and as Bradley³²⁶ notes, an event constitutes overall harm if "pro tanto harms to that person outweigh its pro tanto benefits to that person".³²⁷ It is therefore important to differentiate between pro tanto harm and overall harm and the latter accounts for all the ways that

³²³ See Woollard, F. (2015). *Doing and allowing harm*. Oxford. Oxford University Press; Woollard, F. (2018). Should we talk about the 'benefits' of breastfeeding? The significance of the default in representations of infant feeding. *Journal of Medical Ethics*. Vol. 44. p. 757. In these publications Woollard considers these issues in some detail.

³²⁴ Smith, C.M. (2005). Origin and Uses of Primum Non Nocere— Above All, Do No Harm! *Journal of Clinical Pharmacology*. Vol. 45. p. 371-377.

³²⁵ Shivji, A. (2012). Do no harm: not an ideology but a cornerstone of good humanitarian practice. *Human Welfare*. Vol. 1. Issue. 1. p. 125.

³²⁶ Bradley (2012). Op.cit. n320. p.393.

³²⁷ Sokol, D. (2013) "First do no harm" revisited. *British Medical Journal* 2013; 347: f6426.

an event harms and benefits an individual.³²⁸ When viewed in this way, it is possible to see that not all harms would constitute an ethical problem, and this has clinical implications.

A focus on preventing harm, ignores the clinical reality that health care professionals make decisions about how to balance harms and benefits in the context of treatment. For example, the benefits of antipsychotic medication must be balanced with the harms associated with serious side effects. In these circumstances, the best that can be achieved is to do no net harm as to do no harm would be to effectively do nothing, and this in itself may result in harm.³²⁹ As Sharpe and Faden argue,³³⁰ harm or a risk of harm may be justified if the harm will result in a benefit that is proportionately less harmful than the condition for which the patient is being treated. To use their words; “the aim of achieving a desired net benefit or a net reduction of harms may justifiably and without contradiction involve harming. Sometimes you must do harm to avoid or prevent harm.”³³¹ Thus although there is a professional duty for the health care professional to do no harm, it is possible to allow harm in a pro tanto sense to reduce harm in an overall sense.

In chapter 6, I focus on overall harm and argue that harm minimisation is justified based on a net reduction in harm. The importance of balancing harms and benefits in both a clinical and ethical way is considered. Thus, the harms associated with a person’s self-injury must be balanced against the harms prevented by a harm minimisation approach.³³² In addition, this must be balanced against the harms associated with more restrictive interventions designed to prevent self-injury. Both permissive and restrictive forms of intervention entail harms and benefits. Whether a harm minimisation approach is appropriate depends on the balance of harms and benefits as experienced by the individual and a judgement regarding overall harm. From a clinical perspective if the approach results in better outcomes, it is to be the

³²⁸ Feit, N. (2015). Plural harm. *Philosophy and Phenomenological Research*. Vol. 90. No. 2. p.361.

³²⁹ Folland, A. (2017). *The Dual Nature of Harm. In defence of the disjunctive view*. University of Gothenburg. Department of Philosophy, linguistics and theory of science. p. 6.

³³⁰ Sharpe, V. A. and Faden, A. I. (1998). *Medical Harm: historical, conceptual, and ethical dimensions of iatrogenic illness*. Cambridge. Cambridge University Press.

³³¹ *ibid* p.123; Sokol, (2013). *Op.cit.* n328.

³³² Christie et al, (2008) *Op.cit.* n162. p.54. See also Edwards and Hewitt (2011). *Op.cit.* n126.

preferred intervention.³³³ This fits with a clinical decision-making model based on balancing risks and benefits in order to decide on the preferred therapeutic intervention. My argument in chapter 6 is that in some circumstances, a balancing process based on an analysis of the clinical situation would come out in favour of the adoption of a harm minimisation approach. In chapter 7, I engage with the concept of harm in a more theoretically informed way through the work of Feinberg. It is to this issue that I now turn.

3.5.4 Feinberg and harm

As we have seen, all individuals, argues Feinberg,³³⁴ have interests, and he actually defines these as “all those things in which the person has a stake. Interests are a component of the individual’s wellbeing and s/he flourishes or languishes depending on whether something is ‘in his interest’ or ‘against his interest’.”³³⁵ We have also seen that Feinberg views harm as the thwarting or setting back of an interest”.³³⁶ However, Feinberg goes further, and argues that harming another has two essential components. First, it must lead to an adverse effect on the victim’s interests. Second, it must be inflicted in violation of the victim’s rights.³³⁷ Thus a person can be harmed in a morally neutral way. An infectious illness, for example, is a harm, but the person is not wronged in a moral sense unless the infection could have been prevented. However, if harm is deliberately allowed to occur, then this may be seen as a moral wrong. In these circumstances, Feinberg argues that the person is both harmed and wronged. Moreover, someone may be harmed in one sense, but they are not wronged if the harm they incur is morally justified.³³⁸ The example of any surgical or medical intervention to save a person’s life is an illustration of this point.³³⁹

Feinberg’s analysis is a comparative model of harm. Comparative models of harm are based on the idea that a person may be harmed if he or she is worse off than

³³³ Kleinig, J. (2008) The Ethics of Harm Reduction. *Substance Use and Misuse*. Vol. 43. No. 1. p. 6.

³³⁴ Feinberg (1984). *Op.cit.* n270.

³³⁵ *ibid.*

³³⁶ *ibid.* p. 34.

³³⁷ *Ibid.* p.148.

³³⁸ Noddings, N. (2002). *Starting at Home: Caring and Social Policy*. London. University of California Press. p. 32.

³³⁹ Algonder, P. (2013). *Harm, benefit, and non-identity*. PhD Dissertation. Uppsala University p. 27.

they would have been.³⁴⁰ In such a model, harms are considered bad and benefits considered good. A person is harmed when the harms outweigh the benefits, and a person is benefited when the benefits outweigh the harm.³⁴¹ The comparisons can be made in two ways. First, by comparing what occurred with the counterfactual position that would have occurred had the harmful action not taken place. Second, by comparing the harmful position with the situation prior to the harm.³⁴² In our specific case, using this perspective, would mean that an individual would be harmed if their health/wellbeing were in a worse condition than they would have been had they not been subject to a programme of intervention that involved harm minimisation.

The comparative account of harm proposed by Feinberg offers a valuable conceptual tool for addressing the ethical problems involved in harm minimisation for a number of reasons. First, it can be assumed that everyone has a stake and therefore, an interest in health and wellbeing and I take harm to include actions or omissions that cause physical and /or psychological damage that impact negatively on an individual's health and wellbeing. Second, comparative models of harm are generally used in a bioethical context,³⁴³ and several defences of this position are available in the literature.³⁴⁴ Third, it accords with our intuitions that a harm is something we would not wish to inflict and a benefit is something we would want to support.³⁴⁵ By using a comparative approach to harm, we can frame the questions regarding the rights and wrongs of permissive or preventive approaches to self-injury in terms of the individual's interests, asking whether all things considered they are made worse by the application of different forms of intervention. Although I appreciate the philosophical problems associated with identifying the relevant baselines,³⁴⁶ I take the view that the patient is harmed if he or she is worse off than

³⁴⁰ Grill K. (2012). Paternalism. In Chadwick, R. (ed). *Encyclopedia of Applied Ethics*. Cambridge, Massachusetts. Academic Press. p.359-369.

³⁴¹ Perry, S. (2003). *Harm, history and counterfactuals*. Faculty Scholarship. Paper 1108. http://scholarship.law.upenn.edu/faculty_scholarship/1108 p. 1299.

³⁴² Pursehouse. C. (2016). Op.cit.n n316.

³⁴³ Folland (2017). Op.cit. n330. p. 3

³⁴⁴ Klockseim, J. (2012). A defense of the counterfactual comparative account of harm. *American Journal of Philosophy*. Vol. 49. No. 4. p. 285-300; Pursehouse (2016). Op.cit. n316.

³⁴⁵ Carlson, E. (2018). More problems for the counterfactual comparative account of harm and benefit. *Ethical Theory and Moral Practice*. <https://doi.org/10.1007/s10677-018-9931-5>

³⁴⁶ Wilkinson (2003). Op.cit. n306.p.42.

when treatment was initiated. The intervention is being considered as an independent evaluable action,³⁴⁷ which will take place on a case-by-case basis. The patient subject to harm minimisation is harmed in the sense that she cuts herself and would have been better off if this had not occurred. In some cases, attempts to stop the self-injury may paradoxically increase it. The best clinical outcome is based on whether overall the individual's self-injury is reduced or at least contained. I argue that in some cases, harm minimisation will mean the individual is better off all things considered than he or she would have been using a more preventative approach. I now turn to the important role of the patient in the process.

3.6 Epistemic Injustice

The way that self-injury is understood has important implications for the way that the individual experiences care. The clinical relationship between the healthcare professional and the patient is characterised by asymmetrical relations in terms of social power. A consequence of this is that self-injury is normally interpreted using a biomedical model. This considers the person's behaviour in terms of mental disorder and attempts to categorise the individual's actions in relation to a specific psychiatric diagnosis. The individual may not recognise this way of interpreting their behaviour and may give very different reasons for their actions. This tension is important as people may become aware of how they are perceived and how their actions are classified, and this, in turn, can change the way they perceive and understand their behaviour.³⁴⁸ In effect, the healthcare professional defines what is valid knowledge in a particular situation, even though different and alternative forms of knowledge about that situation may exist.³⁴⁹

This tension forms the basis of the arguments developed in chapter 8, where I consider the issue of self-injury and harm minimisation from the perspective of individuals with lived experience of self-injury. The concept of epistemic injustice

³⁴⁷ Ibid. p. 43.

³⁴⁸ Hacking, I. (1995). The looping effects of human kinds. In Sperber, D. Premack, D. Premack, A.J. (eds). *Causal cognition: a multidisciplinary debate*. Oxford. Oxford University Press. p. 351-383; Terrain, S. (2017). Knowing disability, differently. In Kidd, I. Medina, J. Pohlhaus, Jr. G (eds). *The Routledge Handbook of Epistemic Injustice*. London. Routledge. Chapter 16.

³⁴⁹ Swerdfager, T. (2016). Theorizing resistance: Foucault, cross-cultural psychiatry, and the user/survivor movement. *Philosophy, Psychiatry and Psychology*. Vol. 23. No. 3. p. 289.

is used to help understand the complex issues involved in the clinical management of self-injury when seen from the perspective of the patient. We will also see how the concept of harm minimisation came to be applied to the case of self-injury through increased awareness of the views and perspectives of individuals with lived experience.

The concept of epistemic injustice was first articulated in the work of Miranda Fricker.³⁵⁰ It has recently been defined in the following terms: “those forms of unfair treatment that relate to issues of knowledge, understanding, and participation in communicative practices.”³⁵¹ As this quotation indicates, Fricker's work is concerned with how knowledge is both communicated and understood, and the origin of the concept of epistemic injustice can be traced to debates regarding the relationship between power, knowledge and oppression.³⁵²

In her original work, Fricker describes two different forms of epistemic injustice, and she terms these testimonial and hermeneutical injustice. The former occurs when “the speaker receives a deflated degree of credibility from the hearer owing to prejudice on the hearer’s part.”³⁵³ The lack of credibility that results from these prejudices is based on the presence of negative stereotypes associated with the individual’s identity. As a result of this prejudice, the speaker is misjudged and viewed as less important from an epistemic perspective.³⁵⁴ This means that people do not believe the speaker, and this disbelief is unwarranted as it is grounded in prejudicial judgements. The individual is disadvantaged in relation to those who do not suffer such a deficit in credibility.

Hermeneutical injustice is defined as “having some significant area of one’s social experience obscured from collective understanding owing to a structural

³⁵⁰ Fricker, M. (2007). *Epistemic Injustice: Power and the ethics of knowing*. Oxford. Oxford University Press.

³⁵¹ Kidd, I. Medina, J. Pohlhaus, Jr. G. (2017). Introduction. In Kidd et al (2017). *Op.cit.* n349 p.23.

³⁵² Pohlhaus, Jr. G. (2017). *Varieties of Epistemic Injustice*. In Kidd et al (2017). *Op.cit.* n349. Chapter 1. p. 13-26.

³⁵³ Fricker (2007). n351 p. 69.

³⁵⁴ Fricker, M. (2017). *Evolving concepts of epistemic injustice*. In Kidd et al (2017). *Op.cit.* 349. Chapter 4. p. 53.

identity prejudice in the collective hermeneutical resources.”³⁵⁵ The latter refers to a deficit in the shared tools required to interpret our social environment.³⁵⁶ This means that members of a particular social group may experience bias and be marginalised based on structural differences in social power. The cause of hermeneutical injustice is this hermeneutical marginalisation, which occurs in relation to a specific area of social experience.³⁵⁷ Hermeneutical injustice can only exist where there are significant asymmetries in power associated with both marginalisation and privilege. The result is that the marginalised group is unable to communicate some significant realm of social experience and as a consequence is disadvantaged.

Fricker uses the example of postnatal depression to illustrate this process,³⁵⁸ and draws on the memoir of Susan Brownmiller regarding the women’s liberation movement.³⁵⁹ Citing directly from this work, she describes the condition of a women experiencing postpartum depression. At a workshop, this women engages in a group activity during which this type of depression is discussed. It is a revelatory moment, and Fricker notes how the individual had previously misunderstood her depression and believed that the way she felt was due to a personal weakness and was unique to her. To understand that many other women felt this way helped her to come to terms with her feelings and to realise how her lack of understanding had been as a result of a collective misunderstanding of the issue.³⁶⁰

3.6.1 Epistemic Injustice and healthcare

³⁵⁵ Fricker, M. (2006). Powerlessness and social interpretation. *Episteme: A Journal of Social Epistemology*. Vol. 3. Issue. 1-2. p. 100.

³⁵⁶ Goetze, T.S. (2018). Hermeneutical dissent and the species of hermeneutical injustice. *Hypatia*. Vol. 33. No. 1.p. 73-90.

³⁵⁷ Fricker, (2017). n349. p. 53.

³⁵⁸ Fricker, (2007) n351.

³⁵⁹ Ibid.

³⁶⁰ Brownmiller, S. (1990). *In our time: memoir of a revolution*. New York. Dial Press. p. 182.

The concept of epistemic injustice has been applied to health care generally.³⁶¹ It has also been applied to certain clinical syndromes³⁶² and the practice of mental health care specifically.³⁶³ The general thrust of the debate is that healthcare functions in an environment characterised by power relationships. In this environment, the patient's perspective lacks the epistemic power of the professional, and this can impede the therapeutic relationship in a way that affects their ability to get the right response.³⁶⁴ This is because negative stereotypes associated with the ill person lead an epistemic injustice.³⁶⁵ Testimonial injustice occurs when the individual's experience of illness is not recognised by the health care professional.³⁶⁶ Hermeneutical injustice occurs because the resources needed to understand the ill person's experiences are not part of the dominant hermeneutical resource. Thus, the patient's descriptions of their experience are not accepted as a legitimate clinical description or as important in clinical decision-making.³⁶⁷ As Carel and Kidd

³⁶¹ Carel, H. and Kidd, I. J. (2014). Epistemic injustice in healthcare: A philosophical analysis. *Medicine, Health Care and Philosophy*. Vol. 17. No. 4. p. 529-540; Ho, A. and Unger, D. (2015). Power hierarchy and epistemic injustice in clinical ethics consultation. *The American Journal of Bioethics*. Vol. 15. Issue. 1. p. 40-42; Kidd, I.J. and Carel, H. (2017). Epistemic Injustice and illness. *Journal of Applied Philosophy*. Vol. 34. No. 2. p. 172-190; Carel, H. and Kidd, I. J. (2017). Epistemic Injustice in medicine and healthcare. In Kidd et al (2017). Op.cit. n349. Chapter 32. p. 336-346; Kidd, I. J. and Carel, H. (2018). Healthcare practice, epistemic injustice, and naturalism. *Royal Institute of Philosophy Supplement*. Vol. 84. p. 1-23; Wardrope, A. (2015). Medicalization and epistemic injustice. *Medicine, Healthcare and Philosophy*. Vol. 18. p. 341-352.

³⁶² Bleaze, C. Carel, H. Geraghty, K. (2017). Epistemic Injustice in health encounters: evidence from chronic fatigue syndrome. *Journal of Medical Ethics*. Vol. 43. p. 549-557; Freeman, L. (2014). Confronting diminished epistemic privilege and epistemic injustice in pregnancy by challenging a "panoptic of the womb". *Journal of Medicine and Philosophy*. Vol. 40. Issue. 1. p. 44-68; Buchman, D.Z. Ho, A. Goldberg, D.S. (2017). Investigating trust, expertise, and epistemic injustice in chronic pain. *Journal of Bioethical Inquiry*. Vol. 14. No. 1. p.31-42.

³⁶³ Sanati, A. and Kyratsous, M. (2015). Epistemic injustice in assessment of delusions. *Journal of Evaluation in Clinical Practice*. Vol. 21. No. 3.p. 479-85; Kyratsous, M. and Sanati, A. (2017). Epistemic injustice and responsibility in borderline personality disorder. *Journal of Evaluation in Clinical Practice*. Vol. 23. No. 5. p. 974-980; Carver, L. Morley, S. Taylor, P. (2017). Voices of deficit: mental health, criminal victimization and epistemic injustice. *Illness, crisis and loss*. Vol. 25. No. 1. p. 43-62; Crichton, P. Carel, H. Kidd, I.J. (2017) Epistemic Injustice in psychiatry. *Psychiatric Bulletin*. Vol. 41. p. 65-70. Scrutton, A.P. (2017). Epistemic Injustice and mental illness. In Kidd et al (2017). Op.cit. n349. Chapter 33. p. 347-355; Kurs, R. and Grinshpoon, A. (2018). Vulnerability of individuals with mental disorders to epistemic injustice in both clinical and social domains. *Ethics and Behaviour*. Vol. 28. No. 4. p. 336-346; Newbigging, K. and Ridley, J. (2018). Epistemic struggles: the role of advocacy in promoting epistemic injustice and rights in mental health. *Social Science and Medicine*. Vol.219. p. 36-44.

³⁶⁴ Ho, A. (2011). Trusting experts and epistemic humility in disability. *The International Journal of Feminist Approaches to Bioethics*. Vol. 4. No. 2. p. 111-13.

³⁶⁵ Fricker, (2017). Op.cit. n351 p. 58.

³⁶⁶ *ibid.* p. 58.

³⁶⁷ Carel, and Kidd (2017).Op.cit. n362. p. 184.

argue, structural inequalities and the presence of epistemic injustice mean that the patient's perceptions are not part of the process of care.³⁶⁸

In her original work, Fricker maintained a very clear distinction between testimonial and hermeneutical injustice. This has since been challenged. For example, Maitra³⁶⁹ argues that there is a close interrelationship between the two and that the injustice that is experienced can result from a combination of both individual and structural identity prejudice. Medina³⁷⁰ goes as far as to argue that it is not possible to have testimonial injustice without the presence of hermeneutical injustice.

A significant volume of work has been published since Fricker's original publication and has moved the point of emphasis in several different directions.³⁷¹ In addition to describing different forms of epistemic injustice, much of this debate has placed an increasing emphasis on relationships of power and the structural causes and remedies of epistemic injustice.³⁷² For example, Mason,³⁷³ has argued that Fricker pays only limited attention to what she describes as "non-dominant resources" to which marginalised groups have access, and such access brings with it the possibility of articulating a different perspective of the world. This provides more dominant groups with the opportunity to make use of such epistemic resources to develop different ways of thinking about particular issues.³⁷⁴ Both Pohlhaus Jr³⁷⁵

³⁶⁸ Kidd and Carel (2018) . Op.cit. n62. p. 1-23.

³⁶⁹ Maitra, I. (2010). The nature of epistemic injustice. *Philosophical Books*. Vol. 51. No. 4. p. 195-211.

³⁷⁰ Medina, J. (2011). The relevance of credibility excess in a proportional view of epistemic injustice. *Differential epistemic authority and the social imaginary*. *Social Epistemology*. Vol. 25. p. 27.

³⁷¹ See, for example, Hookaway, C. (2010). Some varieties of epistemic injustice: Reflections on Fricker. *Episteme*. Vol. 7. No. 2. p. 151-163; Dotson, K. (2011). Tracking epistemic violence, tracking practices of silencing. *Hypatia*. Vol. 26. No. 2. p. 236-257; Dotson, K. (2012). A cautionary tale: on limiting epistemic oppression. *Frontiers: A Journal of Women Studies*. Vol. 33. No. 1. p. 24-47; Dotson, K. (2014). Conceptualising epistemic oppression. *Social Epistemology*. Vol. 28. Issue 2. p. 115-138; Coady, D. (2010). Two concepts of epistemic injustice. *Episteme*. Vol. 7. No. 2. p. 101-113; Medina, J. (2012). Hermeneutical injustice and polyphonic contextualism: social silences and shared hermeneutical responsibilities. *Social Epistemology*. Vol. 26. Issue. p.201-220; Medina, J. (2013). *Epistemology of resistance: gender and racial oppression, epistemic injustice, and resistant imaginations*. Oxford. Oxford University Press; Anderson, E. (2012). Epistemic justice as a virtue of social institutions. *Social Epistemology*. Vol. 26. No. 2. p. 163-173; Pohlhaus Jr, G. (2012). Relational knowing and epistemic injustice: toward a theory of willful hermeneutical ignorance. *Hypatia*. Vol. 27. Issue. 4. p. 715-735. See also Kidd, I. Medina, J. Pohlhaus, Jr. G. (2017). Introduction. In Kidd et al (2017). Op.cit. n349 for an overview of the relevant arguments and debates.

³⁷² Anderson, E. (2012).Op.cit.n372.

³⁷³ Mason, R. (2011). Two kinds of unknowing. *Hypatia*. Vol. 26. No. 2. p.306.

³⁷⁴ Pohlhaus Jr, (2012). Op.cit n372.

³⁷⁵ Ibid.

and Dotson³⁷⁶ consider how powerful groups can actively resist such perspectives to maintain the status quo. Dotson has argued that powerful groups may interact with marginalised groups in a way that fails to accept the latter perspective. She terms this a 'contributory injustice'. Tate³⁷⁷ has pointed out that this may occur within a mental health setting.³⁷⁸

Other writers have developed the concept of epistemic injustice in a way that promotes active resistance to oppression and injustice. This has a direct relevance to the issues considered in chapter 8. In this context, Medina,³⁷⁹ building on Fricker's analysis, differentiates epistemic injustice from epistemic justice, in a way that emphasises the importance of the hearer identifying different forms of identity power and adjusting their credibility judgements accordingly.³⁸⁰ Medina focuses attention on the knowledge possessed by individuals and groups who lack identity power, demonstrating how they can develop their voice in a way that makes use of the epistemic resources that they possess. This can allow them to challenge, undermine and change established normative structures that they experience as oppressive.³⁸¹ In chapter 8, I apply Medina's arguments to explain the role the individuals with lived experience have played in the development of new understandings of self-injury.

3.6.2 Epistemic injustice and people who self-injure

Many Individuals who self-injure are likely to experience both testimonial and hermeneutical injustice, as research suggests that self-injury is a particularly stigmatised behaviour, and people who behave in this way are often seen as difficult.³⁸² Negative stereotypes and epistemic prejudices may mean that the perspective of the individual is not heard or understood, and this can impact on their

³⁷⁶ Dotson (2012). Op.cit. n372.

³⁷⁷ Tate, A.J. (2019). Contributory injustice in psychiatry. *Journal of Medical Ethics*. Vol. 45. p. 97-100.

³⁷⁸ I return to the issue of contributory injustice in the conclusion.

³⁷⁹ Medina (2013). Op.cit. n372.

³⁸⁰ Fricker, (2007). Op.cit. n351. p. 98.

³⁸¹ Medina (2013). Op.cit. n372. p. 3.

³⁸² Longdon and Proctor (2012). Op.cit.n7; Klonsky, E.D. Victor, S.E. Boaz, Y.S. (2014). Non-suicidal self-injury: What we know and what we need to know. *The Canadian Journal of Psychiatry*. Vol. 59. No. 11. p. 565-568.

experience of treatment. Moreover, a biomedical conceptualisation of their problems and a psychiatric diagnosis may have an impact on every aspect of the individual's life. They come to affect the person's perception of himself or herself.³⁸³ This can result in both epistemic and non-epistemic harms. The former refers to harm resulting from a failure to believe the individual's perspective and thereby undermine his or her autonomy. The latter refers to the way that such an individual may be treated as a result of this lack of understanding.³⁸⁴

A testimonial injustice may occur as health care professionals and society more generally may fail to recognise the epistemic value of the views of individuals who have lived experience of self-injury.³⁸⁵ Their experiences may be interpreted through the use of negative stereotypes and prejudice and their accounts based on lived experience may not be respected or believed.³⁸⁶ They may be seen as unreliable sources of knowledge regarding their experiences, and their actions may not only be explained in terms of mental disorder but also in terms of weakness of will, manipulation, attention-seeking, irrationality, and irresponsibility and often associated with deliberate intent.³⁸⁷ This is not an interpretation that many individuals who self-injure recognise as applying to them, and it constitutes a fundamental failure to respect the person's autonomy as it questions the person's moral agency.

In addition, a hermeneutical injustice may occur due to the way that the dominant biomedical discourse explains self-injury. It may not provide the individual with a means of understanding their distress or a language with which to express and make sense of their experiences.³⁸⁸ The individual may lack the hermeneutical resources to make sense of the experiences if they do not accept the explanation that they are

³⁸³ Sanati, and Kyratsous, (2015). Op.cit. n364.p.481.

³⁸⁴ Research indicates discriminatory treatment practices such as delayed treatment or punitive approaches such as stitching wounds without anesthesia. See Anon. (2016). Self-harm and the emergency department. *British Medical Journal*. Vol.353. p.1150; Hamilton, I. (2016). Changing healthcare workers' attitudes to self-harm. *British Medical Journal*. Vol. 353.p.2443.

³⁸⁵ Leblanc, S. and Kinsella, E.A. (2016). Toward epistemic injustice: A critically reflexive examination of 'sanism' and implications for knowledge generation. *Studies in Social Studies*. Vol. 10. Issue. 1. p. 59-78.

³⁸⁶ Freeman (2014).Op.cit. n363; Kurs and Grinshpoon, (2018). Op.cit. n364.

³⁸⁷ For a discussion regarding the prejudices associated with the diagnosis of borderline personality disorder, see Kyratsous and Sanati, (2017). Op.cit n364.

³⁸⁸ Carel, and Kidd, (2014). Op.cit. n362. p. 530, who argue that certain forms of knowledge have privileged status in a healthcare setting. For example, scientific evidence is supported at the expense of personal narratives.

indicative of psychiatric pathology. The individual is thus unable to express their views in a way that may reflect their autonomous desires and wishes. A combination of both testimonial and hermeneutical injustice may mean healthcare professionals may interact with the patient based on negative stereotypes and epistemic prejudice rather than on the basis of compassion and empathy.³⁸⁹ This has a direct impact on the quality of care that is provided due to a failure to respect the individual's autonomy. People who self-injure experience a double form of vulnerability, they have to deal not only with the experience of self-injury but also the powerful influence of a caring system that may view them as ill, manipulative, controlling or attention-seeking. This is a narrative that some come to accept, not because they really believe it, but because of the power imbalance that they experience leaves them no alternative.³⁹⁰

Despite these problems, it is possible to develop new forms of knowledge and different ways of understanding self-injury. Crichton et al have argued,³⁹¹ that it is possible to use the perspective of individuals who have experience of mental health conditions to challenge traditional perspectives and effect improvements both in the provision of care and in the healthcare professionals education and training. In chapter 8, I use the concepts of epistemic injustice and epistemic resistance to develop a perspective on harm minimisation that has its foundations in the views of people who have lived experience of self-injury. I argue that in the context of an in-patient setting, individuals' who self-injure have traditionally had limited ability to challenge, undermine or even less change the normative structures in place. As a result, they are often likely to suffer both testimonial and hermeneutical injustice. However, I show how such individuals have in some cases, been able to articulate different ways of knowing and through their actions, attitudes to self-injury have changed. An implication of this change has been the development of harm minimisation approaches in working with people who self-injure.

³⁸⁹ Kidd and Carel (2017). Op.cit. n349. p. 176.

³⁹⁰ My thanks to Simona Giordano for pointing this out to me.

³⁹¹ Crichton et al. (2017). Op.cit. n364.

3.8. Conclusion

In this chapter, I have considered a number of theoretical perspectives that inform the analysis that takes place in chapters 6 to 9. In considering the issues around autonomy, paternalism, harm and epistemic injustice, it becomes clear that any examination of the clinical management of self-injury requires a sophisticated analysis of many different ethical and clinical issues. We have seen that, for example, different understandings of autonomy may lead to markedly different views around whether the individual who self-injures is autonomous and/or has the capacity to self-injure and/or to engage competently in a therapeutic process. We have seen how structural injustices may colour how others, such as healthcare professionals evaluate the individuals choices and actions, but also how individual sufferers may make sense of their own choices and actions. The proposal to use harm minimisation approaches with people who self-injure thus sits in a rather complex terrain. It challenges us to reflect carefully on what we mean by autonomy, risk, harm, benefits, and on the most effective and ethically defensible way of providing care to this vulnerable population.

Chapter 4: Legal Approach

4.1 Introduction

In this chapter, I will examine a number of legal issues associated with the adoption of a harm minimisation approach with in-patients who self-injure. The analysis informs my overall argument but relates particularly to chapter 9. In doing so, I build on the analysis completed in the second part of chapter 2. First, I complement the discussion of autonomy undertaken in chapter 3 and consider the capacity to consent to treatment from a legal perspective. I argue that there are individuals who self-injure and are able to consent to participation in a programme of care involving harm minimisation. In spite of this, as Warner and Feery³⁹² have argued, mental health care also allows people to be prevented from acting in certain ways, and this occurs independently of their decision-making capacity. We will see how this occurs through the legal framework provided by the Mental Health Act.³⁹³ Second, taking the anxiety that harm minimisation often generates for health care professionals as my starting point, I will consider the way that the concept of risk has come to play an increasingly important role in the delivery of mental health services, and show how this contributes to the development of a legalised environment in which health care professionals are increasingly concerned about issues of liability. Third, I will focus particularly on a specific element of this legalised environment; the issue of civil and criminal liability. I will consider whether the fears that many health care professionals have are warranted. Finally, I will discuss the potential impact of Article 2 of the European Convention on Human Rights³⁹⁴ and the states obligation to prevent suicide in certain circumstances. I will argue that this may inadvertently lead to increasingly paternalistic forms of intervention.

³⁹² Warner and Feery, (2007). Op.cit. n176.

³⁹³ Mental Health Act 1983 (amended 2007). www.legislation.gov.uk

³⁹⁴ Council of Europe (1950), *European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos 11 and 14*. 4 November 1950, Article 2.

4.2 Autonomy and the law

English law recognises an individual's right to bodily integrity and to make decisions based on this right.³⁹⁵ As Goff L.J stated in *In Collins v Wilcock*,³⁹⁶ "the fundamental principle, plain and incontestable is that every person's body is inviolate." These comments point to the importance of autonomy in English law and the Individuals right to make independent decisions that provide them with control over their lives.³⁹⁷ Lord Hobhouse in *Reeves* is often cited in this respect when he states that the "person has a right to choose his own fate. He is constrained in so far as his choice may affect others, society or the body politic. But in so far as he himself alone is concerned, he is entitled to choose."³⁹⁸

The law also protects individuals against unwarranted paternalism except in certain circumstances such as the potential of harm to others and a lack of decision-making capacity on the part of the individual.³⁹⁹ Lord Mustill refers to the first in *R v Brown*,⁴⁰⁰ when he says that "the state should interfere with the right of an individual to live his or her life as he or she may choose no more than is necessary to ensure a proper balance between the specific interests of the individual and the given interests of the individuals who together comprise the populace at large." Lady Butler-Sloss refers to the second when she states that, "the only situation in which it is lawful for the doctors to intervene is if it is believed that the adult patient lacks the capacity to decide."⁴⁰¹ When an individual lacks this capacity to make decisions, then others may decide on the person's behalf.⁴⁰² The presence of such capacity enables the law to recognise and support an individual's decisions and permits the exercise

³⁹⁵ Walker L.J. *Re (A) Minors (conjoined twins separation)* [2001]. 2 WLR 480.

³⁹⁶ *Collins v Wilcock* [1984] 3 ALL E.R. 374 at 378.

³⁹⁷ See McLean, S.A.M. (2010). *Autonomy, Consent and the Law*. London. Routledge. She argues that because the law considers a person's decision to be autonomous, it does not necessarily imply that they are truly autonomous. (p.3) It is important to note that the law is generally concerned with the individual's capacity to make a competent decision rather than the more metaphysical debate regarding autonomy (p.40)

³⁹⁸ See, for example, Lord Hobhouse in *Reeves v Commissioner of the Police of the Metropolis* [2000] 1 AC 360

³⁹⁹ Donnelly, M. (2010). *Healthcare Decision- Making and the law. Autonomy, Capacity and the limits of liberalism*. Cambridge. Cambridge University Press. She argues that soft paternalism is a fundamental part of the law's approach to healthcare decision-making p.90.

⁴⁰⁰ *R v Brown* [1993] UKHL 19, [1994] 1 AC 212.

⁴⁰¹ *Re MB* [1997] EWCA Civ 3093, [1997] 2 FCR 541, 555.

⁴⁰² *Re T (Adult Refusal of Treatment)* [1992] EWCA Civ 18.

of autonomous choice.⁴⁰³ The available case law supports this position.⁴⁰⁴ Thus as Quinn⁴⁰⁵ proposes, capacity in law has a dual function; it is a “sword” that advances autonomy and choice and a “shield” that protects others from imposing their will. This has important implications in a healthcare context.

4.2.1 Autonomy and healthcare: the capacity to decide

It is the law on consent to treatment that gives legal expression to autonomy in English medical law.⁴⁰⁶ It starts from the position that all individuals have the capacity to make decisions about their health care needs. The absence of consent can result in criminal charges of assault or battery or a tort action for negligence.⁴⁰⁷ Brazier has argued that there are four functions of consent. First, it affirms and safeguards the patient’s autonomy. Second, it makes manifest respect for the person. Third, the quality of care provided may be enhanced through the informed participation of the individual. Finally, requiring consent is a means of regulating practice and preventing abuse.⁴⁰⁸

The freedom to accept, refuse and choose a therapeutic intervention is a crucial component of autonomy, and the patient has a right to make decisions based on the clinical advice provided. This was clearly stated in *Re T*,⁴⁰⁹ where it was made clear that an adult patient who has capacity, has an absolute right to choose whether to consent to medical treatment, to refuse it, or to choose one rather than another of the treatments being offered. Thus an individual has a legal right to make important decisions about their health even if the healthcare professional believes these decisions to be ill-advised or even plain wrong.⁴¹⁰ There is a presumption that an

⁴⁰³Mclean (2010) Op.cit.n398 notes that legal capacity and autonomy are not synonymous. See chapter 3 for a discussion of this issue in relation to different models of autonomy.

⁴⁰⁴ See *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290; [1994] 1 All ER 819; *Re MB*.Op.cit.n402.

⁴⁰⁵ Quinn (2010) cited in Bach, M. and Kerzner, L. (2010). *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity*. Ontario. Law Commission. p. 43.

⁴⁰⁶ *Airedale NHS Trust v Bland* [1993] 1 ALL ER 821 per Lord Goff at para 861. See also Mclean (2010). Op.cit. n398. p.3.

⁴⁰⁷ *ibid*

⁴⁰⁸ Brazier, M. (1991) Competence, consent and proxy consents. In Brazier, M. and Lobjolt, M. (eds). *Protecting the vulnerable. Autonomy and consent in health care*. London, Routledge. p. 35.

⁴⁰⁹ *Re T (Adult Refusal of Treatment)*. Op.cit. n403 at 653.

⁴¹⁰ Devaney, S. (2005). Autonomy Rules OK. *Chester v. Afshar. Medical Law Review*. Vol. 13. p. 107.

adult patient meeting specific criteria is capable of making their own health care decision and all adult patients are assumed to have capacity unless it is possible to demonstrate that this is not the case.⁴¹¹ If an individual is judged to lack capacity, there are circumstances where they are no longer able to refuse medical treatment, which may then be administered forcibly.⁴¹²

The complex issues associated with decision making in healthcare have been subject to detailed analysis.⁴¹³ It is not my intention to revisit this type of analysis but to make the important point that over the last four decades the legal approach to healthcare decision-making has focused increasingly on ensuring respect for the individual's autonomy.⁴¹⁴ As the law provides the framework within which decisions are made it is no surprise that clinical practice has also developed in a way that supports shared decision making and what Kennedy⁴¹⁵ terms “partnerships of shared endeavour in pursuit of the client's interests.” Both in clinical practice and the law, there has been a recognition of a shift in power from the professional to the patient. This reflects an increasing recognition of personal autonomy and a move away from supporting paternalistic approaches that were traditionally associated with healthcare.⁴¹⁶ This process is recognised in case law, particularly concerning the provision of information on which to base decisions about consent. This culminated in the *Montgomery* judgment in 2015.⁴¹⁷

Montgomery has been seen to provide a legal basis for the vital role of autonomy in promoting patient-centred care. Although the precise implications of this case remain

⁴¹¹ The Mental Capacity Act 2005 www.legislation.gov.uk. Sections 2. (1) 3(1)); GMC 2008 *Consent: patients and doctors making decisions together*. London. General Medical Council.

⁴¹² Saks, E. R. and Behnke, S. H. (1999). Competency to Decide on Treatment and Research: MacArthur and Beyond. *Journal of Contemporary Legal Issues*. Vol. 10. p. 103-129.

⁴¹³ See, for example, Maclean, A.R. (2009). *Autonomy, Informed consent and Medical law. A relational challenge*. Cambridge. Cambridge University Press; McLean (2010). Op.cit. n398; Donnelly (2010). Op.cit. n400; Kong. (2017). Op.cit. n.160.

⁴¹⁴ Donnelly (2010). Op.cit. n400. p. 1

⁴¹⁵ Kennedy, I. (1988). *Treat me right. Essays in medical law and ethics*. Oxford. Oxford University Press. p.178.

⁴¹⁶ Devaney, S. and Holm, S. (2018). The transmutation of deference in medicine: an ethico-legal perspective. *Medical Law Review*. Vol. 26. No. 2, p. 207.

⁴¹⁷ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; *Sidaway v Board of Governors of Bethlehem Royal Hospital* [1985] AC 871; *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR 53; *Chester v Afshar* [2004] UKHL, 41; [2005] 1 AC 134; *Birch v UCL Hospital NHS Foundation Trust* [2008] EWHC 2237 (QB). Australian case of *Rogers v Whittaker* [1992] 175 CLR 479 was also influential.

under debate, there is agreement that discussions about consent to treatment now require a process of shared decision-making. This must incorporate discussions about the material risks and benefits of the treatment options available.⁴¹⁸ This should form part of a dialogue that is part of a more collaborative approach to intervention associated with shared decision-making. This recognises the need to respect the person's values and preferences and to engage them in the decision-making process.⁴¹⁹ Adshead et al⁴²⁰ argue that mental health care is in no way exempt from the implications of *Montgomery* and cite Herring⁴²¹ who has argued that *Montgomery* has extended the principle of supported decision making enshrined in the Mental Capacity Act⁴²² to everyone. As we have seen, harm minimisation incorporates both practical and psychotherapeutic techniques that are dependent on the patient's ability to participate. The individual's consent is, therefore required, and they must possess the capacity to make such decisions.

4.2.2. The capacity to decide and the individual who self-injures

The requirement for consent protects an individual from unwarranted paternalism through respecting the individual's autonomy.⁴²³ In order to do this, the law relies on the rules around consent to treatment to recognise the right of autonomy, and it is the capacity to decide that is the basis for exercising that right.⁴²⁴ As Donnelly has argued, when an individual makes a decision, such as to consent to treatment, this will only be respected if the legal standard for mental capacity is met in relation to the actual decision being made.⁴²⁵ The statutory instrument governing such decisions regarding capacity is the Mental Capacity Act.⁴²⁶ This reflects the case law

⁴¹⁸ Adshead, G. Crepaz-Keazy, D. Deshpande, M. Fulford, K.W.M. and Richards, V. (2018). *Montgomery* and shared decision-making: implications for good psychiatric practice. *British Journal of Psychiatry*. Vol. 213. p. 630.

⁴¹⁹ Hughes, J.C. Crepaz-Keay, D. Emmett, C. Fulford, K. (2018). The *Montgomery* Ruling, individual values and shared decision-making in psychiatry. *British Journal of Psychiatry. Advances*. Vol.24. p.93-100.

⁴²⁰ Adshead et al (2018). Op.cit.n419. p. 630-632.

⁴²¹ Herring, J. Fulford, K.W.M. Dunn, D. Handa, A. (2017). Elbow room for best practice? *Montgomery*, patients' values and balanced decision-making in person centred care. *Medical law Review*. Vol. 24. No. 4. p. 582-603.

⁴²² Mental Capacity Act 2005. Op.cit.n412.

⁴²³ Maclean (2009). Op.cit. n398. p. 5.

⁴²⁴ Donnelly (2010). Op.cit. n400. p. 52.

⁴²⁵ *ibid*.

⁴²⁶ Mental Capacity Act 2005. Op.cit. n412.

developed before its passing in 2005.⁴²⁷

An individual's decision-making capacity is judged on the basis of criteria specified in the Mental Capacity Act.⁴²⁸ This is effectively a two-stage test. The first stage involves identifying the presence of an impairment of the mind or brain. The second stage consists of an assessment of the individual's ability to make a decision, and this assessment has a number of components. First, an individual lacks the capacity to make a decision if at the time he or she is unable to make a decision in relation to the matter because of an impairment of, or a disturbance in, the functioning of the mind or brain.⁴²⁹ Second, in addition to the above, an individual is judged unable to make a decision if he or she is unable to meet the following criteria. He or she is unable to understand the information relevant to the decision. In addition, he or she is unable to retain that information. Third, he or she is unable to use or weigh that information as part of the process of making the decision. Finally, he or she is unable to communicate his decision.⁴³⁰ The accepted principle is that "capacity is the rule and incapacity the exception."⁴³¹

In both law and clinical practise, it is generally accepted that mental disorder and mental incapacity are not synonymous, and even a patient with a severe mental illness may have the capacity to make decisions about treatment.⁴³² However, an individual with a mental health problem is more likely to have their capacity questioned.⁴³³ In relation to this matter, one is reminded of Bennett's analysis of different forms of body alteration and its complicated relationship with the law.⁴³⁴ He makes the point that in some contexts the "rational actor" that dominates legal

⁴²⁷ See *Airedale NHS Trust v Bland*. Op.cit. n407; *Re C (adult refusal of treatment)*. Op.cit. n405; *Re B (consent to treatment; capacity)* [2002] 1FLR 1090; *Re MB*. Op.cit. n402.

⁴²⁸ Mental Capacity Act 2005. Op.cit. n412.

⁴²⁹ Ibid. section 2(1).

⁴³⁰ Ibid. section 3(1).

⁴³¹ Rommelaere, C. (2015). Mental disorders and decision-making capacity: what is the role of the law? *European Journal of Health Law*. Vol. 22. p. 76.

⁴³² See *Re C*. Op.cit. n405; In *Re C*, a patient detained in a high secure hospital sought an injunction to prevent his gangrenous foot being amputated against his will. The injunction was supported on the basis that a person might have capacity notwithstanding that they have a serious mental illness. In this case, schizophrenia. See also *Re JT (Adult Refusal of Medical Treatment)* [1998]. 1. F.L.R. 48. In this case, a patient with severe learning disability detained under the Mental Health Act was judged to possess the competence to refuse treatment for kidney failure.

⁴³³ Perlin, M. (1999) 'Half Wracked prejudice leaped forth'. Sanism, pretextuality, and why and how mental disability law developed as it did. *Journal of Contemporary Legal Issues*, Vol. 10. p. 3-36.

⁴³⁴ Bennett, T. (2015) *Cuts and criminology. Body alteration in legal discourse*. Ashgate. Farnham.

thought is transposed into a view of the individual as irrational and impaired in a way that makes consent impossible due to incapacity. Thus, incapacity is assumed when a decision is deemed unusual or unwise. In clinical terms, this is contrary to good practice as the law is clear that capacity must not be confused with the nature of the decision made and every effort should be made to support the individual to make choices that reflect their particular needs, wants and circumstances.⁴³⁵

There is no doubt that the assessment of decision-making capacity in an in-patient who self-injures can be challenging. As we have seen the reasons that people self-injure and the relationship with mental disorder is both complex and multifaceted. For example, some individuals who self-injure will have a diagnosis of personality disorder. This may affect their ability to use and weigh information. In these situations, as Szmukler⁴³⁶ has argued, increased emotional distress may impede the ability to understand and to appreciate the nature of the situation in which an individual finds themselves. Furthermore, increased levels of impulsivity may appear to be beyond the individual's control and may impact on their ability to appreciate the information provided and to make a reasoned decision about its content. In spite of these issues, it is reasonable to argue that some individuals who self-injure can make decisions about their treatment options. Let us apply Szmukler's⁴³⁷ broader analysis to the specific context of self-injury,

The assessment of capacity to participate in a programme of intervention involving harm minimisation approaches is likely to be complex and time consuming. However, if done correctly, it could have an almost therapeutic dynamic. The reasons why an individual self-injures can only be understood on the basis of a therapeutic dialogue that attempts to understand the individual's life situation. On this basis, it is possible to develop a clinical formulation about both the reasons for self-injury and the most appropriate options for intervention. It also ensures that the individual's concerns about intervention can be verbalised and efforts are made to ensure that the individual does not feel they are being pushed into any particular

⁴³⁵ See *Re C* Op.cit. n405; *Re JT*.Op.cit. n433.

⁴³⁶ Szmukler, G. "Personality Disorder" and capacity to make treatment decisions. *Journal of Medical Ethics*. Vol. 35. p. 647-650.

⁴³⁷Ibid.

form of therapeutic intervention. The approach must be highly individualised, and in relation to the harm minimisation approach, the patient must understand not only the nature of the programme but also the requirement to engage in relevant psychological interventions to support recovery and change.

It could be argued at this point that an individual who self-injures may lack the capacity to consent to a programme that facilitates the very behaviour that is central to their condition. I consider this issue later and make the point that most individuals who act in this way have enduring patterns of behaviour, which are generally not associated with affecting the capacity to make decisions.⁴³⁸ In fact, as Peay⁴³⁹ has argued, even though their ability to exercise control over their behaviour is impaired, many people with a diagnosis of personality disorder are judged by the law to have the capacity to make decisions about their treatment. Furthermore, this has important therapeutic implications as the treatments offered not only require the patient's voluntary participation, they also require the ability to do otherwise, and without this, psychologically orientated therapeutic intervention supporting autonomy and choice would be impossible.⁴⁴⁰

The reality is that many people who self-injure will reflect the wider clinical population. There will be some who self-injure who never possess capacity and will be unable to consent to treatment or to engage in a programme of care involving harm minimisation. There will be other people who possess capacity only on a fluctuating basis and again would be unsuited to interventions associated with a harm minimisation approach. There will, however, be some people who do have the capacity to consent, and the empirical evidence available would appear to support this position.

Although increased levels of incapacity are found in patients with a mental disorder when compared with the general population, some patients do possess such

⁴³⁸See Chapter 6

⁴³⁹Peay, Jill (2011) Personality disorder and the law: some awkward questions. *Philosophy, psychiatry and psychology*, 18 (3). pp. 231-244.

⁴⁴⁰Pickard, H (2015). Self-harm as violence: when victim and perpetrator are one. In Marway, H. and Widdows, H. (eds). *Women and Violence: The Agency of Victims and Perpetrators*. Basingstoke. Palgrave Macmillan. Chapter 4.

capacity.⁴⁴¹ The available figures indicate that the percentage of in-patients lacking the capacity to make treatment decisions is between 40 and 60%.⁴⁴² For example, Owen et al⁴⁴³ found that 60% of patients lacked the competence to consent to treatment on admission to hospital. While Okai et al⁴⁴⁴ found that 29% of patients lacked such competence during their hospital stay. A study of 350 in-patients found that 86% of patients detained under the Mental Health Act lacked capacity while the figure for those not detained was 39%.⁴⁴⁵ Another study found that 50% of informal patients possessed capacity, as did many patients with a diagnosis of personality disorder.⁴⁴⁶ A study that looked specifically at patients who had self-harmed and presented for emergency treatment found that 39.4% of patients lacked capacity on initial presentation although this was increased to 63.4% when the information was provided and supported by a verbal explanation. However, over third of these patients did lack decision-making capacity.⁴⁴⁷

Overall some caution does need to be exercised in interpreting these figures. First, although assessment of mental capacity provides an ethical and legal framework for respecting autonomy, the existing literature suggests that mental capacity is poorly documented in mental health in-patient settings.⁴⁴⁸ For example, Ching et al found that 49.8% of patients had their capacity recorded on admission, and 61.9% had an assessment in the previous week.⁴⁴⁹ This was in spite of an expectation that this occurs in all cases. In another study, Brown et al found only 9.8% of patients with a

⁴⁴¹ Jacob, R. Clare, I.C.H. Holland, A.J. Watson, P.C. Maimaris, C. Gunn, M. (2005). Self-harm, capacity, and refusal of treatment: implications for emergency medical practice. A prospective observational study. *Emergency Medical Journal*. Vol. 22. p. 799-802.

⁴⁴² Cairns R, Maddock C, Buchanan A, David, A.S, Hayward P, Richardson G, Szmukler G, Hotopf M. (2005). Prevalence and predictors of mental incapacity in psychiatric in-patients. *British Journal of Psychiatry* Vol.187 p. 379–385; Owen GS, Richardson G, David AS, Szmukler G, Hayward P, Hotopf M. (2008). Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study. *British Medical Journal*. Vol. 337. p. 448.

⁴⁴³ Owen et al (2008). Ibid p.40-42.

⁴⁴⁴ Okai, D., Owen, G., McGuire, H., Singh, S., Churchill, R., & Hotopf, M. (2007). Mental capacity in psychiatric patients. *British Journal of Psychiatry*.Vol.191. p. 291–297.

⁴⁴⁵ Owen et al (2008) Op.cit. n443. p. 448.

⁴⁴⁶ Brown, P.F. Tulloch, A.D. Mackenzie, C. Owen,G.S. Szmukler,G. Hotopf, M. (2013). Assessments of mental capacity in psychiatric in-patients: a retrospective cohort study. *BMC Psychiatry*. www.biomedicalcentral.com/1471-244x/13/115.

⁴⁴⁷ Ibid. n403.

⁴⁴⁸ Ching, L. Stellman, J. Patel, N. Dalton, F. (2016). Improving capacity and consent to treatment recording in psychiatric in-patient wards: A multi-centre quality improvement project. *BMJ Quality Improvements Reports*.5;u208344.w4094. doi;10.1136/bmjquality.u208344.w4094. p.1.

⁴⁴⁹ Ibid.

capacity assessment suggesting some diversity across services.⁴⁵⁰ Second, some of the research available is now quite dated and given the changes that have occurred in the level of acuity in many in-patient facilities the situation may have changed. In spite of this, it seems reasonable to conclude that there will be some individuals who self-injure who have decision-making capacity and are able to consent to a programme of intervention that includes harm minimisation approaches. The numbers will not be large, but my argument is not about the routine application of such measures. Furthermore, this may sometimes occur even in the context of enforced treatment, as detention under the Mental Health Act does not necessarily imply a lack of decision-making capacity.⁴⁵¹ Before progressing any further, a few words about this legal framework is required.

4.3 The Mental Health Act 1983 (amended 2007)

People who experience mental health problems are subject to a legal framework that differs from that found in the treatment of other disorders. Admission to hospital can be on either a voluntary or a compulsory basis. Where compulsion is used, then this makes use of the statutory framework provided by the Mental Health Act.⁴⁵² The Act is one of the few ways in which an individual who has not been convicted of a criminal offence can be deprived of their liberty and treated against their will. This is on the basis that they have a mental disorder and are either a risk to others and/or to themselves. A focus on risk assessment and management have become explicit concerns of the civil commitment process and as we shall see the concept of risk plays an increasingly important role in the treatment of mental disorder, particularly when the statutory powers are invoked, but not exclusively so.⁴⁵³

Formal detention using the Act is based on the presence of mental disorder and a risk to the patient, others and/or to the individual's health. Where an individual

⁴⁵⁰ Brown et al (2013). Op.cit. n447.p. 115.

⁴⁵¹ Patients with a mental disorder can be treated against their will under the powers of the Mental Health Act 1983 (amended 2007). Section 58 of the Mental Health Act 1983 includes within the Second Opinion Doctors assessment of the facility to record that a person is able to consent to their treatment programme. This is recorded on the form T2.

⁴⁵² Mental Health Act 1983 (amended 2007). Op.cit. n192.

⁴⁵³ Glover-Thomas, N. (2011). The age of risk: Risk perception and determination following the Mental Health Act 2007. *Medical Law Review*. Vol. 19. p. 581-605

agrees to voluntary admission to hospital, they may also be subject to detention if they attempt to leave, and the above criteria are assessed to be present. The number of patients detained under the Act is increasing, as is the ratio of detained patients resident on mental health units.⁴⁵⁴ Although many individuals who self-injure will be admitted to hospital on an informal basis and treated voluntarily, others will be detained under either Part II or Part III of the Act.⁴⁵⁵ Furthermore, those treated on a voluntary basis may be compulsorily detained should they wish to leave hospital and are assessed as being a risk to self or others. Thus, even voluntary admission can be experienced as coercive.

The restrictive nature of interventions used to try and prevent self-injury means that the use of the Mental Health Act is often an inevitable outcome of admission to hospital. In such circumstances the behaviour of the individual is perceived, as a symptom of illness and a change in behaviour is dependent on the treatment of the underlying disorder. Where mental disorder is judged to be present, and the criteria for detention under the Mental Health Act are met, then the individual may be treated against their will, on the basis that the underlying illness makes them a risk to themselves. The Act effectively provides the legal framework that supports the use of coercive or paternalistic interventions that aim to prevent self-injury. Although harm minimisation could not be administered formally under section 63 and section 145 of the Act,⁴⁵⁶ an individual detained under the Act would not be excluded from such interventions, as they may possess the capacity to make decisions about their treatment. This explains why harm minimisation approaches have been used with some women detained under conditions of medium security.⁴⁵⁷

4.3.1 Risk and mental health care

⁴⁵⁴ Care Quality Commission (2019). Op.cit.n47.

⁴⁵⁵ Part II and III of the Mental Health Act 1983 deal with the statutory requirements supporting compulsory admission to hospital. The former deals with admission under civil sections of the Act, the latter deals with compulsory admission through the courts following conviction for a criminal offence.

⁴⁵⁶ Section 63 provides that the consent of a person is not required for any medical treatment given for mental disorder if given under the direction of the responsible clinician. It excludes treatments covered by Sections 57 and 58, which are not directly relevant to my current analysis. Section 145 defines medical treatment as including nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.

⁴⁵⁷ Department of Health Self-Harm Expert Reference Group (SHERG) (2012). Op.cit. n78.

The use or the potential use of the Mental Health Act means that it casts a long shadow over the provision of mental health services. Detention and treatment under the Act are based on a “risk formula” which is focused on reducing the risks associated with harm to self or others.⁴⁵⁸ This focus on risk, does however have a broader application. As Fanning argues, it not only dominates the application of the Mental Health Act and the use of compulsory treatment, it also pervades the delivery of mental health services more generally.⁴⁵⁹ This “riskification” of mental health policy is not only a consequence of improved understanding of risk factors associated with mental disorder and the development of more actuarial approaches to assessment with a more robust evidence base, it also reflects increased anxiety about health care professionals’ ability to contain “risky behaviours”.⁴⁶⁰

Although attempts to work with risk and uncertainty have always been an integral part of mental health practice, what is perhaps different now, is the shift to eliminate uncertainty by introducing systems of regulation that attempt to standardise practice to avoid harm.⁴⁶¹ The concept of risk has become inextricably linked to preventing harm, and it can be argued that this conflicts with the ethical principle of respect for autonomy and policy objectives which focus on the needs of the individual and the requirement on occasion to take positive therapeutic risks. The pressure to avoid harm and manage risk may impact on the relationship between the healthcare professional and the patient in a way that promotes a more defensive and paternalistic approach to clinical practice.⁴⁶² This serves to provide a complicated ethical and legal background that needs to be understood if the practice is to be evaluated in any meaningful way. It is within this context that the practice of harm minimisation must function. It is to this issue that we now turn as we consider the feasibility of harm minimisation in the “age of risk.”⁴⁶³

3.4. Harm Minimisation and the Age of Risk.

⁴⁵⁸ Fanning, J. (2018). *New Medicalism and the Mental Health Act*, London. Hart. p. 2.

⁴⁵⁹ Fanning, J. (2016). Continuities of risk in the era of the Mental Capacity Act. *Medical Law review*. Vol. 24. No. 3. P. 415-433.

⁴⁶⁰ Fanning (2018) Op.cit. n459.p. 130.

⁴⁶¹ Hillman, A. Tadd, W. Calnan, S. Calnan, M. Bayer, A. Read, S. (2013). Risk, governance and the experience of care. *Sociology of Health and Illness*. Vol. 35. No. 6. p. 939-955.

⁴⁶² Clancy, L. Happell, B. Moxham, L. (2014). The language of risk: common understanding or diverse perspectives? *Issues in Mental Health Nursing*. Vol. 35. No. 7. p. 551-557.

⁴⁶³ Glover-Thomas, (2011). Op.cit.n454.

All health care professionals have a duty of care to their patients and as we have seen many health care professionals are concerned about the possible legal implications of adopting a therapeutic intervention that includes some form of harm as a necessary component. This type of concern reflects a broader awareness of the legal and regulatory framework in which health care practitioners now work. As Edelman⁴⁶⁴ has noted the law fosters changes in organisational governance in two ways. It works directly through the implementation of the law in practice, but it also works indirectly through the creation and maintenance of a normative environment to which the organisation must adapt. It is my view that this has occurred in a healthcare context and is focused on risk reduction. This is part of a wider societal concern with risk, and it is important to consider this phenomenon as it may impact directly on the behaviour of the health professional generally and may have a specific impact upon the adoption of harm minimisation techniques with people who self-injure.

The emergence of “risk talk” in mental health care is part of a process by which the concept has become a defining feature of modern society.⁴⁶⁵ There is a considerable literature on what has become known as the “risk society,” and this literature as Hood et al⁴⁶⁶ note describes the general features that make modern approaches to risk different from societies in the past. This extensive literature need not concern us here,⁴⁶⁷ but an understanding of risk and its implications for clinical practice in mental health care is important.

In simple terms, we face a situation of risk, “when circumstances may (or more importantly may not) turn out in a way that we do not wish for.”⁴⁶⁸ The development

⁴⁶⁴ Edelman, L.B. (1999). Legal environments and organisational governance. The expansion of due process in the American workplace. *American Journal of Sociology*. Vol. 95. No.6. p.1442.

⁴⁶⁵ Fanning, J. (2013). *Risk and the Mental Health Act 2007: Jeopardising liberty, facilitating control?* Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor of Philosophy (PhD.). Liverpool. The University of Liverpool.

⁴⁶⁶ Hood, C. Rothstein, H. Baldwin, R. (2001). *The Government of Risk: Understanding Risk Regulation Regimes*. Oxford. Oxford University Press.p. 141.

⁴⁶⁷ See, for example, Beck, U. (1992) *Risk Society: Towards a New Modernity*, London, Sage Publications; Giddens, A. (1990). *Consequences of Modernity*. Cambridge. Polity Press.

Luhmann, N. (2002). *Risk. A sociological Theory*. London. Routledge.;

⁴⁶⁸ Steele, J. (2004). *Risks and Legal Theory*. Oxford and Portland Oregon. Hart Publishing. p. 6.

of the so-called risk society has brought with it a view that such risks can be managed and if this does not occur, this raises questions about responsibility for any adverse outcomes.⁴⁶⁹ This means that the idea of risk is increasingly seen in terms of accountability and blame. There is no doubt that in some cases, this is entirely justified, as those who expose others to risk are responsible for the outcomes of that result.⁴⁷⁰ This is the very essence of accountability. However more ominously, Steele⁴⁷¹ has noted of organisational and political responses to failures of risk management that, “If something goes wrong, they tend to find a human cause, however far away in distance and time”. She suggests that while risk may be accepted, its materialisation is unlikely to be accepted in the same way.

The policy studies and sociological literature supports this perspective when it indicates that the administrative architecture and the dynamics of organisations are influenced by an institutional imperative to prevent blame and liability.⁴⁷² As Luhmann⁴⁷³ points out, “bureaucratic behaviour is notoriously risk averse.” This literature paints a picture whereby cautiousness is embedded into institutional responses to risk, and it has been argued that risk has replaced the concept of need and that this is invariably associated with blame.⁴⁷⁴ One of the most comprehensive analyses of this phenomenon is found in the work of Power.⁴⁷⁵

An enduring theme of Power’s work is that modern forms of risk management have developed in a way that promotes behaviours and processes that demonstrate that everything possible has been done to ensure that no blame is attached should an untoward event occur.⁴⁷⁶ In considering Power’s analysis of risk in modern society,

⁴⁶⁹ Lupton, D. (2013). *Risk*. London. Routledge.

⁴⁷⁰ Ripstein 1999 p. 65 cited in Steele (2004). Op.cit. n469. p. 104.

⁴⁷¹ Steele (2004) Op.cit. n469. p. 48.

⁴⁷² Hood, et al. (2001). Op.cit. n467.p.171.

⁴⁷³ Luhmann (2002). Op.cit. n468. 190.

⁴⁷⁴ Kemshall, H. (2002). *Risk, Social policy and welfare*. Buckingham. Open University Press; Douglas, M. (1992). *Risk and blame. Essays in cultural theory*. London. Routledge. Douglas is much cited in this respect. “Every death is chargeable to someone’s account, every accident is caused by someone...negligence...adverse events immediately give rise to questions which seek to identify and punish the people responsible for them” (p.15)

⁴⁷⁵ See Power, M. (1999). *The Audit Society. Rituals of verification*. Oxford. OUP; Power, M. (2004). *The Risk Management of Everything. Rethinking the politics of uncertainty*. London. Demos; Power, M. (2007). *Organised Uncertainty. Designing a world of risk management*. Oxford. Oxford University Press; Power, M. Scheytt, T. Soin, K. Sahlin, K. (2009). Reputational risk as logic of organising in late modernity. *Organisation Studies*. Vol. 30. No. 2&3 p.301–324.

⁴⁷⁶ Power (2007). Op.cit. n476.

Moran⁴⁷⁷ has noted how “we are living in an age where risk and its construction is a dominant influence on modes of governance.”⁴⁷⁸ When Power turns his attention to healthcare, he argues that clinical risk management was initially conceptualised in terms of accidental harm. It has, however, moved from these origins and now reflects a regulatory regime concerned with the effectiveness of health care in general. As a result, increasing internal and external scrutiny is focused on ensuring that appropriate systems and processes are in place. For Power, the idea of ‘legalisation’ is particularly important and a concept we return to in chapter 9. This is based on a concern for what is defensible,⁴⁷⁹ and results in a situation where legal norms and varieties of these norms are “hard-wired” into the routines and practices of various organisations, including those that deliver health services.

This type of environment can have significant implications for the delivery of health services. Rothstein et al⁴⁸⁰ have pointed out that the environment described above leads to a situation whereby the professional may not only have to address the primary risk to the client or their colleagues but also the secondary risks to the organisation, obvious examples being negligence, organisational failure and the loss of reputation. This has been identified as an issue in healthcare organisations. Underhill⁴⁸¹ notes how the risk assessment and management approaches designed to identify and manage clinical risks are increasingly preoccupied with the secondary risks to the organisation. The secondary risk is often justified in terms of the primary risk, but the real concern is how a particular action or decision would play out in court.

The formal legal system, quasi-legal and judicial processes, professional rules and regulations, organisational governance and quality systems all contribute to a highly

⁴⁷⁷ Moran, M. (2008). Organised uncertainty: designing a world of risk management by Michael power. *Public Administration*. Vol. 86. No. 4. p. 1133-1134.

⁴⁷⁸ Ibid. p. 1133.

⁴⁷⁹ Power (2007). *Op.cit.* n476. p. 170.

⁴⁸⁰ Rothstein, H. Huber, M. Gaskell, G. (2006). A Theory of Risk Colonization: The Spiralling Regulatory Logics of Societal and Institutional Risk. *Economy and Society*. Vol. 35. p. 91–112.

⁴⁸¹ Underhill, G. (2007). The risks of risk assessment. *Advances in Psychiatric Treatment*. Vol. 13. p. 291-297.

controlled environment.⁴⁸² This has led to some mental health professionals suggesting that a therapeutic consciousness has been replaced by a risk consciousness, which does not necessarily benefit the patient.⁴⁸³ Rather than responding directly to the needs of the patient, the relationship between the patient and the professional is increasingly dominated by a focus on risk that informs assessment, defines the interventions that should be used and imposes strict boundaries on the therapeutic relationship.⁴⁸⁴ In fact, Stanford⁴⁸⁵ has argued that this approach results in six distinct effects. First, people who are subject to risk assessment are effectively objectified.⁴⁸⁶ Second, risk becomes a forensic resource to evaluate the actions of staff in the event of an untoward incident. Third, services are increasingly taking on what is described as a defensive and timid position. Fourth, professional practice is increasingly dominated by the logic of risk minimisation. Fifth, this results in increasingly paternalistic, and in some cases coercive forms of control. Finally, if things go wrong professionals perceive that the response to their actions is reflective of a culture of blame and there is some evidence that supports the claim that a blame culture operates in some mental health services.⁴⁸⁷

This dominant discourse around risk is negative and focused on reducing adverse outcomes. The emphasis tends to be on what has been described as “dramatic

⁴⁸² Heimer, C. A. Petty, J. Culyba, R. J. (2005). Risk and Rules: the ‘legalisation’ of medicine. In Hutter, B. M. and Power, M. (eds). *Organisational encounters with risk*. Cambridge. Cambridge University Press.

⁴⁸³ Sawyer, A. M. (2005). From therapy to administration: deinstitutionalisation and the ascendancy of psychiatric; risk thinking’. *Health Sociology Review*. Vol. 14. Issue 3. p. 283-296.

⁴⁸⁴ Sawyer, A.M. (2009). Mental Health Workers negotiating risk on the frontline. *Australian Social Work*. Vol. 62. No. 4. p. 441-459. See also Sawyer, A. M. (2009). Should the nurse change the light globe. Human service professionals managing risk on the frontline. *Journal of sociology*. Vol. 45. No. 4. p. 361-381.

⁴⁸⁵ Stanford, S. (2010). “Speaking back” to fear: Responding to the moral dilemmas of risk in social work practice. *British Journal of Social work*. Vol. 40.No. 4. p.1065-80.

⁴⁸⁶ See also Callaghan, P.and Grundy, A. (2018). Violence risk assessment and management in mental health: a conceptual, empirical and practice critique. *The Journal of Mental Health Training Education and Practice*. Vol. 13. Issue.p. 7. They argue that patients become risk objects while staff become risk managers.

⁴⁸⁷ See Wand, T. (2017). Considering the Culture of Blame in mental health care and service delivery. *International Journal of Nursing*. Vol. 26. Issue 1. p.3 -4; Khatri, N. Brown, G.D. Hicks, L.L. (2009). From a blame culture to a just culture in health care. *Health Care Management Review*. Vol. 34. Issue 4. p. 312-322; Godin, P. (2004). ‘You don’t tick boxes on a form’. A study of how community mental health nurses assess and manage risk. *Health Risk and Society*. Vol. 6. No. 4. p. 347-360; Muir-Cochrane, Gerace, A. Mosel, K.Oster, C. (2011). Managing risk: clinical decision making in mental health services. *Mental Health Nursing*. Vol. 32. No. 12. p. 726-34.

risks.”⁴⁸⁸ These include suicide and serious violence to others. What is often ignored are the risks that may arise as a result of paternalistic or coercive approaches to intervention. These include negative impacts on an individual’s choices and autonomy. As Higgins et al have said, “the dominant risk discourse, which frames risk in negative terms and views service users as risk-laden objects’ precludes the adoption of a more positive approach to risk.”⁴⁸⁹ Higgins and colleagues call for a widening of the concept of risk to include more positive approaches that permit a professional to work with individuals in a way that risks are considered, weighed and judged in terms of the needs of the individual rather than the needs of the organisation.

The overall result is a risk-averse clinical environment with an emphasis that goes beyond a legal responsibility to act in accordance with the law to a situation whereby a whole range of legal, regulatory and professional accountability frameworks impact upon the way health professionals work. The net result is a reluctance to intervene unless there is a degree of certainty that the intervention can be judged defensible in both legal and regulatory terms. This has been accompanied by the standardisation of practice and more defensive approaches to intervention. This is illustrated by the use of an increasing range of risk assessment and risk management processes, which are often defensive in nature and concentrate on preventing personal and organisational liability. Obviously, some of this is a force for good and promotes high standards of care. On the other hand, such a level of accountability is often associated with the allocation of blame, and many health care professionals believe they work in a blame culture. The case of Doctor Bawa-Garba, who was convicted of gross negligence manslaughter and removed from the medical register, has done little to allay such fears, although she has now been allowed to return to work.⁴⁹⁰

Thus, aspirations to promote autonomy can be contrasted with a reality in which health professionals may feel constrained from taking therapeutic risks. The

⁴⁸⁸ Higgins, A. Doyle, L. Downes, C. Nash, M. Morrissey, J. Brennan, M. & Costello, P. (2015). *Risk assessment and safety planning within mental health nursing services: an exploration of practices, policies and processes*. Dublin: Health Service Executive.

⁴⁸⁹ Ibid. p. 168.

⁴⁹⁰ Dyer, C. (2019). Hadiza Bawa-Garba can return to practice under close supervision. *British Medical Journal*. Vol.365. p.1702.

continued dependence on more traditional forms of intervention may appear more defensible. Autonomy is constantly at odds with pressure to reduce harm and manage risk. It is difficult to square the circle, as the laws of liability and the regulatory context do not generally acknowledge the unique environment of mental health care or the value of taking risks. Thus, harm minimisation may be accepted in principle, but in practice, it is often the professional and legal issues that appear to be uppermost in the practitioner's minds. If the benefits of harm minimisation fail to materialise, then the health professional may worry that they will be called to account and be subject to criticism. In chapter 9, I consider these issues in more detail. In the remaining part of this chapter, I wish to discuss two particular issues of concern. These are civil and criminal liability and the legal position regarding the prevention of suicide. I refer to both in chapter 9.

3.5 A Question of liability

Negligence that results from the actions of a healthcare professional may result in a civil action by the person who has experienced harm or criminal prosecution if it is felt that a crime has been committed. A civil case will be decided on the basis of the balance of probabilities while a criminal conviction is determined based on the facts being beyond reasonable doubt. The former results in compensation the latter in punishments and may result in a custodial sentence. A further type of claim can be made in the event of suicide and relates to the responsibilities of the State under article 2 of the European Convention on Human Rights.⁴⁹¹ In what follows, I consider these issues in more detail in relation to harm minimisation.

3.5.1 A question of civil liability

Regardless of the type of therapeutic intervention, a case of clinical negligence is always a possibility, and harm minimisation would be no exception.⁴⁹² There are three elements to such a claim, a duty of care, a breach of that duty and the ability to

⁴⁹¹ ECHR Op.cit. n198.

⁴⁹² In 2017/18 10,673 new clinical negligence claims were received by NHS Resolution. See NHS Resolution (2018). Annual Report and Accounts. London. HMSO.

demonstrate that the breach resulted in harm.⁴⁹³ All three components must be demonstrated for a negligence claim to be successful. This is a high threshold, and the claimant can often be frustrated. However, in 2004, Hewitt took the view that; “ it is likely that the practice of assisting psychiatric patients to self-harm would be held to be negligent per se, and even if it were not, its application in particular circumstances would be susceptible to challenge in the civil courts.”⁴⁹⁴ It is important to unpick the basis of such an argument given the length of time that has passed since this claim was made.

That a duty of care exists is not contentious and constitutes a legal obligation imposed on healthcare professionals.⁴⁹⁵ Based on this duty, the health care professional must take reasonable care to avoid acts or omissions, which can be reasonably foreseen to cause injury.⁴⁹⁶ They must exercise reasonable care and skill in the care of the patient.⁴⁹⁷ Harm minimisation occurs in the context of a therapeutic relationship and where this relationship is developed on the basis of an individual’s admission to a hospital setting, then a duty of care exists. In such circumstances, the healthcare professional has assumed responsibility for the individual’s care,⁴⁹⁸ and the presence of such a duty would not be contested.⁴⁹⁹ It is the breach of duty and the issue of causation that would be key.

A breach of duty is established through reference to accepted standards of practice. The standard is judged through the *Bolam* test.⁵⁰⁰ This provides the legal foundation for any consideration of a breach of care and is well established in case law.⁵⁰¹ A practitioner is not guilty of negligence if he or she has acted in accordance with a

⁴⁹³ Laurie et al (2016). Op.cit. n175 p. 138.

⁴⁹⁴ Hewitt (2004). Op.cit. n71. p.161. It should also be noted in a professional circular published later Hewitt appears to have modified his position. See Hewitt, D. (2012). *Self-harm minimisation and the law*. Weightmans solicitors.

⁴⁹⁵ See *Cassidy v Ministry of Health* [1951] 2 KB 343; *Bull v Devon Health Authority* 4 Med LR 117 (CA); *Caparo Industries plc v Dickman* [1990] UKHL 2.

⁴⁹⁶ *Donoghue and Stevenson* [1932]. AC 562 (HL).

⁴⁹⁷ Jackson, E. (2010). *Medical Law. Text, Cases, and materials*. Oxford. Oxford University Press. p. 104.

⁴⁹⁸ *Cassidy v Ministry of Health; Bull v Devon Health Authority*. Op.cit. n496.

⁴⁹⁹ Ibid.

⁵⁰⁰ *Bolam v Friern Hospital Management Committee*. Op.cit.n207.

⁵⁰¹ *Whitehouse v Jordan* [1981] 1 WLR 247; *Maynard v West Midlands Regional Health Authority* [1984] All ER 635; *Sidaway v Bethlem Royal Hospital*. Op.cit.n418; *Bolitho v City and Hackney Health Authority*.Op.cit. n208.

practice accepted as proper by a responsible body of professional opinion.⁵⁰² Such opinion is derived from the evidence of expert witnesses, and it is accepted that different opinions and practices exist.⁵⁰³ Moreover, the body of expert opinion does not need to be large,⁵⁰⁴ and deviation from normal practice is not necessarily evidence of negligence.⁵⁰⁵ As long as there is sound evidence that the practice under scrutiny was appropriate, then that opinion has to be accepted, and the *Bolam* test will apply.

There are circumstances where such evidence may be challenged.⁵⁰⁶ The basis of such a challenge is the *Bolitho* test. In *Bolitho*, Lord Browne-Wilkinson effectively refines the *Bolam* test. In considering the words responsible, reasonable and respectable as used in previous case law,⁵⁰⁷ he interprets this to mean that the court must be satisfied that the expert opinion that has been presented must be capable of “withstanding logical analysis.” In addition, it must not be otherwise “unreasonable” or “irresponsible.”⁵⁰⁸ The application of the *Bolitho* test means that the evidence of the professional expert can be challenged if their reasoning appears to be outside the boundaries of acceptable responsible opinion.⁵⁰⁹

Bolam and *Bolitho* are the legal tests against, which harm minimisation, would be judged. The *Bolam* test means that it is incumbent on the claimant to prove that no reasonable body of professional opinion would support harm minimisation in the specific case under scrutiny. *Bolitho* means the expert evidence could be subject to scrutiny to decide whether the practice is reasonable. In undertaking this task, it would consider the risks and benefits involved and the logical basis for the evidence. Lord Brown- Wilkinson put it in the following terms;

⁵⁰² McNair J in *Bolam v Friern Hospital Management Committee*. Op.cit. n207.

⁵⁰³ *Maynard v West Midlands Regional Health Authority*.Op.cit. n502.

⁵⁰⁴ *Defreitas v O'Brien and Another* [1993] 4 Med LR 281.

⁵⁰⁵ *Hunter v Hanley* [1955] SLT 213.

⁵⁰⁶ *Bolitho v City and Hackney Health Authority*.op.cit.n208.

⁵⁰⁷ See *Bolam v Friern Hospital Management Committee*. Op.cit.n207; *Maynard v West Midlands Regional Health Authority* [1984]. Op.cit. n502.

⁵⁰⁸ *Bolitho v City and Hackney Health Authority*. Op.cit. n.208. at 238, 241 and 243. The exact meaning of these terms remains open to debate. For a detailed discussion of the issues see Mulheron, R. (2010). Trumping “Bolam”: A critical legal analysis of Bolitho’s “Gloss”. *The Cambridge Law Journal*. Vol. 69. No. 3. p. 609-638.

⁵⁰⁹ *Muller and Kings College Hospital NHS Foundation Trust* [2017] EWHC 128 (QB) at 44.

*“a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.”*⁵¹⁰

If evidence supporting harm minimisation were not considered reasonable, a breach of duty would be demonstrated.

Not all negligence cases engage the *Bolitho* test, in fact, most do not, a case involving harm minimisation, may well do so. In her analysis of *Bolitho*, Mulheron⁵¹¹ points out that the fundamental questions posed by *Bolitho* are what is meant by “not capable of withstanding logical analysis” and when is an opinion “unreasonable” or “irresponsible.” She argues that an analysis of English law suggests seven factors, which may lead to a conclusion that the evidence provided is difficult to substantiate. Two have particular relevance in the case of harm minimisation. First, a clear precaution was available that would have prevented the adverse outcome. Mulheron cites Beatson J in this respect, when pointing out that, *Bolitho* is more likely to be activated when a case is not addressing complicated questions regarding medical treatment or complex technical detail but will be decided on whether the healthcare professional failed to take a simple precaution that would be obvious to an ordinary person considering the issue.⁵¹² Second, there is a failure to weigh the comparative risks and benefits of the chosen course of conduct and as a result, harm minimisation put the patient at unnecessary risk.⁵¹³

This brings into focus the tension between permitting self-injury and taking action to prevent it. This debate is crucial to my analysis and would be crucial to any negligence case. A focus on safety often results in the use of interventions that are

⁵¹⁰ *Bolitho v City and Hackney Health Authority*. Op.cit. n208.

⁵¹¹ Mulheron (2010). Op.cit. n509.

⁵¹² *French v Thames Valley Strategic Health Authority [2005] EWHC 459 (QB) at 112.*

Sullivan (2017). Op.cit. n71.

⁵¹³ *Bolitho v City and Hackney Health Authority*. Op.cit. n208.

restrictive and focused on containment.⁵¹⁴ In reality, the patient experiences these interventions negatively, and more importantly, they do not always work.⁵¹⁵ For example, continuous observation is not only of dubious therapeutic value; it is also of limited value in maintaining patient safety.⁵¹⁶ The data available indicates that this form of surveillance does not prevent suicide.⁵¹⁷ In spite of this, these Interventions are accepted practice and used throughout mental health services. They certainly provide an alternative to harm minimisation that is readily available to healthcare professionals. Furthermore, it is an intervention that is used routinely to support individuals who are at risk and particularly at risk of suicide.⁵¹⁸ Should enhanced levels of observation not be instigated and the patient came to serious harm, then such action would require justification. A decision on whether or not they should have been used would be based on weighing the comparative risks and benefits with harm minimisation. The question of the evidence supporting either intervention would be important, and although the evidence available to support more restrictive interventions is problematic, the position concerning harm minimisation is no less of a challenge.

Harm minimisation is a controversial intervention, and any professional evidence supporting the approach must be defensible. If it cannot withstand logical analysis, it is neither reasonable nor responsible.⁵¹⁹ In an analysis undertaken from a clinical perspective, Lee⁵²⁰ reviewed the development of the law since *Bolam* and suggested that it is possible to observe a greater weight being given to the importance of evidence-based practice and particularly the guidelines and standards laid down by the relevant professional bodies. Unfortunately, in this respect, the evidence around harm minimisation is weak. There is a general acceptance of the principles associated with harm minimisation in working with people who self-injure particularly

⁵¹⁴ Sullivan (2017) Op.cit. n.71; Morrissey et al (2018). Op.cit. n43; Sullivan, P.J. (2019b) Harm minimisation and self-injury in the Age of Risk. *European Journal for Person Centred healthcare*. Vol. 7. No. 1. P61-69.

⁵¹⁵ Sullivan (2019a). Op.cit. n515. p.63.

⁵¹⁶ Ibid. p.63.

⁵¹⁷ National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. (NCISH). (2015). *In-patient suicide under observation*. Manchester. The University of Manchester.

⁵¹⁸ See the Mental Health Act Code of Practice. Op.cit. n196. Chapter 26

⁵¹⁹ Jackson (2010). Op.cit. n 498 p. 118.

⁵²⁰ Lee, A. (2016). 'Bolam' to 'Montgomery' is a result of evolutionary change of medical practice towards patient-centred care. *Postgraduate Medical Journal*. Vol. 93. No 1095. p. 46-50.

in community settings.⁵²¹ Moreover, the NICE guidance does provide support for the idea of harm minimisation in circumstances where the individual's self-injury is persistent and resistant to change. However, it is silent on its potential application in an in-patient setting.

The strongest support for harm minimisation comes from qualitative research based on the views of people who self-injure⁵²² and small case studies based on isolated examples of clinical practice.⁵²³ Herein lies the difficulty, as in England, the courts do not routinely privilege the patient perspective over what is perceived as more empirically valid and reliable evidence.⁵²⁴ In the absence of agreed professional guidance, the limited evidence available, and the lack of a professional consensus regarding the intervention, then questions are inevitably raised about the clinical effectiveness of the approach.⁵²⁵ The problem is that given these difficulties, it is not inconceivable that a court could take the view that harm minimisation occupies a place on the "fringe of medical consciousness" and is of dubious practical value.⁵²⁶ This makes the finding of a breach of duty more likely.

Even if a breach of duty is demonstrated, the claimant must also show causation.⁵²⁷ This is the third component of a negligence claim that is the most difficult for the claimant to demonstrate. Proving causation in a health care setting is difficult, and it is at this stage that many cases fail.⁵²⁸ Although it is important to note that in a recent

⁵²¹ See, for example, Pickard and Pearce (2017) Op.cit. n113. Spandler, H. and Warner, S. (2007). Op.cit. n176.

⁵²² Brown, T. B. and Kimball, T. (2013). Op.cit. n10. p10. Wadman, R. (2016). An interpretive phenomenological analysis of the experience of self-harm repetition and recovery in young adults. *Journal of Health Psychology*. 1-11. DOI: 10.1177/1359105316631405

⁵²³ Holley et al. (2012). Op.cit. n77. Pengally, et al (2008). Op.cit. n77.

⁵²⁴ Syrett, K. (2015). Rationing, resource allocation and appropriate medical treatment. In Fovargue, and Mullock (EDS). Op.cit. n202. Chapter 12. p. 197-215.

⁵²⁵ *R (on the application of AC) v Berkshire West Primary Care Trust* [2010] EWHC 1162 (Admin).

⁵²⁶ *Dr Khoo James And Another v Gunapathy d/o Muniandy and another appeal* [2002] SGCA 25. See chapter 10 for some further discussion of the difficulties associated with the problem of evidence.

⁵²⁷ Causation involves two components. Factual causation where it must be shown that the harm is related to the breach of duty and legal causation which makes a judgement about whether the healthcare professional should be held liable. See *Pomphrey v Secretary of State and Anor* [2019] 4 WLUK 483 for a recent discussion of causation in clinical negligence. See also Green, S. (2015). *Causation in negligence*. London. Bloomsbury.

⁵²⁸ See *Wilsher v Essex Area Health Authority* [1988]. AC 1074.

analysis of negligence in general practice, Heywood⁵²⁹ has made the point that once a breach of duty was established a finding of causation normally followed. In fact, in only one case he reviewed did Heywood find an exception to this rule. As we have seen, it must be possible to establish a link, between the negligent actions of the healthcare professional and the injuries or harm sustained by the patient. Without this link the claim for negligence fails.⁵³⁰ This requires the claimant to demonstrate on the balance of probabilities, that but for the breach of duty, the harm would not have occurred.⁵³¹ Obviously, in many settings, there may be multiple causes, and identifying the actual cause may be problematic. In these circumstances, a modified approach to causation may be adopted, and the actions of the defendant must be shown to have materially contributed to the harm, which occurred.⁵³² However, this contribution must be substantial.⁵³³ The courts have applied such a modified test for causation within a health care setting.⁵³⁴

The difficulties associated with demonstrating the causal link between the actions and/or omissions of the healthcare professional and the harm that has occurred were illustrated by *Wilsher*. In this case, the death of a child was possibly due to five different causes.⁵³⁵ In the current context, the ability to demonstrate a causal connection between the use of harm minimisation techniques and the individual's injuries may be difficult, particularly in those situations where the individual has a long history of self-injury. In these situations, there are a minimum of two potential causal factors, the harm minimisation approach and the original problems that resulted in self-injury in the first place.⁵³⁶ As the individual has a propensity to cause harm, it may be difficult to argue that the harm would have occurred because of the harm minimisation programme rather than in spite of it. This would suggest that in those cases where a patient who has a history of persistent and repetitive self-injury

⁵²⁹ Heywood, R. (2018). "If the problem persists, come back to see me..."-An empirical study of clinical negligence cases against general practitioners. *Medical Law Review*. Fwy030, <https://doi.org/10.1093/medlaw/fwy030> p.132

⁵³⁰ The "but for test" is the relevant legal test and was articulated by Lord Denning in *Cork v Kirby Maclean Ltd* [1952] 2 All ER 402.

⁵³¹ *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428.

⁵³² *Bonnington Castings Ltd v Wardlow* [1956] AC 613.

⁵³³ *McGee v National Coal Board* [1973]. 1 WLR HL.

⁵³⁴ *Bailey v Ministry of Justice and Another* [2008] EWCA Civ 883.

⁵³⁵ *Wilser v Essex Area Health Authority*. Op.cit. n529.

⁵³⁶ *Jackson* (2010). Op.cit.n498. p. 100.

causation may be difficult to prove.⁵³⁷ Set against this will be the court's duty to ensure that everything has been done to ensure that vulnerable individuals are not subjected to an unnecessary level of risk.⁵³⁸

Ultimately the success of any claim will be highly dependent upon the actual circumstances of the case. Laurie et al⁵³⁹ outline the types of questions that a court would consider in any negligence case, and these can be applied to a scenario involving harm minimisation. The court would examine why a harm minimisation approach was taken and whether it was justified in the case in question.⁵⁴⁰ Any Judge would be particularly interested in considering whether the actions taken by the clinical team were an appropriate way of ensuring the safety of the individual in question. In applying the various legal tests, the court would need to examine the various therapeutic interventions available for people who self-injure and the clinical presentation of the individual. It would be important to understand the various risks and benefits associated with a harm minimisation approach and why it was proposed in this particular instance.

The decision-making process for adopting such an approach would need to be based on a clear rationale that could be understood based on the clinical details of the specific case. As risks are involved, these would need to be offset against any potential benefits in order to make a judgement on whether the harm minimisation approach was responsible.⁵⁴¹ Questions about the previous use of the approach and any risks and dangers it presented would need to be answered. A court would be interested in any factors that indicated harm minimisation was an unsafe option. For example, it could be argued that the health care professional failed to assess the patient's propensity to inflict the level of harm that occurred. If they had done so a harm minimisation approach would not have been used, and alternative methods would have been more appropriate. The previous response of the patient to

⁵³⁷ Hewitt (2004). Op.cit. n71.

⁵³⁸ On this point, see *Hucks v Cole* (1968) [1993] 4 Med LR 393 at 397. Sachs LJ made the point that "when the evidence shows that a lacuna in professional practice exists by which risks of grave danger are taken, then however small those risks, the courts must anxiously examine that lacuna-particularly if the risks can be easily and inexpensively avoided".

⁵³⁹ Laurie et al (2016). Op.cit. n475 p. 129.

⁵⁴⁰ Ibid.

⁵⁴¹ *Bolitho v City and Hackney Health Authority*.Op.cit.n208.

treatment and support would be important, as would the attitude of the patient towards the intervention.⁵⁴²

At an organisational level, it would be important that the actual practice was supported by a policy and procedural framework approved through the relevant clinical governance arrangements. At a clinical level, the process would require a detailed care plan supported by relevant risk assessments and management plans which all the multidisciplinary team and the patient have agreed. In reviewing this, the foreseeability of harm would be considered. This would take into account the fact that what is obvious with hindsight is not always foreseeable at the time of assessment.⁵⁴³ Foreseeability is not synonymous with predictability or preventability.

One of the difficulties associated with any consideration of civil liability in this area is the absence of any case law. There are, however, three cases that have come before various professional bodies and may have some relevance. In the first case, a social worker employed in a CAMHS service had introduced a process whereby a child cut herself on alternative days, at set times, with her mother attending to the wounds without comment. The Health and Care Professions Council accepted that these actions put the child at risk of harm, and a case of professional misconduct was proven.⁵⁴⁴ In the second case, in 2013, a "controlled self-harm" policy was instituted at a specialist education facility for young people with autism. A pupil was provided with access to sterilized razor blades and escorted to the bathroom where he was permitted to cut himself while staff waited outside. At a disciplinary hearing, the Professional Conduct Panel of the National College for Teaching, the Head Teacher's actions were described as naïve, but allegations of misconduct were not upheld.⁵⁴⁵ The last case is perhaps of most relevance to the issues addressed in this thesis.

⁵⁴² Ibid p 149.

⁵⁴³ Simon, R.I. (2002). Suicide risk assessment: What is the standard of care? *American Academy of Psychiatry and Law*. Vol. 30. p. 340-44.

⁵⁴⁴ Health and Care Professions tribunal's services website: https://www.hcpts-uk.org/hearings/listing/201608081000-final_hearing-sw38894#.

⁵⁴⁵ Self-harm pupil given razor at Unsted Park School. BBC News 26 March 2013; Unstead Park 'self-harm blades' head teacher cleared. BBC News, 16 May 2016. www.bbc.co.uk; School set up "controlled self-harm" policy for pupil. The Telegraph. 25 March 2013. www.telegraph.co.uk.

In 2013 the Nursing and Midwifery Council (NMC) heard how a registered nurse had, on her own initiative, given a razor blade to a known self-harming patient after she became distressed. The patient was vulnerable, her level of risk had increased since admission, and her risk assessment indicated that the higher level of risk was associated with suicidal ideation. A razor blade was provided for the purpose of self-injury, on the condition that the patient agreed to five-minute observations and the use of clean materials to clean and dress any wound. The nurse did not dress the wound after the patient had self-injured. The NMC agreed that this placed the patient in extreme danger, and a case of misconduct was proven.⁵⁴⁶

What is important about these cases is that what the professional bodies were concerned about was not the practice of harm minimisation per se, but the wider professional issues involved. For example, in the first case, the panel accepted that in some circumstances, harm minimisation was an acceptable option.⁵⁴⁷ In all cases, there were other concerns relating to professional judgement, clinical practice and the supporting governance framework in place. The professionals involved appear to have operated independently of the wider multidisciplinary team and their employing organisation. They acted outside any agreed policy and procedural guidance and failed to adhere to an accepted governance framework. For example, the nurse did not adhere to basic clinical standards concerning care planning and risk assessment. Moreover, her actions appear to have been seriously misguided at best and reckless at worst. Her actions certainly constituted a serious risk to the patient. These deficiencies in care would have raised serious questions regardless of the type of clinical intervention used. Good standards of clinical practice and an effective organisational governance framework supporting such practice is always an important defence against any allegation made.

4.5.2 A question of Criminal liability

In English law, a health care professional's actions are most likely to be considered

⁵⁴⁶ Nursing and Midwifery Council: Conduct and Competence Committee Substantive hearing. 26 – 27 September 2013.

⁵⁴⁷ Health and Care Professions tribunal's services website: Op.cit.n545.

criminal in relation to a situation that results in the death of a patient.⁵⁴⁸ A prosecution for gross negligence manslaughter could occur should the patient die as a result of a grossly negligent act or omission. In such a scenario, there must be a criminal disregard for the life and safety of others “as to amount to a crime against the state and conduct deserving punishment”.⁵⁴⁹ *R v Adomako*⁵⁵⁰ is the leading case regarding gross negligence manslaughter.⁵⁵¹ In *Adomako*, Lord Mackay argues that the ordinary principles of negligence law apply in ascertaining whether gross negligence has occurred. Where negligence is established, it must be shown to have caused death. The jury is then required to decide whether this constitutes gross negligence and is a crime. They must be convinced that the defendant’s conduct put the patient at risk of death and was so far from the required standard to constitute a crime.⁵⁵² Lord Mackay made the point in the following terms. The “supreme essential question is whether, having regard to the risk of death involved, the defendant’s conduct was so bad, in all the circumstances, as to amount to a criminal act or omission.”

In working with someone who self-injures, gross negligence could become an issue if the patient were to die through suicide. A successful prosecution would be based on the following.⁵⁵³ First, the health professional must have known, or ought to have known, that there was a real risk of suicide. As a consequence, they had a duty of care to take reasonable steps to prevent the patient from deliberately taking their own life and not to do anything to exacerbate the risk. Second, the health professional breached their duty of care by failing to provide care to the required

⁵⁴⁸ Brazier, M. and Alghrani, A. (2009). Fatal Medical Malpractice and Criminal Liability. *Journal of Professional Negligence*. Vol. 25.No. 2. p.52.

⁵⁴⁹ *R v Bateman* [1925] 19 Cr App R 8. See also *Rose v R* [2017] EWCA Crim 1168. This, as Mullock (2018) points out, modifies the test in *Adomako*. To be liable, the serious risk of death was rather than ought to have been foreseeable to the defendant. In a case where the risk of death was not immediately obvious, then the threshold for conviction will be even higher. Mullock considers this in the context of not only the *Rose* case but also *R v Rudling* [2016] EWCA Crim 741. *R v Sellu* [2016] EWCA Crim 1716. See Mullock, A. (2018). Gross Negligence (Medical) Manslaughter and the Puzzling Implications of Negligent Ignorance. *Rose v R* [2017] EWCA Crim 1168. *Medical Law Review*. Vol. 26. No. 2.p.346-356.

⁵⁵⁰ *R v Adomako*.Op.cit.n209.

⁵⁵¹ This case provides authority for cases of gross negligence manslaughter generally and not just in situations involving health care professionals.

⁵⁵² *R v Adomako*. Op.cit. n209 at 64.

⁵⁵³ The following analysis is based on the legal reasoning applied in *R (on the application of the Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire* [2012] EWHC 1634 (Admin).

standard. Third, it was reasonably foreseeable that their actions would cause or contribute to a decision by the patient to commit suicide. Fourth, the actions of the health professional caused or contributed to the patient's suicide. Finally, whether the health professional's actions went beyond a mere matter of compensation and showed such disregard for the life and safety of the patient as to constitute a crime. All of the components outlined above would need to be demonstrated to be beyond reasonable doubt.

In chapter 9, I argue that a successful prosecution for gross negligence manslaughter is a theoretical but unlikely scenario. The basis for my argument is that the threshold for conviction is high. Not only is a high level of proof required, but also the degree of negligence is of a high degree. In *R v Mishra*⁵⁵⁴ it was argued that “mistakes, even serious mistakes and errors of judgment, and the like are nowhere near enough for a crime as serious as manslaughter to be committed,” it is a serious risk to life that matters, not more general considerations of safety.⁵⁵⁵ Add to this the fact that suicide is a rare occurrence even in a hospital environment, and cutting is rarely used as a means of suicide and has a low mortality rate.⁵⁵⁶ Then suicide in the context of a harm minimisation is possible but unlikely.⁵⁵⁷ Hence an allegation of gross negligence manslaughter is likely to be rare.

In spite of this, it is not difficult to see why health professionals remain anxious. Although there is yet to be a case of gross negligence manslaughter involving a patient who has committed suicide, it is a theoretical possibility. Furthermore, there are aspects of the offence that cause concern. Many health professionals remain concerned that they work in a high-risk environment where a prosecution can occur in the absence of intent; in legal terms, there is no mens rea. Moreover, although the actual application of the threshold to the specific case appears clear as a general principle of law, it can be difficult to apply in a specific case. The argument is circular in the sense that the practitioner's actions are criminal because the jury thinks it

⁵⁵⁴ *R v Mishra* [2004] EWCA Crim 2375.

⁵⁵⁵ *R v Yaqoob* [2005] EWCA Crim 2169.

⁵⁵⁶ Ersen, B. Kahveci, R. Saki, M.C. Tunali, O. Aksu, I. (2017). Analysis of 41 suicide attempts by wrist cutting: a retrospective analysis. *European Journal of Emergency Surgery*. Vol. 43. No. 1. p.129-135.

⁵⁵⁷ Walsh (2012).Op.cit. n90. p. 8.

ought to be a crime, and it is criminal because the jury thinks it is.⁵⁵⁸ Lodge⁵⁵⁹ has argued that the offence prioritises the outcome and points out that just because serious harm occurs, this does not automatically mean that someone is culpable. She points out that the central concept lacks clarity, and this means it is difficult to have a clear and consistent way of identifying exactly what “gross” actually means. This explains how convictions have occurred that were later found to be unsafe on the basis that the judge failed to provide sufficient clarity to the Jury about the legal meaning of the term.⁵⁶⁰ This has led to widespread concern amongst the medical profession.⁵⁶¹ A concern only exacerbated by the case of Dr Hadiza Bawa Garba,⁵⁶² referred to earlier. This has resulted in a government-initiated review and a subsequent review by the General Medical Council.⁵⁶³ Interestingly neither has proposed a change in the law.

4.5.3 How would it play out in court?

Whether civil or criminal liability would be more likely in situations where a harm minimisation approach is used is a difficult question to answer. There is always a possibility, in any clinical environment, regardless of the type of treatment been undertaken or the safeguards that have been put in place, that sometimes things will go wrong. A patient sometimes experiences significant harm or even death as a result of their own conduct and/or that of the health care professional. In any environment where staff deal with illness, distress, unpredictability and crisis

⁵⁵⁸ This has led to criticisms of the whole concept of gross negligence manslaughter as a legitimate criminal offence. It has been described in the academic literature as a “dog’s breakfast”- see Moore, M. and Hurd, H. (2011). Punishing the awkward, the stupid, the weak, and the selfish: The culpability of negligence. *Criminal law and Philosophy*. Vol. 5.No. 2. p. 192. An example of the “common law at its worst.” See Baker, D. (2015). *Glanville Williams: Textbook of Criminal law. 4th Edition*. Hebdon Bridge. Sweet and Maxwell. p.512.

⁵⁵⁹ Lodge (2012). Gross negligence manslaughter on the cusp: the unprincipled privileging of harm over culpability. *Journal of Criminal Law*. Vol.81. No.2. p.125-142.

⁵⁶⁰ *R v Sellu* [2016] EWCA Crim 1716.

⁵⁶¹ Following the conviction of the surgeon David Sellu, in 2103 a letter signed by over 300 doctors was circulated to all the Royal Colleges voicing concern about the increasing tendency to prosecute doctors.

⁵⁶² *Bawa-Garba v R* [2016] EWCA Crim 1841; *General Medical Council v Bawa Garba* [2018] EWHC 76 (Admin). *Bawa-Garba v The General Medical Council* [2018] EWCA Civ 1879.

⁵⁶³ Williams, N. (2018). *Gross negligence manslaughter in healthcare. The report of a rapid policy review*. London. Department of Health and Social care. Hamilton, L. (2019). *Independent Review of gross negligence manslaughter and culpable homicide*. London. GMC.

regularly, then untoward incidents will occur. Questions then arise about whether clinical practice had fallen below an acceptable level.

It would also be naive and unrealistic to argue that a person subject to a harm minimisation approach could not act in a way that resulted in serious injury or death. This occurs even in cases where individuals are subject to sustained efforts to stop them from harming themselves. Harm could result from the individual's actions or the actions or omissions of a health care professional. Moreover, if the means of self-injury are provided, then it is also possible that another patient or member of staff could be injured. It is certainly feasible in these situations that a healthcare professional could have acted in a negligent or reckless manner. This is very different from saying that participation in a programme of care using harm minimisation approaches is negligent or reckless. The critical issue would be whether a reasonable standard of care was provided and that adequate protective measures were implemented.

Harm cannot be eradicated, and if it occurs, it is not necessarily synonymous with negligence or in a situation where death was to result is this necessarily indicative of gross negligence. Mental health facilities are always areas where the possibility of self-injury causing serious harm is a possibility and issues of liability need to be kept in perspective. Although the possibility of a legal claim cannot ever be excluded, harm minimisation, in theory at least, is no different from any other health care intervention if done properly the risk is diminished. In situations where harm minimisation is used based on a detailed assessment of the individual's risks and needs, and implemented using an appropriate policy and procedural framework, which forms part of an agreed governance structure, then the risk of such an occurrence is considerably reduced.

This conclusion may provide little reassurance to many health care professionals who although perhaps not privy to the detail, and the nuances of the law are cognisant of its effects and are rightly concerned about legal repercussions.⁵⁶⁴ The reality is that although civil claims are not uncommon, the numbers continue to rise.

⁵⁶⁴ Inckle, (2017). Op.cit. n63.

However, less than 1% of litigation cases against the NHS go to trial and in most of these, the claimant is unsuccessful,⁵⁶⁵ in fact, only 54.5% of cases settled in 2017/18 resulted in compensation and only 3 % of claims were received about mental health care.⁵⁶⁶ Similarly, although there has been a growing trend for health care professionals to face criminal prosecution,⁵⁶⁷ the numbers do remain small, and the reality is that although the number of police investigations is increasing the number of prosecutions of health care professionals remains low and the number of convictions even lower.⁵⁶⁸

Despite this, it has to be acknowledged that where convictions have occurred, the punishment has been increasingly severe. It must also be remembered that any involvement in the legal process can be traumatic for the health professional, and there is certainly evidence of how this impacts negatively.⁵⁶⁹ Furthermore, there is no doubt that health care professionals are concerned about an increasingly litigious environment that fosters a blame culture and makes learning from mistakes more difficult and defensive practice more likely.⁵⁷⁰ I return to these issues in chapter 9. At this juncture, I would like to consider another area where the courts may also become involved. This relates to the responsibilities of the state to prevent suicide based on article 2 of the European Convention on Human Rights.

4.6 Article 2 and the prevention of suicide

A common law duty of care to protect patients from the risk of suicide is well established.⁵⁷¹ This means that the healthcare professional has a legal obligation to

⁵⁶⁵ NHS Resolution (2018). *Annual Report and Accounts*. London. HMSO.p. 18.

⁵⁶⁶ *ibid*.

⁵⁶⁷ McDowell, S.E. and Ferner, R.E. (2013). Medical Manslaughter. *British Medical Journal*. BMJ. 2013;347:f5609

⁵⁶⁸ See Griffiths, D. Sanders, A. (2012). The road to the dock: prosecution decision making in medical manslaughter cases. In Sanders, A. and Griffiths, D. (eds). *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society*. Vol. 2. Cambridge. CUP. p. 117-158. See also Williams (2018). *Op.cit*.n618.p. 12. He notes that since the Adomako case in 1994, there have been 47 prosecutions of a healthcare professional with 23 convictions. 4 cases were overturned on appeal. Since 2013 there have been 15 prosecutions with 6 convictions of which 2 were overturned on appeal.

⁵⁶⁹ Robertson, J.H. and Thomson, A.M. (2014). A phenomenological study of the effects of clinical negligence on midwives in England. The personal perspective. *Midwifery*. Vol. 30. No.3. p.121-30.

⁵⁷⁰ Jackson (2010). *Op.cit*. n498p. 100.

⁵⁷¹ See *Thorne v Northern Group HMC* [1964] Times 6 June 1964; *Selfe v Ilford and District HMC* [1970] Times 26 November 1970; *Hyde v Tameside AHA* [1986] PN 26; *Reeves v Commissioner of*

adhere to appropriate standards of care when working with individual's who may be at risk of suicide. The case law supports this position both in cases where the person is autonomous⁵⁷² and non-autonomous.⁵⁷³ In practical terms, this means health services must ensure high professional standards and effective systems of work.⁵⁷⁴ A failure to comply could, as we have seen amount to clinical negligence.⁵⁷⁵

In addition to this, Article 2 of the European Convention on Human Rights⁵⁷⁶ imposes a special duty to prevent suicide in circumstances where it is known or should have been known that there was a "real and immediate risk of suicide."⁵⁷⁷ In these circumstances, a positive obligation requires the state to take reasonable and practical measures to protect the right of the individual to life and to prevent suicide.⁵⁷⁸ In taking such steps, the court must account for operational realities and the unpredictability of human behaviour.⁵⁷⁹ Furthermore, taking steps to meet this obligation must be compatible with the rights and freedoms of the individual concerned.⁵⁸⁰ Therefore the duty is not absolute.

What the positive obligation requires is that hospitals adopt a regulatory framework that ensures appropriate measures are in place for the protection of a patient's life.⁵⁸¹ The actual measures required are outlined in *Kilinc v Turkey*.⁵⁸² This case involved the states failure to protect the life of Mrs Kilnic's daughter, who was subject to domestic violence. A legislative and administrative framework must be in place, which is suited to the risk of life that is encountered. This must consider the specific

Police of the Metropolis. Op.cit.n399; *Dunn v South Tyneside AHA* [2003] EWCA Civ 878; *Smiley v Home Office* [2004] EWHC 240; *Kirkham v Chief Constable of Greater Manchester* [1990] 2 QB 283.

⁵⁷² *Kirkham v Chief Constable of Greater Manchester*. Op.cit. n572.

⁵⁷³ *Reeves v Commissioner of Police of the Metropolis*. Op.cit. n399.

⁵⁷⁴ *Powell v United Kingdom*. 30 ECHR CD 362.

⁵⁷⁵ Allen, N. (2009). First do no harm. Second save life? *Journal of Mental Health Law*. Winter 2009. P. 180-185.

⁵⁷⁶ ECHR Op.cit. n196.

⁵⁷⁷ See *Savage v South Essex Partnership NHS Foundation Trust* [2010] EWHC (QB).

⁵⁷⁸ *Savage v South Essex Partnership NHS Foundation Trust*; *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2; *Reynolds v United Kingdom* [2012] 55 EHRR 35.

⁵⁷⁹ Akandji-Kombe, J. F. (2007) *Positive obligations under the European Convention on Human Rights: A guide to the implementation of the European Convention on Human Rights*. Strasbourg. Council of Europe.

⁵⁸⁰ *Keenan v United Kingdom* [2001] ECHR 27229/95.

⁵⁸¹ *Calvelli and Ciglio v. Italy* [GC]. 49; *Vo v. France* [GC]. 89; *Lopes de Sousa Fernandes v. Portugal* [GC]. 166.

⁵⁸² Akandji-Kombe (2007) Op.cit. n580.

activity combined with the human factors engaged. Based on this, the authorities must introduce practical measures that protect those individuals subject the specific circumstances under scrutiny. In a clinical environment, this means that general measures and precautions must be in place to reduce the risk of harm. This would involve the recruitment of competent staff, proper policies and procedures and effective systems for supporting a patient at risk of suicide. These measures must not constitute an unnecessary infringement on an individual's personal autonomy, and the nature of the preventative measures imposed depends upon the circumstances of the case.⁵⁸³

Article 2 also imposes a duty to ensure the effective implementation and functioning of that regulatory framework.⁵⁸⁴ In the event of a patient's death problems with the regulatory framework do not result in a potential claim under Article 2 unless it can be shown that there is a link with the patient's death.⁵⁸⁵ The law concerning article 2 was summarised in *Parkinson V HM Senior Coroner for Kent, Dartford and Gravesend NHS Trust*.⁵⁸⁶ The test has recently been articulated in *Lopes de Sousa Fernandes v. Portugal* in the context of providing emergency treatment and has four components.⁵⁸⁷ First, the acts and omissions of the health care providers had to go beyond error or negligence and occur in the context of an awareness that the person's life is at risk. Second, a systemic or structural problem has to be objectively and genuinely identifiable and attributable to the State authorities. Third, there is a link between these problems and the harm sustained. Finally, the problem must have resulted from a failure to provide a regulatory framework. Thus, there must be assurances that high professional standards are in place that serve to protect the life of the patient. However, an error of judgment on the part of the health professional or even the presence of negligence is not in itself sufficient to establish a breach of Article 2.⁵⁸⁸ This case has yet to be applied in a mental health context in the case of suicide.

⁵⁸³ Korff, D. (2006). The right to life a guide to the implementation of Article 2 of the European Convention on Human Rights. Human Rights Handbooks, No.8. Strasbourg. Council of Europe.

⁵⁸⁴ *Lopes de Sousa Fernandes v. Portugal*. Op.cit. n582 at 190.

⁵⁸⁵ Ibid at 188.

⁵⁸⁶ *Parkinson V HM Senior Coroner for Kent, Dartford and Gravesend NHS Trust*. [2018] EWHC 1501 (Admin) at 52-91.

⁵⁸⁷ Ibid at 191-196.

⁵⁸⁸ *Powell v. the United Kingdom*. Op.cit. n575.

There is no general duty to prevent suicide, but it certainly arises where an individual is under the care in a mental health facility.⁵⁸⁹ As Kombe notes, in these and similar circumstances, Article 2 imposes a “ special duty of vigilance.”⁵⁹⁰ However, where reasonable care has been taken, then Article 2 does not apply.⁵⁹¹ The legal question is whether all that was required was done in the circumstances to deal with the risk to the individual’s life.⁵⁹² Although the positive obligation to safeguard life is extensive and demanding, as Kaffe points out, it usually accounts for the realities of the situation and the interpretation of Article 2 has been quite narrow. It takes into account both the need to respect an individual’s autonomy and the practical realities of the situation, causing concern.⁵⁹³

Thus, both the common law and European jurisprudence supports the prevention of suicide and healthcare professionals have a legal obligation to prevent suicide and where individuals injure themselves with the intention of suicide then the use of paternalistic measures can be justified, and this case has been made.⁵⁹⁴ Many individuals who have a mental disorder are at risk of suicide require constant supervision to avoid harm in certain circumstances. Moreover, the case law on Article 2 has been critical of situations where inadequate measures to prevent suicide were put in place, and these refer to patients who were both compulsorily detained⁵⁹⁵ and receiving treatment voluntarily.⁵⁹⁶

In the United Kingdom, human rights such as those enshrined in article 2 are protected by the Human Rights Act 1998.⁵⁹⁷ If a public authority such as a healthcare provider breaches such rights, then it is possible to take action under the Human

⁵⁸⁹ Akandji-Kombe, (2007) Op.cit. n480.p. 27.

⁵⁹⁰ *ibid.*

⁵⁹¹ *Keenan v United Kingdom*. Op.cit. n581.

⁵⁹² *LCB v United Kingdom* [1998]. ECHR 23413/94.

⁵⁹³ Korff, D. (2010). *The right to life. A guide to the implementation of Article 2 of the European Convention on Human Rights. Human Rights Book 8*. Strasburg. Council of Europe.

⁵⁹⁴ Bloch, S. and Heyd, D. (2009). Suicide. In Bloch, S. and Green, S.A. (eds). *Psychiatric Ethics*. Oxford. Oxford University Press.

⁵⁹⁵ *Savage v South Essex Partnership NHS Foundation Trust*. Op.cit.n 578

⁵⁹⁶ *Rabone v Pennine Care NHS Foundation Trust* Op.cit.n579; *Reynolds v United Kingdom* [2012] Op.cit.n579.

⁵⁹⁷ Human Rights Act 1998 www.legislation.gov.uk

Rights Act. This is exactly what occurred in the case of Rabone,⁵⁹⁸ where Miss Rabone's parents took action against the NHS for a breach of their daughters Convention right to life. Although following the Rabone case, there was some anxiety that many similar claims would follow, in reality, as I point out in chapter 9, very few cases have materialised. This argues Allen⁵⁹⁹ is a consequence of the high threshold required to meet the article 2 requirements. However, this does not detract from the importance of public authorities taking steps to prevent suicide, and an article 2 claim is always a possibility. This has the potential to add to the anxiety that healthcare professionals experience about the management of risk.

It could be argued here that this has very little relevance to the question of harm minimisation, as an individual considered at high risk of suicide would not be subject to a programme of care using such approaches. The simple answer would be that they are not, the reality, however, is more complex and involves some discussion of the complex interrelationship between self-injury and suicide. Harm minimisation is only suitable in those situations where the individual's actions are not associated with suicidal intent. The intervention is, therefore predicated on the ability to exclude such intent. However, when one subjects this to detailed empirical analysis, the situation becomes far more complex. This is discussed in detail in chapter 9, but some preliminary comments are required here.

4.7 Self-injury and suicide

The literature on the complex relationship between self-injury and suicidal behaviour can be broadly divided into two strands. First, a set of behaviours can be described, that constitute what the North American literature refers to as Nonsuicidal self-injury (NSSI).⁶⁰⁰ These differ from suicidal behaviour in terms of causation, levels of psychological impairment, functions, methods and causes.⁶⁰¹ Cutting occurs in this context, and such actions result in less than one percent of completed suicides.

⁵⁹⁸ Ibid.

⁵⁹⁹ Allen, N. (2013). The right to life in a suicidal state. *International Journal of Law and Psychiatry*. Vol. 36. No. 5-6. p. 350-7. See also Allen, N. (2009). Op.cit.no. 576.

⁶⁰⁰ Nock, M.K. and Favazza, A.M. (2009). Non-Suicidal Self-injury: Definition and classification In Nock, M.K. (ed). *Understanding Nonsuicidal self-injury: origins, assessment and treatment*. Washington. American Psychological Society. p.9-18.

⁶⁰¹ Walsh, (2012).Op.cit. n90.

⁶⁰²These non-suicidal behaviours have been described as a distinct syndrome in their own right. ⁶⁰³ Second, self-injury and suicidal behaviours are not distinct, and represent different parts of the same continuum and self-injurious and suicidal behaviours are related and may coexist. ⁶⁰⁴ This type of analysis is supported in the literature in the United Kingdom, which rarely differentiates between self-harm and suicidal behaviours.⁶⁰⁵

The various interrelationships are complex, but it appears that there are a subset of individuals who self-injure and demonstrate a low but clinically meaningful and low association between NSSI and suicidal behaviour. However, it has to be acknowledged that there is a relationship between this form of self-injury and future suicidal behaviour.⁶⁰⁶This relationship is well documented in the wider literature and where the truth lies on this complex issue is yet to be resolved.⁶⁰⁷ It does pose a problem for advocates of harm minimisation within an in-patient environment.

Healthcare professionals engaged in supporting individuals who self-injure must, therefore, accept that although there are differences between self-injurious and suicidal behaviour, they are also related and self-injurious behaviour is associated with future suicidal behaviour. Moreover, in some cases, self-injury and suicidal behaviour may coexist. ⁶⁰⁸ More worryingly amongst psychiatric in-patients, self-injury has been associated with suicidal behaviour and increased suicide risk.⁶⁰⁹ From a clinical perspective, this raises two issues. First, it is important to successfully intervene to reduce the levels of self-injury as ultimately, this will impact on the potential for suicide. Second, it is even more crucial to identify those individuals who do not present with a risk of suicide. In practical terms, this is

⁶⁰² Ersen et al. (2017). Op.cit. n55.

⁶⁰³ Selby et al. (2015). Op.cit. n33.

⁶⁰⁴ Ibid.

⁶⁰⁵ Royal college of Psychiatrists (2010). Op.cit.n17.

⁶⁰⁶ Ibid.

⁶⁰⁷ Hamza, C.A. Stewart, S.L. Willoughby, T. (2012). Examining the link between nonsuicidal self-injury and suicidal behaviour: A review of the literature and an integrated model. *Clinical Psychology Review*. Vol. 32. p. 482-495; Whitlock, J. Minton, R. Babington, P. Ernhout, C. (2015). *The relationship between non-suicidal self-injury and suicide. The information brief series*. Cornell Research Program on Self-injury and Recovery. Cornell University. Ithaca. New Jersey.

⁶⁰⁸ Hamza et al (2012). Op.cit.n608. p. 484.

⁶⁰⁹ Singh, H. Chandra, P.S. Reddi, S.K. (2016). Association of Non-Suicidal Self-injury and suicide attempts in psychiatric in-patients with high suicidal risk. *Suicidology online*. Vol. 7. p. 51-57.

extremely difficult to do.

Suicidal behaviour is common and actual suicide is rare and attempts to differentiate between the two is extremely difficult to achieve. For example, efforts to identify the risks as high, medium or low are of limited predictive value.⁶¹⁰ Based on an analysis of the available evidence, Large et al⁶¹¹ found that the ability to predict suicidal behaviours based on individual risk factors was particularly difficult. In fact, they found that the “overwhelming majority of people who might be viewed as at high risk of suicide will not die by suicide, and about half of all suicides will occur among people who would be viewed as low risk.”⁶¹² The problem is, that although the risk factors for suicide are well known at a population level, translating this into a predictive tool that works for the professional faced with a specific patient is problematic. Large et al⁶¹³ suggest the best way forward is to deal with each patient on a case-by-case basis developing a negotiated individualised treatment based on a sympathetic assessment of need. This is an approach I have supported in this thesis in relation to harm minimisation.

This complicated interrelationship between suicidal and self-injurious behaviour does have implications for the adoption of harm minimisation approaches with people who self-injure. The problem is that if such techniques are only viable in situations where the patient is not at risk of suicide and identifying the risk of suicide is so difficult; then the reality is that practitioners may err on the side of caution and avoid using such interventions. In chapter 9, I deal with these issues in more detail. In doing so, I develop my arguments in the context of the case law around Article 2 and particularly the way that expert evidence was dealt with concerning risk assessment of suicide in the Rabone case.⁶¹⁴ I set the Rabone judgement in the context of an increasingly legalised environment in which healthcare practitioners work and ask whether in light of this harm minimisation poses a step too far.

⁶¹⁰ Large, M.M. Ryan, C.J. Carter, G. Kapur, N. (2017). Can we usefully stratify patients according to suicide risk? *British Medical Journal*. 359:j4627 doi: 10.1136/bmj.j4627.

⁶¹¹ *ibid* .p. 2

⁶¹² *Ibid*.

⁶¹³ *ibid*.

⁶¹⁴ *Rabone v Pennine Care NHS Foundation Trust*. Op.cit. n579.

4.8 Conclusion

This chapter has considered a number of legal issues that are pertinent to the issue of using harm minimisation approaches in supporting people who self-injure. Building on the work already undertaken in chapter 3, I first considered the way that autonomy is recognised in law through the legal rules around consent to treatment. Although mental disorder can be associated with a lack of decision-making capacity, I made the point that the two are not synonymous. Decision-making capacity may be present in an individual with a mental disorder and even in some cases when the individual is detained in hospital. I concluded that some people who self-injure would undoubtedly have the capacity to make decisions about participating in a therapeutic programme that made use of harm minimisation approaches. I then went on to consider the organisational context in which harm minimisation must be implemented. I described the current preoccupation with risk and the increasingly legalised healthcare environment in which care takes place. I examined in more detail two particular elements of this legal framework, the issues of liability raised by the civil law on negligence and the criminal law around gross negligence manslaughter. In the final section, I focused my attentions on the problems posed by the specific risk of suicide and placed these within the legal requirements of Article 2 of the European Convention on Human Rights. The chapter has provided the legal context for the thesis and provides a more theoretically informed analysis of the issues that are considered in chapter 9.

Chapter 5: Outline of papers

5.1 Introduction

In this chapter, I will provide a brief overview of the four papers that reflect my research endeavours and the research questions that they addressed. Three are now published and the other accepted for publication. These papers provide the content for chapters 6 to 9.

5.2 Article summaries

5.2.1 Paper 1: Should health care professionals sometimes allow harm? The case of self-injury. ⁶¹⁵

As we have seen the well-established principle of “Primum non nocere” continues to be a guiding principle in healthcare ethics. In chapter 6, I subject this principle to rigorous analysis by addressing my first research question. This was whether a healthcare professional should sometimes allow harm. The paper considers whether there are circumstances in which it is morally acceptable or even morally required to allow harm to come to a patient in support of a broader therapeutic goal. I ask whether a health care professional should sometimes allow harm and conclude that in certain circumstances, they should. In this paper, I contrast the standard management of self-injury in an in-patient setting with harm minimisation. I argue that although harm minimisation approaches allow harm as part of the therapeutic process, on balance, they should be supported on the basis that it supports the individual's autonomy and it results in an overall reduction in harm when compared with interventions that try to stop self-injury. Thus, the individual who self-injures experiences a net reduction in harm and it is the right intervention for some people.

5.2.2 Paper 2: Allowing harm because we care: self-injury and harm minimisation. ⁶¹⁶

⁶¹⁵ Sullivan (2017). Op.cit. n71.

⁶¹⁶ Sullivan (2018b). Op.cit.n131.

In chapter 7, I consider an objection to the practice of harm minimisation. I address the question of whether harm minimisation is just a misguided collaboration between the healthcare professional and the person who self-injures that is morally and clinically questionable. The objection has two components, the first component is moral in nature and asserts that the health care professional is complicit in any harm that occurs, and as a result, they can be held morally responsible and subject to moral blame. The second component is clinical in nature and suggests that harm minimisation involves the health care professional in colluding in the perpetuation of self-injury. This element of the objection is based on a psychodynamic understanding of why self-injury occurs. It is argued that harm minimisation is merely a mechanism for avoiding thinking about the psychotherapeutic issues that need to be addressed. The health care professional reinforces a dysfunctional pattern of behaviour and supports the perpetuation of self-injury. This clinical objection is drawn from the work of Scanlon and Adlam. I consider both components of the objection and argue that it fails on both counts. I conclude that the use of harm minimisation techniques is an appropriate form of intervention that is helpful to certain individuals in some situations.

5.2.3 Paper 3: Epistemic Injustice and Self-injury: a concept with clinical implications.⁶¹⁷

In chapter 8, I consider whether the application of the philosophical concept of epistemic injustice provides a way of facilitating a different understanding of self-injury. An understanding that allows us to consider the issue from the perspective of those individuals with lived experience of self-injury. This understanding helped facilitate the adoption of harm minimisation approaches in clinical practice. The paper applies the concept of epistemic injustice as a means of understanding some of the problems associated with supporting people who self-injure. I argue that people who self-injure may be subject to both testimonial and hermeneutical

⁶¹⁷ Sullivan, P.J. (2019). Epistemic Injustice: a concept with clinical implications *Philosophy, Psychiatry and Psychology*. Vol. 26. No. 4. p. 349-362.

injustice, and this can impact negatively on the care they receive. If we respect their position as a source of knowledge, this can have significant clinical implications. I use the development and introduction of harm minimisation techniques into this area of clinical practice as an example to illustrate this point. Respecting the perspective of those who have lived experience of self-injury has resulted in different ways of understanding self-injury and led to the development of more innovative and less restrictive ways of working. I take the position that we must be constantly vigilant to the possibility of epistemic injustice as its presence has a negative impact on the quality of care provided. I end my analysis with a note of caution about the progress made so far.

5.3.4 Paper 4: Risk and responding to self-injury: Is harm minimisation a step too far?⁶¹⁸

In chapter 9, I turn my attention to the legal and policy issues that arise concerning the use of harm minimisation in this area of clinical practice. The paper provides a legally informed analysis of some of the challenges associated with using harm minimisation techniques with people who self-injure. As we have seen, the literature has not considered the position of the healthcare professional in any depth and the legal position is not clear. In this final paper, I attempt to understand how the law may impact on the healthcare professional. I pose the question of whether; in the “age of risk” is harm minimisation just a step too far. The paper considers some of the legal implications of adopting a harm minimisation approach in supporting people who self-injure within in-patient mental health units. It is argued that a focus on risk and the increasing influence of the law and legal styles of thinking often associated with the allocation of blame have produced a more risk-averse clinical environment. As a result, health professionals are more likely to err on the side of caution rather than engage in practices that although potentially therapeutic are not without their risks. The analysis draws on the clinical, policy and legal literature to help understand how harm minimisation may support people who self-injure. It considers

⁶¹⁸ Sullivan, P.J. (2019a). Risk and responding to self-injury: is harm minimisation a step too far? *The Journal of Mental Health Training, Education and Practice*. Vol.14. No. 1.p1-11.

some of the complex medico-legal issues that arise in a clinical environment dominated by risk.

A focus on risk and accountability has produced an environment where the law and legal styles of thinking have come to influence practice. This is often associated with blame in the minds of the health professional. Given the legal obligation to prevent suicide, health professionals may take a conservative approach when working with people who self-injure. This makes the adoption of harm minimisation difficult, and changes in both policy and practice are required to make it a more realistic option.

Chapter 6: Should health care professionals sometimes allow harm? The case of self-injury.⁶¹⁹

6.1 A case history

Alison is thirty-five years old and has a long history of mental health problems. As a teenager, Alison started to cut herself, and this has continued. In conversation, Alison describes how she started to self-injure almost by accident and found that it made her feel better. Her self-injury follows a particular pattern, and she becomes anxious and distressed if prevented from acting in this way. She describes wanting to stop and understands that there are better ways of coping, but at the moment, cutting is her preferred means of dealing with feelings of distress. Alison has spent long periods in mental health units, and staff describe her behaviour as challenging. When in hospital, her admissions are characterised by episodes of self-injury and attempts to prevent such behaviour. These attempts at preventing self-injury have not always been successful, and on occasions, she has been so desperate to injure herself that she has made use of more dangerous methods of self-injury such as ligatures. This is a fictional case, and although not capturing all the complexities associated with self-injury, it does point to some of the ethical issues that arise in many similar situations.

6.2 Introduction

Self-injury is a common occurrence in many mental health units, and there is no agreed and empirically supported means of reducing its occurrence.⁶²⁰ Self-injury raises ethical and clinical challenges. There are moral questions regarding prevention of harm, especially as the behaviour often involves an individual who appears to understand the nature and consequences of their actions. There are also complex clinical issues regarding what interventions do and do not work.

⁶¹⁹ Sullivan (2017). Op.cit. n71.

⁶²⁰ National Collaborating Centre for Mental Health (2004). Op.cit. n4.

I will first describe the standard clinical management of self-injury. This involves attempting to stop the person from performing self-injuring acts. I will illustrate the pitfalls of this approach and describe an alternative approach termed harm minimisation. I will argue that in certain circumstances harm minimisation is a viable and ethical alternative to more traditional interventions on the basis of a net reduction in harm.

Previous analyses of this issue have made similar proposals.⁶²¹ Edwards and Hewitt,⁶²² for example, have argued that among all options open to healthcare professionals, prevention is the least plausible and supervising self-injury the most appropriate form of intervention. While Guttridge⁶²³ also supports safer self-injury, although she argues that the individual who self-injures is not fully autonomous, and she supports harm minimisation based on its therapeutic benefits.

I will add to their analysis by making a moral and clinical case for harm minimisation. This is based on the view that self-injury may, in fact, be an autonomous decision as it provides a means of coping with distress and therefore serves an important function for the individual. Furthermore, even if it were not autonomous, it does not follow that the individual lacks the capacity to participate in this type of therapeutic programme. This position promotes supporting autonomy and promoting independence in people, some of which are amongst the most vulnerable in society. The clinical perspective is predicated on engagement in a psychotherapeutic process that aims to change the person's behaviour.

I will not argue that harm minimisation should be adopted routinely, and that in no circumstances, individuals should be prevented from harming themselves. Harm minimisation and preventative approaches are not binary opposites, and both may be appropriate in certain circumstances.

⁶²¹ See, for example, Guttridge (2010). Op.cit. n71; Edwards and Hewitt, (2011). Op.cit. n126; Holley et al, (2012) Op.cit.n77.

⁶²² Edwards, and Hewitt, (2011) op.cit.126.

⁶²³ Guttridge (2010). Op.cit. n71.

This implies that the health care professional sometimes has a moral obligation to allow harm. Although this appears to contravene the established ethical principle to first do no harm, I will argue that, in specific situations, this course of action may be clinically and morally justified.

6.3 First Do No harm: preventing self-injury

It is estimated that amongst the general population, the rate of self-injury is somewhere between 1% and 4%.⁶²⁴ In mental health units, the rates are much higher.⁶²⁵ In hospital standard practice has been to try and stop self-injury occurring. Such a preventive strategy makes use of a range of interventions.⁶²⁶ These include searches of the individual and their possessions, removal of potentially harmful implements and the use of continuous observation. In more challenging cases, more intensive interventions such as seclusion, sedation and physical restraint may be used. Furthermore, patients are often detained under the Mental Health Act, which makes forced treatment and limitations of movement more likely. These measures are characterised by restrictions, attempts to increase control and on occasions the use of force. There are legal and ethical reasons to prevent harm, and these will now be discussed.

6.4 Context for preventative practices

Although the laws on professional obligations differ across jurisdictions, in most countries, as in England, the health care professional owes a duty of care to the patient they are responsible for.⁶²⁷ If such a duty is breached, a legal liability is imposed upon the practitioner. This liability could be addressed through criminal or civil proceedings. A failure to comply could amount to clinical negligence if it could be demonstrated that an individual experienced harm as a result of a breach of the duty

⁶²⁴ Prinstein, M.J. (2008). Introduction to the special section on suicide and nonsuicidal self-injury: A review of unique challenges and important directions for self-injury. *Journal of Consulting and Clinical Psychology*. Vol. 76. No. 1. p. 1-8.

⁶²⁵ James et (2012) Op.cit.n174.

⁶²⁶ Bowers, L. Hackney, D. Nijman, H. Grange, A. Allan, T. Simpson, A. and Eyres, S. (2007). *A Longitudinal Study of Conflict Bowers and Containment in Acute Psychiatric Wards*. London: City University.

⁶²⁷ Jackson (2010). Op.cit. n498, p.100.

of care on the part of the professional. In addition, in circumstances where there is a real and immediate risk of substantial harm, such as death, Article 2 of the European Convention on Human Rights imposes an operational duty to protect the life of a specific individual.⁶²⁸ This duty is established for any patient detained under the Mental Health Act⁶²⁹ and, more recently, it has been extended to individuals who are not subject to such detention.⁶³⁰

In this context, it is reasonable for a health care professional to act cautiously, particularly when dealing with self-injury. Although not all who self-injure are suicidal and self-injury is not normally life-threatening, it is reasonable of a health care professional to be concerned that failing to prevent injury may constitute a potential breach of their duty of care. Organisational policies and protocols tend to support this stance and emphasise the prevention of harm.⁶³¹ The difficulty, as will be shown below, is that attempts to prevent self-injury are not always effective and have important limitations.

6.5 Preventing self-injury: the paradox of preventative practice

The first problem with a preventative strategy is that it can exacerbate rather than contain the problem. Self-injury has a purpose and follows a fairly deliberate pattern. This is described in some detail in psychological models of self-injurious behaviour.⁶³² Self-injury is used as a coping strategy to release emotional tension. An almost stereotypical pattern of behaviour is described, whereby the individual starts to experience negative feelings. These feelings become intolerable, and injury reduces tension and increases control.⁶³³ The behaviour provides a positive relief from distressing feelings that threaten to overwhelm the person. Preventing such behaviour arguably deprives an individual of an important coping strategy and may increase his or her level of distress.

⁶²⁸ Keenan. *v United Kingdom*. Op.cit. n581.

⁶²⁹ *Savage v South Essex Partnership NHS Foundation Trust*. Op.cit. n578.

⁶³⁰ *Rabone v Pennine Care NHS Foundation Trust*. Op.cit. n579.

⁶³¹ Boardman, J. and Roberts, G. (2014). *Risk, Safety and Recovery*. London; Centre for Mental Health.

⁶³² Nock and Prinstein (2004). Op.cit. n28.

⁶³³ Haines et al (1995). Op.cit. n38.

The second problem is moral in nature; preventative strategies involve taking control and attempting to prevent the individual from acting as they wish. For example, continuous observation involves a nurse being with the patient throughout the twenty-four-hour period; hence the person's most intimate acts are observed by another. This fails to respect the individual's autonomy and conveys the message that the individual's choices lack value. By failing to acknowledge that self-injury is something the individual does for deliberate and important reasons the health care professional is acting in a way that implies the individual lacks moral agency. The message given is that the person needs to be saved from themselves. Such a violation of a person's autonomy accompanied by restrictions on the individual's basic liberties, it can be argued, thwarts the person's interests in exercising their autonomy and as such constitutes harm.⁶³⁴

It could be objected here, that self-injury is not an autonomous choice and therefore, the decision to engage in such behaviour should not be respected, even less valued. It is not clear, however, that people who self-injure are not autonomous; such a judgement would depend on the notion of autonomy adopted.⁶³⁵ The reality is, that many individuals who self-injure are highly functioning in other ways and appear to understand the nature and consequences of their actions. Thus, it is possible that the choice they make to self-injure is made autonomously in the same way as individuals choose to smoke, drink or engage in dangerous recreational activities. All these are harmful and yet regarded as legitimate choices. But even if their actions were not autonomous, there still remain moral and clinical questions about the means used to prevent such behaviour imposed interventions are in fact often ineffective and are certainly perceived negatively.⁶³⁶

Significant infringements on basic freedoms are likely to produce a confrontational rather than therapeutic environment that increases levels of distress and reduces the chance of a positive outcome in the longer term.⁶³⁷ In such circumstances,

⁶³⁴ Shiffrin (2006). Op.cit. n317.

⁶³⁵ I am indebted to Simona Giordano for this point and the main argument outlined in this paragraph.

⁶³⁶ Priebe, S. and McCabe, R. (2008). Therapeutic relationships in psychiatry: The basis of therapy or therapy in itself? *International Review of Psychiatry*. Vol.6. p.521–526.

⁶³⁷ Sandy and Shaw (2012). Op.cit. n46.

attempts to take away someone's ability to self-injure, reduces their coping options and is likely to increase their distress or increase the risk of harm. For example, it must be noted that an individual who self-injures may have a history of abuse or trauma and preventative measures may increase their feelings of powerlessness and in extreme cases result in additional trauma and therapeutic alienation.⁶³⁸ This increases the risk that such an individual will self-injure covertly, in more dangerous ways, or attempt suicide. For example, anecdotal evidence suggests the use of ligatures is increasingly prevalent on in-patient units often amongst individuals whose preferred form of self-injury is to cut their skin. In some cases, this can be fatal. This occurs in spite of high levels of observation.

In these circumstances, at best, what restrictive measures achieve is a reduction in the number of incidents but brings with it the danger of more serious harm. When applied routinely, they encounter the classic objections to paternalism. They do not always work, and the utilitarian argument whereby the constraints on fundamental liberties are justified in terms of a reduction in the overall level of harm fails. The actions taken to prevent the behaviour can be more harmful in their consequences than the behaviour itself.

If we add to this the fact that enforced intervention affects key personal interests such as, “autonomy, bodily integrity, privacy, property and liberty.”⁶³⁹ It then becomes clear that routine prevention is likely to lead, to a net increase in harm. Let us now return to the vignette described above to start to articulate an alternative position.

6.6 An alternative approach: Harm Minimisation

Rather than trying to stop Alison cutting herself the clinical team has agreed that she be able to access clean razors for her own use and that staff should work with her to help her understand how to injure herself more safely. In return, Alison has agreed to

⁶³⁸ Watts and Morgan (1996). *Op.cit.* n110.

⁶³⁹ Gostin, L.O. (2000). Human Rights of Persons with Mental Disabilities. The European Convention of Human Rights. *International Journal of Law and Psychiatry*, Vol. 23, No. 2, p. 125–159.

participate in psychological therapy, where she will explore the meaning and function of her behaviour as she tries to reduce and ultimately stop it.

Alison's story illustrates an alternative based on the principles of harm minimisation. These are interventions that aim to reduce the immediate harm associated with self-injury. In practical terms, the approach may include providing access to sterile cutting implements for personal use and education regarding how to injure more safely.⁶⁴⁰ For example, explaining basic anatomy and physiology and ensuring the individual understands concepts such as sepsis and the implications of infection. The development of first aid skills and an understanding of the possible consequences of self-injury may support this. The development of problem-solving skills and plans of what to do if a crisis occurs are integral to the approach. These interventions form part of a longer-term strategy to reduce the likelihood that the person resorts to self-injury. Access to psychological therapies designed to support the individual explore the meaning and function of their behaviour and help them to change is an essential component of harm minimisation. Self-injury is being allowed in order to maintain its role as a coping mechanism based on the understanding that this occurs safely. Without access to psychological therapies designed to facilitate change, the arguments supporting harm minimisation are weakened significantly.

Harm minimisation is a concept drawn from the discipline of public health, with wide application in areas such as substance misuse where the approach is associated with needle exchange programmes and supervised injection sites.⁶⁴¹ The aim is to prevent harm by reducing the potentially harmful consequences of engaging in high-risk behaviours. For example, in substance misuse, harm reduction provides an alternative to abstinence. The approach has been criticised. For example, Christie et al⁶⁴² note that it encourages drug use, it sends a mixed message, and it fails to get people off of drugs. Whether it is cost-effective and its validity as an appropriate treatment has also been questioned.⁶⁴³ Critics of harm reduction, particularly in the

⁶⁴⁰ Guttridge (2013). Op.cit n182.

⁶⁴¹ Hunt, N. Ashton, M. Lenten, L. Mitcheson, S. Nelles, B and Stimson, G. (2008). A review of the evidence-base for harm reduction approaches to drug use. London: Forward Thinking On Drugs.

⁶⁴² Christie et al (2008). Op.cit. n162.

⁶⁴³ Ritter, A. & Cameron, J. (2005). *Monograph No. 06: A systematic review of harm reduction*. DPMP Monograph Series. Fitzroy: Turning Point Alcohol and Drug Centre.

context of substance misuse, tend to focus on the moral issues involved, for example, a health care professional condoning illegal activity. In the context of self-injury, it has to be accepted that there is limited evidence of its effectiveness, but the high incidence of self-injury found in mental health units suggest that traditional approaches to dealing with self-injury are not effective. It is argued here that there is a strong moral reason to consider alternatives and harm minimisation provides a realistic and pragmatic alternative to traditional ways of working. Although evidence is weak or not available, proponents suggest it is a more realistic and pragmatic response to a complex health and social issue.

As we have seen there are accounts of using harm minimisation to support people who self-injure in mental health units in both the philosophical and clinical literature. Its use has been a pragmatic and direct response to the needs of people who self-injure. Inckle,⁶⁴⁴ for example, argued that listening to people who use self-injury as their main coping strategy invites professionals to consider the value of prohibiting such strategy; prohibition, in her words, is a form of control rather than support.

In cases such as Alison's, harm minimisation emerges as a therapeutic option for a number of reasons. Self-injury may range from superficial cuts to potentially life-threatening injury and intervention should reflect the risks involved. Where the risks of serious injury are low, limitations on basic freedoms are more difficult to justify. Furthermore, where self-injury is used as a way of coping, harm minimisation provides a means by which health care professionals can engage therapeutically with individuals, as they work with the individual as an equal and are less likely to be seen as someone who exerts power and control. This is clinically important, as there is evidence that a positive therapeutic relationship leads to more favourable outcomes across a range of diagnoses and treatment settings.⁶⁴⁵

As part of the therapeutic process, self-injury is accepted as necessary during a period when different coping strategies are developed. For many individuals, this

⁶⁴⁴ Inckle, K (2010). *The First Cut Is the Deepest: A Harm-Reduction Approach to Self-Injury Social Work in Mental Health*. Vol. 9. No. 5. p.370.

⁶⁴⁵ Priebe and McCabe (2008). *Op.cit.* n637.

acceptance of risk may prove beneficial and provides the flexibility to work with the individual in a way that aims to contain rather than control risk based on an understanding of what works for the individual. It does not promote harm but aims to reduce it. Pembroke notes that the majority of health risks associated with self-injury relate to the dangers of permanent injury or infection. For example, the risk of infection due to using dirty cutting instruments or sharing such implements or cutting into areas that may risk serious injury.⁶⁴⁶

Harm minimisation is designed to reduce risks of this sort. The provision of education and access to sterile equipment reduces the danger of infection, haemorrhage, permanent injury or death. These strategies are also accompanied by advice around dress, make-up and camouflage that support individuals in managing longer-term harms such as scarification. Incidents of self-injury are accepted, but the harmful nature of the self-injurious act is reduced, and the patient benefits through participation in a therapeutic process.

Finally, harm minimisation respects and enhances autonomy. Self-injury is supported as an autonomous choice and participation in the programme is based on consent. It provides a means whereby individuals are able to express what they are feeling inside and by doing so to make a clear statement about both their identity and agency. The approach is controversial, and I will now briefly address three possible objections to harm minimisation.

6.7 Harm minimisation: objections

The first objection concerns consent.⁶⁴⁷ As stated above, harm minimisation requires the individual to consent to participation in the process; it cannot be enforced. In the context of drug misuse, Charland asks whether it is possible for individuals to consent to a programme of intervention that involves harm when it is not clear that the individual can control their behaviour. Whether the act of self-injury is

⁶⁴⁶ Pembroke, L. (2006). Limiting self-harm. *Emergency Nurse*. Vol.14. No.5.p8-10.

⁶⁴⁷ Charland, L. C. (2002). Cynthia's Dilemma: Consenting to Heroin Prescription. *The American Journal of Bioethics*. Vol. 2. No.2. p.37- 47.

autonomous raises philosophical questions that go beyond the remit of this paper. However, most people who self-injure appreciate the nature and consequences of their choices. But even if they are unable to control their actions, that does not mean they are unable to consent to a certain form of intervention.

Even if it is accepted that self-injury is symptomatic of a mental disorder, it is to be noted that many people with mental health problems still have some degree of autonomy and few lack autonomy completely. In English law, adults are assumed to have capacity unless demonstrated otherwise, and it is accepted that mental health problems do not necessarily jeopardise the capacity to make decisions about health care, even in relation to the mental health problem itself.⁶⁴⁸ For these reasons, it is reasonable to assume that at least some individuals who self-injure may be able to make autonomous and capacitous decisions about their therapy even if they struggle to control their behaviour. At least some individuals can, therefore, make competent decisions about participation in a harm minimisation programme.

The second objection concerns allowing the person to self-injure. It may be argued that supporting someone to injure him or herself encourages the problem, thereby undermining treatment efforts. The concern may be that such an approach suggests that it is acceptable to injure yourself and to risk the harm that may result from your actions, therefore supporting a maladaptive coping strategy. This could lead to an increase in harm and in the worst-case scenario, be fatal. For these reasons, some psychological therapists insist that the cessation of self-injury is a precondition for therapy and continuation of the behaviour may result in the therapy being withdrawn.⁶⁴⁹

The problem with this objection is that individuals for whom harm minimisation is a possibility have already accepted the use of self-injury as a routine and necessary part of their life. The risks associated with the behaviour do not constitute a deterrent. Although not necessarily addictive, the behaviour has some similarities

⁶⁴⁸ Okai, et al (2007). Op.cit. n445.

⁶⁴⁹ Conterio, K and Lader, W. (1999). *Bodily Harm: The Breakthrough Healing Programm for Self-Injurers*. New York, Little, Brown and company.

with addictive behaviour and is difficult to stop. Allowing some degree of self-injury is a realistic and pragmatic approach to addressing the issue and in some cases may be the only option the individual is willing to accept. The patient may, in fact, see insisting on stopping the behaviour as indicative of a poor prognosis, and this may lead to an increased sense of helplessness. Furthermore, as already indicated earlier, insisting on cessation may be interpreted in a pejorative way by the person who self-injures, perceived as implying that self-injury is wrong, and this may inhibit the development of an effective therapeutic alliance as moral and clinical issues become confused.⁶⁵⁰

The final objection concerns allowing harm to occur within a clinical setting. As we have seen, the health care professional has an obligation to do what their profession requires, and in health care, the principle of "first do no harm" has a long tradition.⁶⁵¹ Allowing self-injury thus appears, at least, at first sight, to go against the professional's duty of care, as reasonable care must be taken to avoid acts or omissions, which are likely to cause harm.

A weakness with this argument is that although the maxim to do no harm has such credence if applied precisely, it would mean that many health care interventions would not be provided. Many medical interventions do harm and yet are provided routinely and seen as ethical and lawful. Painful surgery or other invasive procedures are obvious examples.⁶⁵² When the benefits outweigh the harm, the intervention is normally justified. For example, antipsychotic medications have significant side effects such as weight gain and sedation, yet are generally accepted due to the control of distressing symptoms that allows the individual to function independently.

On a day-to-day basis, health care professionals working in mental health facilities are constantly weighing the risks of harm that interventions may entail against the likely benefits for patients. Harm minimisation may lead to an increase in the number of actual incidents, but the approach is justified by a reduction in the harmful nature

⁶⁵⁰ Potter, N. N. (2006). What is manipulative behaviour anyway? *Journal of Personality Disorders*. Vol. 20. No. 2. p.139–15.

⁶⁵¹ Smith (2005). Op.cit. n324.

⁶⁵² Sokol, (2013) Op.cit. n328.

of the injuries sustained. More restrictive approaches may reduce the actual number of incidents, but the level of harm may increase. On this view, we are permitting harm to the person, as on balance the approach results in a net reduction in harm.

6.8 Conclusions

There are good reasons to try and prevent harm, and this usually leads to attempts to prevent self-injury within a mental health setting. This paper has challenged this perspective and shown how there are problems associated with a preventative strategy. It has been argued that an appeal to a prevention of harm cannot be sufficient reason to support the routine use of restrictive practices. This is not to say that restrictive measures should never be used, as there will be situations where self-injury poses such immediate and serious risks that the only option is to try to prevent it. This paper has argued that harm minimisation provides a viable, ethically and clinically sound therapeutic option in dealing with self-injury, one that combines a reduction in overall harm with fewer restrictions on autonomy. It does not involve a blanket permission to self-injure with staff, allowing significant harm to occur. Harm minimisation is a sophisticated approach to intervention, and in adopting the approach the health care professional allows the infliction of a lesser harm to prevent a more serious harm and as such the harm allowed serves a legitimate function.

There are without doubt practical difficulties in implementing such an approach, as organisations will struggle with the legal and ethical implications, while many health care professionals will struggle with the idea of supporting harm in the context of a therapeutic relationship. However, it has been argued that health care professionals may sometimes have good reasons to allow harm, in fact, they routinely do so; allowing harm is not necessarily contrary to the professionals' duty of care, and, in fact, it may be required if the benefits are significant and likely to outweigh such harm. Harm minimisation provides a means of working with an individual in a way that recognises their autonomy and accepts that they have a different way of coping with distress. By trying to prevent their injury; we not only harm them, we may also

fail to help them.⁶⁵³ I conclude that the health care professional sometimes has an obligation to allow harm.

⁶⁵³ Tudor, S. (2001). *Compassion and Remorse: acknowledging the suffering other*. Leuven Peeters Publishers.p. 10.

Chapter 7: Allowing harm because we care: self-injury and harm minimisation

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7.1 Introduction

Although it is generally accepted that current approaches to supporting people who self-injure require improvement, an alternative presented by the use of harm minimisation approaches is controversial. When adopting this approach, rather than trying to stop self-injury immediately, the person is allowed to injure safely while working to develop more appropriate ways of dealing with distress. There is some support for the approach in the literature.⁶⁵⁵ However, it has also been subject to challenge.⁶⁵⁶ This paper will consider a specific objection to harm minimisation. That is, it is merely a misguided collaboration between the health care professional and the person who self-injures that is morally and clinically questionable. I will argue that the argument fails and that the use of harm minimisation techniques is an appropriate form of intervention that is helpful to certain individuals in some situations.

In the first part of the paper, I will make some preliminary comments about the nature of self-injury and show how the current clinical response is inadequate. I will then explain how harm minimisation should be understood and how it is applied in the context of self-injury. I will then consider the objection. This objection has both moral and clinical components. By responding to these components, a more robust understanding of these complex issues will emerge. The paper will focus on current practice within the context of the United Kingdom, and reference will be made to the legal framework operating in England and Wales. The arguments do, however have a wider application.

7.2 Self-injury

⁶⁵⁴ Sullivan (2018b). Op.cit.n617.

⁶⁵⁵Guttridge (2010) Op.cit. n71; Edwards and Hewitt, (2011). Op.cit.126.

⁶⁵⁶ Scanlon and Adlam, (2009). Op.cit. n114; Pickard and Pearce, (2017). Op.cit. n113.

Self-injury is a complex and multifaceted phenomenon that remains poorly understood. For this reason, it is often difficult to identify the specific motivation and reasons for a particular act of self-injury since one individual may self-injure for a number of different reasons or purposes. In his detailed analysis of the phenomena, Favazza,⁶⁵⁷ suggests there are, in fact, four different types of self-injury; stereotypic, major, compulsive, and impulsive. The focus of my analysis is on what Favazza, refers to as impulsive self-injury. These are actions defined in terms of the following components. First, the deliberate, direct, and self-inflicted destruction of body tissue. Second, the action results in immediate tissue damage. Third, it occurs for purposes not socially sanctioned and finally, there is no suicidal intent.⁶⁵⁸ This type is the most prevalent form of self-injury and may take many forms. For some people, it is a regular occurrence and has an almost addictive quality.⁶⁵⁹

It could be objected at this point that this is an oversimplification and such an objection must to some extent be accepted. People do not fit easily into broad classificatory systems, and their motives are often difficult to understand without a detailed assessment of the specific clinical situation. For example, in some cases, the behaviour may be associated with mental disorder and the underlying illness will require treatment.⁶⁶⁰ In other cases, it may be a unique response to a particular life situation, a response that is about survival rather than destruction of the self.⁶⁶¹ Some people who self-injure will not have insight into the full reasons for their behaviour,⁶⁶² and others may be ambivalent about whether their injury leads to death. All forms of self-injury are dangerous and harmful in the longer term. For example, acts such as cutting may result in scarring, numbness or paralysis.⁶⁶³ Furthermore,

⁶⁵⁷ Favazza (2011). Op.cit. n24.

⁶⁵⁸ International Society for the Study of Self-injury. (2007). Op.cit. n26.

⁶⁵⁹ Buser, T.J. and Buser, K.J. (2013) Conceptualizing Nonsuicidal Self-Injury as a Process Addiction: Review of Research and Implications for Counselor. Training and Practice. *Journal of Addictions & Offender Counselling*. Vol. 34. p. 16-29; Victor, S.E. Glenn, C.R, Klonsky, E.D. (2012) Is non-suicidal self-injury an "addiction"? A comparison of craving in substance use and non-suicidal self-injury. *Psychiatry Research*. Vol. 197. No.1-2. p.73-7.

⁶⁶⁰ Fagin, L. (2006). Repeated Self-injury: Perspectives from General psychiatry. *Advances in Psychiatric Treatment* vol. 12. p. 193- 201.

⁶⁶¹ Nathan, J. (2006). A strategy for survival and a nodal point of change. *Advances in Psychiatric Treatment* Vol. 13. p. 329-337.

⁶⁶² Hjelmeland, H. Hawton, K. Nordvik, H. et al. (2002). Why People Engage in Parasuicide: A Cross-Cultural Study of Intentions. *Suicide and Life-Threatening Behaviour*. Vol.32. No.4. p. 381.

⁶⁶³ Todd, J. Ud-Din, S. Bayat, A. (2012) Extensive self-harm scarring. Successful Treatment with Simultaneous use of a single layer skin substitute and split-thickness skin graft. *Eplasty*. Vol. 12. E23.

although self-injury appears to be psychologically and phenomenologically different from suicide and the current risk of suicide may be low, the lifetime risk of suicide is increased⁶⁶⁴

Due to these risks, the traditional approach to intervention is to try and get the person to stop. Within an in-patient mental health unit, this may involve trying to stop the behaviour occurring through strategies such as continuous observation, the use of searches, the removal of personal possessions and in some cases the use of restraint and detention under the Mental Health Act. As we shall see, these interventions are perceived as intrusive and coercive and are experienced negatively by the person to whom they are applied. Paradoxically they may increase the level of risk.⁶⁶⁵ It is my contention that where self-injury is carried out without suicidal intent, in some circumstances, harm minimisation may be a safer option in trying to help the person to change.

7.3 Harm minimisation

Harm minimisation is an option to support people who self-injure. It is an alternative approach that developed in response to the views of those with lived experience of self-injury.⁶⁶⁶ Personal narratives, supported by more phenomenological academic accounts of self-injury have facilitated a greater understanding of the meaning associated with this phenomenon.⁶⁶⁷ They provide what Schweiger⁶⁶⁸ terms “windows into reality.” In these accounts, the meaning of self-injury is considered to be part of a person’s identity, whereby the body represents what the person feels on

⁶⁶⁴ Muehlenkamp (2005). Op.cit. n18; Hawton, K. Bergen, H. Cooper, J. Turnbull, P. Waters, K. Ness, J. Kapur, N. (2015). Suicide following self-harm. Findings from the multicentre study of self-harm in England. 2000-2012. *Journal of Affective Disorders*. Vol. 175. p. 147-151.

⁶⁶⁵ Bowers, L. Whittington, R. Nolan, P. Parkin, D. Curtis, S. Bhui, K. Hackney, D. Allan, T. Simpson, A. Flood, C. (2006). *The City 128 Study of Observation and Outcomes on Acute Psychiatric Wards*. Research Report Produced for the National Co-coordinating Centre for the National Institute for Health Research Service Delivery and Organisation Programme (NCCSDO); Bowers, L. Whittington, R. Nolan, P. Parkin, D. Curtis, S. Bhui, K. Hackney, D. Allan, T. Simpson, A. (2008). The relationship between service ecology, special observations and self-harm during acute in-patient care: City-128 study. *British Journal of Psychiatry* (2008) vol. 193. p. 395–401.

⁶⁶⁶ Pembroke, L. (2006). Op.cit. n647; Shaw (2012). Op.cit. n76; Cresswell (2005a). Op.cit. n51.

⁶⁶⁷ Brown and Kimball, (2013). Op.cit.n10.

⁶⁶⁸ Schweiger, G. (2016) Epistemic Injustice and Powerlessness in the context of Global Justice: An Argument for "Thick" and "Small" Knowledge. *Wagadu. A Journal of Transnational Women's and Gender Studies*. Vol. 15. p. 105.

the inside. Its function is a means of reducing the experience of overwhelming stress. A number of psychological accounts of the phenomenon have also confirmed its value as a coping strategy.⁶⁶⁹

A number of healthcare professionals have accepted this narrative and frustrated with traditional ways of working with people who self-injure have promoted the use of harm minimisation techniques.⁶⁷⁰ This involves allowing the individual to injure him or herself safely. This focus on reducing rather than eliminating harm has been used in a range of different contexts, substance misuse services being the obvious example.⁶⁷¹

This is an alternative to traditional approaches that attempt to stop the individual from sustaining any injury. Rather than using more restrictive and preventative measures, harm minimisation is based on the idea that self-injury is allowed as long as it is practised safely. It is a means of supporting the person while they develop a different range of coping strategies in the longer term.⁶⁷² The approach is recognised as a valid form of intervention by NICE guidance, although they do not suggest it is an approach that can be universally applied. It may be a necessary and proportionate intervention where other approaches have not been successful.⁶⁷³ The adoption of harm minimisation is recognition that self-injury has a function in helping the individual to deal with distress.

7.4 An argument and an objection

In supporting harm minimisation, both moral and clinical arguments are engaged.

⁶⁶⁹ Bentley, K.H. Nock, M.K. and Barlow, D.H. (2014). The Four-Function Model of Nonsuicidal Self-Injury: Key Directions for Future Research. *Clinical Psychological Science*. Vol XX. No.X. p. 1–19; Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review*, Vol.27. No.2. p.226–239; Nock, M. (2008). Actions speak louder than words: An elaborated theoretical model of the social functions of self-injury and other harmful behaviours. *Applied and Preventative Psychology*. Vol. 12. No. 4. p.159–168.

⁶⁷⁰ Crowe and Bunclark (2000). Op.cit. n78; Holley, et al (2012).Op.cit. n77; Department of Health Self-Harm Reference Group (2012). Op.cit. n78.

⁶⁷¹ Marlott, G.A. (1998) *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviours*. New York. The Guildford Press.

⁶⁷² Babiker and Arnold (1997). Op.cit. n93.

⁶⁷³ National Collaborating Centre for Mental Health (2004). Op.cit.n4; National Collaborating Centre for Mental Health (2012). Op.cit.n4.

The moral argument is that by attempting to prevent harm occurring, it is necessary to use a range of restrictive interventions that infringe on the person's autonomy. Given that in some cases, the person's autonomy may not be jeopardised in any relevant way, these attempts at prevention may be an example of strong paternalism and be morally questionable. The clinical argument is that these attempts at prevention may not work and paradoxically lead to an increase in the level of risk, as the person, desperate to self-injure, resorts to more extreme methods to achieve his or her goal. Furthermore, the relationship between the health care professional and the patient deteriorates in ways that may be detrimental to the person's safety. The ethical argument is thus based on the view that if you cannot achieve the good, we should at least attempt to reduce the bad. The clinical argument is based on the view that allowing harm to occur in a controlled way is safer and overall the risks are reduced particularly as by engaging the person who self-injures in a therapeutic way there is a greater chance of involving the person in psychological treatments that may help change.

The objection considered in this paper is directed at both the moral and clinical components of this argument. First, by allowing harm to occur, the health care professional is complicit in supporting a wrong. Harm minimisation involves the health care professional participating in a process that allows harm to occur and in acting in such a way the health care professional acts contrary to their moral and professional obligation to prevent harm. Thus, it is not the right thing to do for moral reasons, and as a consequence, they can be held morally responsible and subject to moral blame.

The second component is clinical in nature and is based on the work of Scanlon and Adlam.⁶⁷⁴ They question the practice of harm minimisation on clinical grounds and argue that harm minimisation involves the health care professional colluding in the perpetuation of self-injury. Their objection is based on a psychodynamic understanding of why self-injury occurs. They argue that harm minimisation is merely a mechanism for avoiding thinking about the psychotherapeutic issues that need to be addressed in working with people who self-injure. By their actions, the health care

⁶⁷⁴ Scanlon and Adlam, (2009). Op.cit. n114.

professional merely reinforces a dysfunctional pattern of behaviour and supports the perpetuation of self-injury. Thus, it is not the right thing to do for clinical reasons. I will argue that this argument succeeds in emphasising the importance of a psychologically informed approach to working with self-injury but fails by taking a limited perspective regarding harm minimisation as an approach.

7.5 A moral objection,?

In any relationship, Gardiner has argued,⁶⁷⁵ there are two parts to morality, what I should do, and then there is what I should do by way of contribution to what you do. So, the health care professional is responsible for the actions they take and the person who self-injures is also responsible for their actions. However, the former must consider the consequences of their actions upon the latter. It is within this relationship that harm occurs. Mellema⁶⁷⁶ argues that actions may enable harm, or they may facilitate harm, where harm is enabled the health care professional's action constitutes a necessary condition for the harm to occur. Facilitating harm is a weaker notion than enabling harm and merely makes it more likely that harm will occur. I take harm to be a setback of interests and return to this issue below.⁶⁷⁷

When supporting a person to continue to self-injure, albeit safely, the health care professional enables harm. It could be argued that by supporting the person in this way, the health care professional by their actions or omissions harms the person and thus the individual's interests are thwarted and he or she is wronged.⁶⁷⁸ This is because there are strong moral and legal reasons against allowing harm, and generally it is accepted that where an individual is subject to harm, then others have reasons to prevent it from occurring.⁶⁷⁹ Health professionals particularly have a specific responsibility to do no harm based on the concept of "primum non nocere."⁶⁸⁰ When using a harm minimisation approach instruments that may be used

⁶⁷⁵ Gardiner, J. (2007) *Complicity and causality. Criminal Law and Philosophy*. Vol. 1. p.127- 141.

⁶⁷⁶ Mellema, G. (2016). *Complicity and moral accountability*. The University of Notre Dame. Notre Dame Press.

⁶⁷⁷ Feinberg (1986). *Op.cit.* n140.

⁶⁷⁸ *Ibid.*

⁶⁷⁹ Shiffrin, (2012). *Op.cit.* n317.

⁶⁸⁰ Smith, (2005). *Op.cit.* n324.

for self-injury may be provided or not removed, and the health care professional and the patient cooperate and work collaboratively to ensure that self-injury occurs more safely. Therefore, it cannot be denied that injury and therefore harm occurs.

In allowing a person to inflict wounds on their body, we enable harm. Furthermore, the wounds may become infected, and there are dangers from long-term problems associated with scar tissue and muscle damage. In allowing such injuries to occur, it could be argued that the health care professional acts in a way that is contrary to a moral obligation to do no harm. He or she acts wrongly as their actions and /or omissions not only fail to prevent harm but actually enable harm. As a result, they are morally blameworthy. I am going to show that this argument is unsubstantiated.

In an institutional setting, attempts are made to stop self-injury occurring and such interventions, as I will show below, are by their very nature restrictive. So, whereas harm minimisation raises a number of ethical questions, traditional approaches raise others, which are not ethically neutral. In particular traditional approaches raise serious moral questions as the person is harmed through direct infringements on important interests such as autonomy, privacy, bodily integrity, dignity and liberty.⁶⁸¹ The impact of continuous observation illustrates this point.

Continuous observation is by its nature highly intrusive, as a person is observed throughout the twenty-four hour period, and all activities are subject to the professional gaze. One is reminded of an interesting comparison with the work of Bell⁶⁸² who writes about the in-patient treatment of eating disorders. She identified parallels between the protocols governing these interventions, and the Foucaultian idea of panoptic disciplinary power. She emphasises the processes of surveillance and routinisation that aims to enhance the control of the patient by the health care professional. This analysis could equally be applied to the use of continuous observation. Moreover, the actual process of observation is often undertaken by very junior staff and follows a set procedure. This has to be followed, clearly documented

⁶⁸¹ Gostin, (2000). Op.cit. n640.

⁶⁸² Bell, M. (2006). Re/Forming the Anorexic "Prisoner": In-patient Medical Treatment as the Return to Panoptic. *Femininity. Cultural Studies. Critical Methodologies*. May Vol. 6. No. 2 p. 282-307.

and is subject to audit. The recipient often experiences the process as coercive and intrusive, and it has been described as akin to “watching” rather than as a form of therapeutic engagement.⁶⁸³

From a clinical perspective, questions also arise as research suggests continuous observation does not always work. There are two problems. First, it may not, in fact, prevent harm as the risk of harm increases when such intrusive methods are used. People become increasingly distressed and may attempt to use more dangerous means to self-injure.⁶⁸⁴ Second, It has also been shown to have a negative impact on the therapeutic relationship.⁶⁸⁵ This does not mean there is no place for such a process, for example in cases where the person is actively suicidal and their actions life-threatening then such an intervention arguably can be justified on the balance of harms and benefits.

Thus, whether we are considering these traditional measures, or an alternative harm minimisation, balancing harms and benefits is crucial to the argument. The idea of a harm and benefits ratio is fundamental to clinical decision-making, and health care interventions may both harm and benefit the patient.⁶⁸⁶ The judgment of whether harm minimisation is a positive strategy is based on a comparison of the actual injury incurred set against the long-term benefits of the intervention. Thus, the person who self-injures is *prima facie* worse off due to the injuries incurred but better off overall due to an increased possibility that harm will be reduced in the long term.

If harm minimisation is to be defended as a legitimate intervention, then the harm incurred must occur in the person's interests. It is not difficult to imagine a scenario where it is permissible to allow a person to cut him or herself safely in order to prevent the use of more unsafe actions or even an escalation of risks through the adoption of more dangerous forms of harm such as the use of ligatures. Pembroke,

⁶⁸³ Scanlon, C. and Adlam, J. (2011). Who watches the watchers?: Observing the dangerous liaisons between forensic patients and their carers in the perverse panopticon. *Organisational & Social Dynamics*. Vol. 11. No. 2. p. 175–195.

⁶⁸⁴ Stewart, D. Bilgin, H. and Bowers, L. (2010). *Special observation in psychiatric hospitals: a literature review*: Report from the Conflict and Containment Reduction Research Programme. London. Institute of Psychiatry.

⁶⁸⁵ Cremin et al (1995). *Op.cit.* n.108.

⁶⁸⁶ Francis, L. (2015) Benefit and Harm. In ten Have, H. (ed). *Encyclopedia of Global Bioethics*. DOI 10.1007/978-3-319-09483-0.

⁶⁸⁷ writing from the perspective of someone with lived experience of self-injury, notes that the majority of health risks associated with self-injury relate to the dangers of permanent injury or infection. For example, the risk of infection due to using dirty cutting instruments. She goes on to point out that harm minimisation approaches are specifically designed to reduce risks of this sort by promoting safer means of self-injury. This is achieved by ensuring the individual is informed about basic anatomy and physiology and is able to access first aid and use the correct dressings. If this information is not available, then the individual's choices about self-injury are restricted in a way that makes self-injury less safe. She concludes by stating that she has yet to hear someone who self-injures say they want to lose a hand or arm and yet she had seen this occur in situations where the individual lacked basic knowledge of anatomy and physiology. In essence, what is observed is an agreed level of injury that is negotiated with the person and based on a therapeutic understanding of what is allowed.

The moral argument supporting such an approach is that although the health care professional does not want harm to occur, in cooperating with the person in allowing this harm to occur, a greater harm was prevented by assisting in the production of a lesser harm. This type of argument has been developed in a number of settings, and Mellema⁶⁸⁸ explains how this moral phenomenon may occur in a situation where the person "perceives that the only way to prevent a great harm from occurring is to assist in the production of a lesser harm." At this point, I return to the conceptual framework developed by Feinberg⁶⁸⁹ and suggest that it provides a conceptual lens through which to view harm minimisation.

My underlying argument is based on an attempt to balance harms and benefits, with the former perceived as bad and the latter perceived as good. Harm setbacks a person's interests, in this case, by infringing upon their autonomy and benefits enhance a person's interests, in this case, their health and wellbeing. In evaluating harm minimisation, we must consider whether the person's interests are better at the end of the process than they were at the start or how they would have been if the

⁶⁸⁷ Pembroke, (2006). *Op.cit.* n647.

⁶⁸⁸ Mellema, G. (2016). *Op.cit.* n677.

⁶⁸⁹ Feinberg, (1986). *Op.cit.* n140.

process had not been followed. The comparison of harms and benefits results in an evaluation of whether the person has been harmed or benefited. In my view, the moral arguments developed are similar to those employed by Feinberg in his rescue case.⁶⁹⁰ He argues that in spite of having his arm broken when rescued, the individual was not harmed given the overriding benefits he experienced when being rescued.

We do not have to go far to see this principle applied in healthcare, as it is not an unusual scenario, surgery being the obvious example. The moral argument is made by Harman⁶⁹¹ when she makes the point that, we would accept that in normal circumstances, the doctor does not harm the patient. However, she goes on to say that what a doctor does often results in harm and the use of a scalpel to cut the skin is used as an example. She argues that the statement that the doctor does not do harm is a means of justifying the permissibility of their action. It is, therefore, a rhetorical device. Harman deals with this by suggesting that an alternative means of examining the actions of the healthcare professional is to accept that harm occurs and that in some circumstances this may cause significant damage to an individual's body. In surgery, the damage to the body has a purpose. The harm resulting from the actual surgical intervention is weighed against the harm that would result if such an intervention did not take place. Harman suggests that the reasons for performing the surgery are stronger than the reasons for not performing the surgery. As a result, the surgery is permissible. In this sense, something that would constitute a crime in a different context is perceived as a legitimate medical treatment. The harm experienced is outweighed by the benefits received and the moral argument is made.

I conclude that harm minimisation can be justified in a moral sense. Although the person may be harmed in a narrow sense that is through cutting their skin, for example, they are not harmed in a more global sense as we respect their autonomy in a way that more paternalistic interventions do not. By allowing harm to occur in a controlled and safe way, a greater harm is prevented by avoiding the possibility that

⁶⁹⁰ *ibid.*

⁶⁹¹ Harman (2004). *Op.cit.* n321.

more risky means will be used to inflict self-injury. There is thus a net reduction in harm. As a consequence, on balance, the health care professional is morally justified in allowing harm and as such, cannot be subject to moral blame. However, things do not end there, and there is an equally important and related objection that needs to be addressed from a clinical perspective. This concern evolves from the work of Scanlon and Adlam.⁶⁹² It is to their concern that we now turn.

7.6 A clinical objection?

In an analysis of self-injury, undertaken from a psychodynamic perspective, Scanlon and Adlam⁶⁹³ deal with the issue of harm minimisation only briefly but provide a serious criticism of the approach from a specific clinical perspective. They question the ethics of harm minimisation by challenging its clinical validity. They argue that harm minimisation reflects a failure to deal with important and underlying therapeutic issues.

The understanding of self-injury proposed by Scanlon and Adlam, argues that self-injury is a defence against internalised threats to psychological functioning that must be controlled in order to prevent more serious behaviour.⁶⁹⁴ The response of health care professionals, they argue, is based on a view that the person's actions are both deliberate and rational. This results in professionals judging the behaviour in negative terms and responding to the person's actions in ways that can be thoughtless and punishing.⁶⁹⁵ The patient is therefore humiliated, and as a result, the person who self-injures and the health care professional become locked in a reciprocal relationship whereby both parties ask 'why do you treat me this way'?⁶⁹⁶

These professional attitudes are pervasive, given societies inability to understand why another human being would want to damage their own body. It is a phenomenon that is contrary to shared ideas about health and well-being.⁶⁹⁷

⁶⁹² Scanlon and Adlam, (2009). Op.cit. n114.

⁶⁹³ Ibid. p.69.

⁶⁹⁴ Ibid. p.54

⁶⁹⁵ Ibid. p. 55-56.

⁶⁹⁶ Ibid. p.56.

⁶⁹⁷ Ibid. p.58.

Through the means of unconscious collusion, both the patient and the practitioner avoid confronting the reciprocal violence ingrained in their relationship. By attributing intentionality to the action, the system of care perceives the person's actions in terms of wrongdoing and effectively punishes the patient by its actions.⁶⁹⁸ An extreme example of this is the provision of sterile cutting instruments as part of a harm minimisation. To use the author's actual words, such an approach;

*"Invites the clinician into an active collusion with the perpetration of a 'crime against the body' or into the negotiation of an acceptable level of violence, in ways that would not be accommodated if this was a crime against someone else's body."*⁶⁹⁹

The health care practitioner colludes with what Scanlon and Adlam term, " active or more passive-aggressive positions of societal sadism, from within which we give razorblades to 'them' because we really do not care enough to think with 'them' about their relationship with 'us'."⁷⁰⁰

The language used by Scanlon and Adlam is important. The term collusion is used in a very specific sense. When a therapeutic encounter is understood using a psychodynamic model, the focus will be on both the person and the therapist and refers to a subconscious process whereby staff and patients avoid addressing painful issues that need to be addressed as part of the therapeutic encounter. As a result, both parties become stuck in a pattern of behaviours that merely perpetuates the status quo.⁷⁰¹

The use of the term "crimes against the body" is also used in a very specific way. The term was originally used by Motz ⁷⁰² in her work on female violence, which makes use of the conceptual model developed by Welldon,⁷⁰³ which is based on the idea of "female perversion." She developed her ideas to help understand the

⁶⁹⁸ Ibid. p.63.

⁶⁹⁹ Ibid. p.69.

⁷⁰⁰ Ibid. p.77.

⁷⁰¹ Kets de Vries, M.F.R. (1999) What's playing in the Organisational theatre? Collusive Relationships in management. *Human Relations*. Vol. 52. No. 6. p. 745-773.

⁷⁰² Motz, A. (2008) *The Psychology of Female Violence: Crimes Against the Body*, 2nd Edition, London: Routledge.

⁷⁰³ Welldon, E.V. (1988) *Mother, Madonna, Whore: The Idealisation and Denigration of Motherhood*, London: Karnac.

psychology of women who commit violent acts either on others or themselves. This term, when used correctly, describes instances of human behaviour that deviate from what is considered normal. Welldon's work includes reference to different forms of violent behaviour, of which violence directed by a woman against her own body is one. Motz has developed these ideas and argues that such actions are a form of communication that is indicative of internal pain, and she uses the term 'crimes' in both a literal and metaphorical sense.⁷⁰⁴ It is in the latter sense that Scanlon and Adlam apply the term and theirs is a broader discussion, as their analysis is not only confined to women. The use of language and the context from which it originates, places their analysis of self-injury, like that of Motz and Welldon, firmly within a psychodynamic model. As a result, their understanding of self-injury and the approach to intervention is explained using this model. In a general sense, this type of analysis helps to describe some of the complex dynamics in play between health care professionals and people who self-injure.

Self-injury is hard to understand, and it is not difficult to identify reasons why people become concerned and even disturbed by acts self-injury. Intuitively most people would want to prevent injury occurring. However, people who self-injure not only allow injury to occur, they inflict such injury on themselves.⁷⁰⁵ This challenges and disturbs the notion, which Kristeva⁷⁰⁶ describes as the "self propre". By this, I understand her to mean a clean, proper and self-contained body. Many types of ill health or disease challenge this notion and it is within this context that Kristeva makes her argument regarding abjection. These are phenomena that disturb the social order and deeply held communal values. This idea is relevant to self-injury, as by disrupting the 'self propre' a person who self-injures challenges societal ideas about what is acceptable and goes against accepted social norms in a way that we find difficult to understand.

As a consequence, when faced with a person who has inflicted wounds upon their body, most people, including health care professionals, will feel different emotions.

⁷⁰⁴ Motz, (2008). Op.cit n703. p. 2.

⁷⁰⁵ Hodgson, S. (2004). Cutting through the silence: A sociological construction of self-injury. *Sociological Inquiry*. Vol. 74. p. 162-79.

⁷⁰⁶ Kristeva, J. (1982) *Powers of Horror: An Essay on Abjection*, trans. L.S.Roudiez. New York: Columbia University Press.

These range from pity and sympathy, on the one hand, to fear and shock on the other. The nature of the injuries themselves may disturb, and it can be difficult to feel empathy in such situations. This coexistence of positive and negative emotions often results in very different views about the best way of supporting individuals who self-injure. As Rozien⁷⁰⁷ has pointed out, when we fail to understand something, we will try to impose meaning upon the unknown. Certain actions may acquire a moral content as they are linked with our values as individuals, as members of society or as health care professionals. This has direct implications for people who self-injure.

In their analysis of these emotions in the context of a therapeutic relationship, Scanlon and Adlam, allude to the complex emotions that come into play and like Nussbaum⁷⁰⁸ appear to suggest the presence of an unease that may be due to an unconscious fear of contamination and a need to differentiate us from the object of our concern and this is played out in a moral way. When this occurs, health care professionals perceive the person to be different from themselves and understanding their perspective becomes difficult. Furthermore, because the person's actions are contrary to the norms of society, they become stigmatised both through the act of cutting and literally through the scars that demonstrate their difference. The person's identity is, therefore defined in terms of their self-injury.

In a clinical setting, the fact that the person who self-injures may be seen by the health care professional to be intrinsically different is important. They may find it difficult to feel empathy with the way the individual copes with their distress and this impacts on the development of an effective therapeutic relationship. This is not a criticism of health care professionals as this need to differentiate between "them and us" often operates at an unconscious level. The health care professional may want to help but finds it difficult to have empathy with the person who is in front of them, bleeding from wounds that they have inflicted upon themselves. They cannot understand why this has happened. This is illustrated by negative attitudes and prejudicial judgements about the person who has self-injured. Stereotypical

⁷⁰⁷ Rozien, P. (1999). The Process of Moralization. *Psychological Science*. Vol. 10. No. 3. P. 218-221.

⁷⁰⁸ Nussbaum, M" C. (2004) *Hiding from Humanity: Disgust, Shame, and the Law*. Princeton, NJ: Princeton University Press.

perceptions of people who self-injure are illustrated through the use of prejudicial language. People who self-injure may be described as manipulative or attention-seeking, just another “self-harmer.” The health care professional may inadvertently condemn both the action and the person, speaking disparagingly of the “behaviour” and the need for it to be “managed”. Even brief, everyday interactions, may send out these negative messages which impact on the development of any type of therapeutic relationship.⁷⁰⁹

Why do you treat me this way?; Is the title of Scanlon and Adlams paper, and that the way people who self-injure are treated needs to change, is part of Scanlon and Adlams argument. However, they see harm minimisation as part of the problem rather than a potential solution. It merely perpetuates this problem and fails to deal with the underlying therapeutic issues. In one sense, they are right to make this point, as the current treatment of people who self-injure is inadequate and empirical evidence would support this claim.⁷¹⁰ Furthermore, there is a deficit of psychological therapies available to people with mental health problems, and this includes those who self-injure. As a result, the focus of intervention is often based on the use of medication supported by efforts to contain the person’s behaviour. As we have seen, these measures are certainly restrictive and often perceived as coercive and intrusive. These measures are an adjunct to treatment and harm minimisation would also fall into this category. Where it differs is the overall ethos of the approach, which is not just about keeping the person safe, although this is important, what it also does is to promote a more positive therapeutic relationship than is possible when more restrictive interventions are used.

Although harm minimisation is part of a therapeutic process, and although it is not a therapeutic intervention in its own right, it is a means to such an intervention. Progress is dependent on a certain type of moral and clinical relationship. While an examination of the application of care ethics to the issues raised by self-injury is beyond the scope of the current paper there are elements of this ethical approach

⁷⁰⁹ Sue, D, W. (2010). Microaggressions, Marginality, and Oppression: An Introduction. In Wing Sue, D (ed) *Microaggressions and Marginality. Manifestation, Dynamics, and Impact*. New Jersey. John Wiley and Sons.

⁷¹⁰ Taylor et al (2009). Op.cit. n54.

that help us to consider the issues raised in a way that is helpful. It would be easy to adopt a principled approach to the ethical issues and develop a potentially unhelpful binary focused on the tension between autonomy and paternalism that pervades mental health care. Although this is important, it is more important to focus on the particularities of the situation and to consider what is right for the person. The right thing to do is what is right for the patient.⁷¹¹ The moral question thus becomes one of how we best meet our caring responsibilities based on a detailed knowledge and understanding of the situation.⁷¹²

In some cases, this will mean that harm minimisation becomes an option as it provides perhaps the only means of engaging the patient in a therapeutic process. In other cases, it may not be an option given the patient's particular needs, ability to engage in the process, and the risks involved. For example, where a person's autonomy is compromised, where their psychological distress has spiralled out of control and/or when self-injury is used as a form of self-punishment or suicide is considered a possibility then harm minimisation will not be an option. Where harm minimisation is an option, it is likely that it provides the only means by which we can engage with the person on his or her terms, by respecting the meaning that self-injury has for them and understanding that change is unlikely to occur without the active participation of the person who self-injures. By recognising the function, self-injury serves for the person and developing a therapeutic relationship on this basis, a range of therapeutic possibilities may become available.

Thus, harm minimisation is more than keeping the person safe, as there is more to the approach than this. Regardless of whether we are teaching people to cut themselves safely and in a sterile way, helping drug users to inject safely or supporting alcoholics to moderate their drinking, immediate safety is only a secondary objective (unless, as mentioned earlier, there was a significant imminent risk). The fundamental purpose of intervention is to help the person change. As McLeod and Sherwin⁷¹³ argue in describing their work with women who abuse drugs,

⁷¹¹ Manning, R. (2012). A Care Approach. In Kuhse, H. and Singer, P. (Ed). *A Companion to Bioethics*. London. Wiley-Blackwell. p. 113.

⁷¹² Verkerk, (1999). Op.cit. n167.

⁷¹³ McLeod and Sherwin, (2004). Op.cit. n245.

the therapeutic approach is always twofold, part of the work focusing on the problem area itself and the need to ensure the person is safe. The second part, however, is just as important and in McLeod and Sherwin's example, this involved making space available to work with the women on areas such as self-esteem and self-respect. Harm minimisation mirrors this process.

An approach to harm reduction that merely supported safer self-injury would be limited in its scope. Although it could be argued that safety in itself is a good thing, it is not enough. This is exactly what alternative and more traditional interventions are designed to do. Enabling harm without the long-term aim of reducing harm cannot be supported. A mere perpetuation of the status quo would raise obvious moral and clinical questions about the overall benefit and justifiability of the process. The approach has to be seen as a means to an end; otherwise, its very purpose is morally questionable. The harm allowed must be seen to support a greater good, and that good is the development of alternative coping strategies that will ultimately reduce and even stop the behaviour in question.

A focus on the act of self-injury and the process of allowing this to occur fails to take into account the overall context and the person's wider interests. The overall approach is a means of supporting an individual while essential treatment and therapy is fully undertaken. This should include a range of interventions that facilitate engagement in different types of therapeutic support. When viewed in the round, harm minimisation is far more sophisticated and complex than is often acknowledged. In promoting safer self-injury, the importance of the self-injury as a coping strategy is both accepted and respected. In addition, therapeutic work is undertaken to replace this means of coping with more appropriate strategies. Different treatment and therapeutic interventions will be used depending on the needs of the individual. If harm minimisation does not facilitate such work, and in some cases, it may not, then it cannot be considered as an option.

The ultimate aim is for self-injury to stop, but the rationale is about helping the person to stop not making them stop. The means of achieving this is through engaging the person in a therapeutic process that supports change and understanding. This is exactly what Scanlon and Adlam are promoting. Towards the

conclusion of their paper, they describe the use of reflective work with health care professionals to help them understand their relationship with the person in order to work therapeutically with the individual to understand their needs and to help them to change where this is required. Although counterintuitive, we give people razor blades not only because we think that on balance this is the safest thing to do but as it allows health care professionals to develop a therapeutic position from where it is possible to explore and help change the reasons for the actions that threaten the individual's safety.

7.8 Conclusion

Supporting people who self-injure is an important issue for health care professionals working in mental health care. Sometimes restrictions on a person's liberty and choice may be justified, and in other situations, it is not. There may be occasions when such restrictions are necessary to ensure that people who injure are kept safe. Using harm minimisation approaches in helping people who self-injure brings this tension into clear focus. In allowing someone to continue to harm him or herself moral and clinical questions are asked, and the approach is controversial.

This paper has considered a specific objection to harm minimisation, namely, that the health care professional collaborates in a process that cannot be justified on moral or clinical grounds. I have considered whether in allowing harm the health care professional is complicit in an action that is morally questionable, and as such morally blameworthy. Based on a consideration of the harms and benefits involved, it is argued that this argument fails. Harm minimisation offers a safe and proportionate means of providing support when set against the alternatives.

We have also seen that difficult questions can be asked about the approach from a therapeutic perspective. Is it merely means of colluding with the person who self-injures, as Scanlon and Adlam suggest, merely perpetuating a dysfunctional behaviour, and avoiding addressing important psychological issues in order to promote change. It has been proposed that it is something more therapeutically acceptable, a means to a positive therapeutic end. We have seen that it was accepted that an approach to harm minimisation focused only on safety would have

significant limitations. It was also accepted that harm minimisation is not a treatment in its own right. It must be supported by psychological interventions based on the needs of the individual. It was then proposed that the argument that the health care professional merely colludes with the person ultimately fails as it is based on a limited perception of harm minimisation and fails to consider the importance of therapeutic interventions that promote change and recovery.

Finally, let us finish with reference to the real experts in this matter. We must not forget that harm minimisation was adopted in this area of clinical practice, through the influence of people who have lived experience of self-injury. Their voice has challenged more traditional approaches that emphasise the prevention of self-injury. In responding to this challenge health professionals have had to try and enter the psychological world of those who self-injure and to respond on the basis of what they have come to understand about its purpose and meaning. In responding to what they have learned, they have tried to provide support in a way that is controversial and yet based on three underlying principles; safety, understanding and compassion. In the final analysis, we provide razor blades because we really do care enough to think about the person's welfare and their relationship with us.

Chapter 8: Epistemic Injustice: a concept with clinical implications.⁷¹⁴

8.1 Introduction

Self-injury is a complex phenomenon that is encountered on a regular basis by health care professionals in mental health care. In this paper, I will use the concept of epistemic injustice to examine this complex phenomenon and argue that this helps us to understand developments in the way we think about and support people who self-injure. Individuals with lived experience have important knowledge about the nature of self-injury and particularly how it relates to them. If the credibility of this knowledge is denied, for example through accusations of emotional instability, manipulation and attention-seeking, then we may cause epistemic and non-epistemic harms. The former by not accepting the validity of the individual's experience, and denying that an individual has the capacity for knowledge, and the latter by a failure to provide the help and support required. Thus, a failure to respect the individual who self-injures as a “knower” is harmful and it can have significant clinical implications.

I will propose that people who self-injure can be subject to both a testimonial and hermeneutical injustice. They experience the former when healthcare professionals fail to make proper use of the patient's expertise. They experience the latter when self-injury is seen purely in diagnostic terms as a symptom of mental disorder. This fails to provide an appropriate framework for explaining the phenomena in terms the patient recognises. This limits the articulation of different perspectives, due to the language used and the dominance of objective evidence and diagnostic criteria over subjective accounts based on personal experience. I will demonstrate that where the epistemic position of individuals who self-injure is recognised, attitudes to self-injury change and this can have a positive impact on clinical care. I argue that individuals who self-injure are still prone to epistemic injustices, and these will be described, however, by taking seriously the testimonies of such individuals there have been improvements in the care provided. We must, however, be vigilant to the possibility of such injustices to continue to make advances in care.

⁷¹⁴ Sullivan(forthcoming). Op.cit. n618.

The paper will be organised in the following way. I will begin with some preliminary comments about self-injury and then go on to describe the concept of epistemic injustice as elucidated by Fricker.⁷¹⁵ She distinguishes between testimonial and hermeneutical injustice. I will then show how the concept of epistemic injustice can be applied to health care generally and mental health care specifically. I will then apply the concepts of testimonial and epistemic injustice to the problem of self-injury and demonstrate two things. First, how a failure to understand the meaning of self-injury for the individual has negative clinical implications. Second, how when approached in a certain way, the act of self-injury can be understood differently, and this has positive therapeutic implications.

I illustrate my argument by showing how people with lived experience of self-injury, have been able to contribute to the creation of new knowledge and the development of a different language with which to describe self-injury. This has promoted a different way of understanding self-injury and influenced the development of more innovative and less restrictive ways of working. I will show, using the adoption of harm minimisation techniques as an example, how this occurred when health care professionals, frustrated with traditional ways of dealing with self-injury, often involving futile attempts to try and stop it happening, adopted a range of harm minimisation techniques in both in-patient and community settings. Although these techniques remain controversial, they have contributed to changes in the way that professionals think about self-injury and continue to influence clinical practice.

These developments illustrate how the unique forms of knowledge available to people with lived experience of self-injury, have influenced the testimonial sensibilities of health professionals and help develop a range of different hermeneutical resources. Attention to the epistemic status of individuals, who self-injure, is a corrective to past epistemic injustice as well as a way to facilitate better care. It is a form of epistemic justice. I do however conclude with a cautionary note.

⁷¹⁵ Fricker (2007). Op.cit. n351.

8.2 What is Self-injury?

Although it is difficult to be clear about the exact prevalence of different forms of self-injury, there is no doubt that self-Injury is a significant clinical issue.⁷¹⁶ Estimates vary but in the general population it appears to be between 1% and 6%,⁷¹⁷ and in mental health in-patient units the rates are much higher.⁷¹⁸ Self-injury is a term that can cover a variety of actions and it is therefore important to be clear about exactly what is being considered. In this paper, I am referring to what the International Society for the Study of Self-injury ⁷¹⁹ describes as “the deliberate, direct, and self-inflicted destruction of body tissue resulting in immediate tissue damage, for purposes not socially sanctioned and without suicidal intent.” This behaviour has been defined in psychiatric terms through the application of the concept of Non-Suicidal Self-injury (NSSI). In the most recent Diagnostic and Statistical Manual of Mental disorders, NSSI is recognised as a diagnostic condition in its own right, listed in Part 111 as an emerging condition that requires further study. This type of behaviour can be contrasted with a suicide attempt where the injury is inflicted with the intention to die, or a suicide gesture where the act is undertaken to lead others to believe that their intention is to make a suicide attempt. ⁷²⁰

There is no well-established treatment that is empirically supported and as a consequence intervention tends to be eclectic.⁷²¹ What is clear, however, is that many people are concerned about the help provided. A systematic review of the literature demonstrates that many people who have received health care services in relation to problems associated with self-injury were negative about the help they received.⁷²² Moreover, in spite of the introduction of clinical guidelines associated with self-injury in 2004,⁷²³ a study of general hospital services in 2013 found services to be variable and the results to be similar to findings obtained ten years earlier.⁷²⁴

⁷¹⁶ Brown and Kimball, (2013). Op.cit. n10. p. 195.

⁷¹⁷ Klonsky, (2011). Op.cit.n25.

⁷¹⁸ James et al. (2012). n174.

⁷¹⁹ International Society for the Study of Self-Injury (2007). Op.cit. n26.

⁷²⁰ Nock, (2008). Op.cit. n670.

⁷²¹ National Collaborating Centre for Mental Health (2004). Op.cit. n4; National Collaborating Centre for Mental Health (2012). Op.cit. n4.

⁷²² Taylor et al. (2009). Op.cit. n54.

⁷²³ National Collaborating Centre for Mental Health. (2004). Op.cit. n4.

⁷²⁴ Cooper, J. Steeg, S. Bennewith, O. Lowe, M. Gunnell, D. House, A. Hawton, K. Kapur, N. (2013). Are hospital services for self-harm getting better? An observational study examining management,

Although these results do not relate to mental health services directly, there are indications that the situation may be similar. For example, the Care Quality Commission has reported that the routine use of restrictive practices remains a problem across in-patient units and although this is a general comment it will impact on people admitted to such units who self-injure.⁷²⁵ Recent research continues to note how individuals with experience of self-injury continue to advocate for better treatment and draw attention to what they perceive as abusive and regressive treatment approaches.⁷²⁶

8.3 What is epistemic injustice?

Epistemology is concerned with how knowledge is created developed and understood. Without knowledge, we cannot interact with others or interpret and communicate our experience of the world. It has an integral relationship with our rationality and contributes to our sense of identity. The capacity to provide information to others and our ability to interpret our experiences is an integral part of our capacity for autonomy.⁷²⁷ The concept of epistemic injustice derives from this approach to philosophy and is associated with the work of Miranda Fricker.⁷²⁸

In her work, Fricker (2007) differentiates between two forms of epistemic injustice; testimonial injustice and hermeneutical injustice. By the former, she means that a person's credibility to convey and make sense of their social experiences is challenged or just not heard by others. The speaker receives a deflated degree of credibility from the hearer due to prejudice on the hearers part.⁷²⁹ This threatens the persons capacity as a "knower". The central case of testimonial injustice is what Fricker⁷³⁰ terms "identity prejudice credibility deficit." This refers to a disparaging

service provision and temporal trends in England. *British Medical Journal Open* 2013;3:e003444. Doi:10.1136/bmjopen-2013-003444.

⁷²⁵ Care Quality Commission (2019). Op.cit. n47.

⁷²⁶ Chandler (2016). Op.cit. n48.

⁷²⁷ Kidd and Carel, (2017). Op.cit. n362.

⁷²⁸ Fricker, (2007). Op.cit. n351.

⁷²⁹ Ibid. p. 69.

⁷³⁰ Ibid. p. 28.

association between a social group and certain attributes that are connected to what Fricker calls an ethically objectionable investment such as disdain for a particular social grouping.⁷³¹ This prejudice causes the hearer to give a deflated level of credibility to the speaker's world. This failure to believe peoples testimony puts the person at a systematic disadvantage in relation to those who do not experience such deficits in credibility. These prejudices operate through the application of stereotypes and Fricker has illustrated this process by reference to the failure of a police officer to believe the testimony of a young black man who says that he owns the car that he is driving.⁷³²

By hermeneutical injustice, Fricker is making reference to particular groups of people, whose capacity to interpret their experiences is inhibited by a social structure and prejudice that makes this impossible.⁷³³ She talks of significant areas of social experience being obscured from collective understanding as a result of structural identity prejudice. This type of injustice is dependent upon what Fricker terms hermeneutical marginalisation. By this, she means that the person belongs to a group who do not have access to participation in the generation of social meaning. Members of this group are disadvantaged as they are not able to make their experiences intelligible to others or in some cases themselves. Fricker uses the example of sexual harassment to make the point. In the past women were not heard when they voiced their concerns about acts of sexual harassment and part of the reason was that society had no conceptual framework to understand these behaviours until it was named and became part of our social understandings. Women who suffered from postnatal depression were subject to a similar injustice for the same reasons.⁷³⁴ This is an example of what Carel and Kidd⁷³⁵ describe as an agency-based hermeneutical injustice. Some Individuals, in this case, women with postnatal depression, were prevented from participating in meaning-making practice as the resources required to understand the woman's experience was not part of the dominant hermeneutical resource.

⁷³¹ Carel and Kidd, (2014). Op.cit. n362.

⁷³² Fricker, M. (2013). Epistemic Injustice as a condition of political Freedom. *Synthese*. Vol.190. No.7. p. 1319.

⁷³³ Fricker, (2007). Op.cit. n351.

⁷³⁴ Ibid.

⁷³⁵ Carel and Kidd, (2017). Op.cit. n362.p. 371.

The relationship between testimonial and hermeneutical injustice is complex and differentiating between the two can be difficult. There is a subtle interrelationship between the two concepts as the interaction between the individual and the social structures in which they function are complex and multi-layered. For example, Maitra⁷³⁶ argues that the experience of injustice often results from a combination of both structural and identity prejudice, while Medina⁷³⁷ goes as far as to argue that it is not possible to have testimonial injustice without the presence of hermeneutical injustice. A full description of these issues is beyond the scope of the current paper. The crucial issue, however, is that, where testimonial or hermeneutical injustice occur they result in real harm.

The capacity for knowledge is part of the capacity for reason. Thus, wronging someone as a giver of knowledge by perpetrating a testimonial injustice is wronging the person as a knower, a reasoner, a human being.⁷³⁸ By interfering with our rationality, our identity and capacity for agency is affected. It, therefore, constitutes “a source of deep harm.”⁷³⁹ In these circumstances, the very autonomy of the individual is challenged, as they are deemed unsuitable for epistemic activity. They cannot contribute to the production of knowledge, as their perspective is not valid. Closely linked are the harms associated with hermeneutical injustice, which denies the individual the capacity to express him or herself, and this is important, as it is a basic human capacity. A hermeneutical injustice can, argues Fricker, be so damaging that it impedes the development of the self.⁷⁴⁰

8.4 Epistemic injustice and healthcare

It has been argued that epistemic injustice is likely to occur in a health care context. For example, Carel and Kidd⁷⁴¹ propose that a testimonial injustice is a strong

⁷³⁶ Maitra, (2010). Op.cit. n370.
p. 10.

⁷³⁷ Medina, (2011). Op.cit. n372.

⁷³⁸ Fricker, (2007). Op.cit. n351.p. 44

⁷³⁹ Carel & Kidd, (2014). Op.cit. n362.

⁷⁴⁰ Fricker, (2007). Op.cit. n351. p. 163.

⁷⁴¹ Carel & Kidd, (2014). Op.cit. n362.

possibility due to the impact of illness on a persons cognitive, emotional and existential functioning. Illness or emotional distress may interfere with our ability to interpret our experiences and to provide information to others. This may result in a testimonial injustice as the professional may not hear the information the patient is trying to convey, and this may have an impact on the care they receive.

A hermeneutical injustice may also occur as the modern healthcare system is structured in a way that may promote ways of thinking that can exclude the patient's perspective. This is because in any interaction, the health care professional and the patient operate using different types and levels of knowledge. Carel and Kidd⁷⁴² make this point when they argue that certain types of evidence and forms of communication are privileged. The example they use is that empirical data is preferred to anecdotal information and therefore privileges certain forms of testimony. The process of evidence-based medicine appears to see the patients account of illness as subjective and unreliable.⁷⁴³ This may leave the patient without the hermeneutical resources to express their perspective, and as a result, their views may be marginalised.

Epistemic injustice has been considered to be a relevant concept for examining health care and the process of medicalisation.⁷⁴⁴ Moreover, testimonial and hermeneutical injustices have been reported in various areas of health care including; chronic fatigue syndrome, midwifery and chronic pain.⁷⁴⁵ It appears to be a particular issue in mental health care.

8.5 Epistemic Injustice and mental health care

It has been argued that epistemic injustice is more likely to occur in the context of mental health care.⁷⁴⁶ There is no doubt that in a mental health care context, there is

⁷⁴² Ibid.

⁷⁴³ Chandler, (2016). Op.cit. n48. p.104.

⁷⁴⁴ Carel, H. H. & Kidd, I. J. (2014). Op.cit.n362; Ho, A. and Unger, D. (2015). Op.cit. n362; Wardrope, A. (2015). Op.cit. n362; Carel, and Kidd (2017). Op.cit. n362p. 371.

⁷⁴⁵ Freeman, (2014) n363; Buchman et al. (2016). n363; Bleaze et al. (2016). n363.

⁷⁴⁶ Sanati and Kyratsous (2015). Op.cit. n364; Kyratsous and Sanati, (2017). n364; Carver et al. (2016). Op.cit. n364; Crichton, et al (2013). Op.cit. n364.; Scrutton (2017). Op.cit. n364; Kurs, R. and

ongoing tension between respecting the patient's autonomy and acting beneficently. This can, on occasions, result in paternalistic or even coercive forms of intervention. The power dynamic between the patient and the health care professional provides a context in which epistemic injustice can flourish. What is more important, however, is the presence of negative attitudes towards people with mental health problems, which makes negative stereotypes resistant to alternative evidence.⁷⁴⁷

There is always a danger that in this situation, the perspectives of those individuals who experience mental disorder may be questioned. Their status as a "knower" is challenged, and their views may be deemed irrational and not worthy of serious consideration as they are merely a reflection of an underlying mental disorder. Furthermore, their capacity to make decisions about their care and treatment may be questioned based on the presence of a mental disorder. There is a risk that the view of the patient is seen to lack credibility, and the healthcare professional is able to impose a specific understanding of the individual's problems associated with their psychiatric diagnosis. The individual, may struggle to recognise this understanding or the reasoning on which it is based, and the language used may not be seen as helpful. The worst-case scenario is one in which the individual is treated as if they lack full epistemic capacity and some form of epistemic injustice is therefore almost inevitable.

In some circumstances, psychiatric diagnosis may come to colour all facets of a patient's life⁷⁴⁸ and thus impact on a person's identity. Where this is considered in the context of negative social attitudes towards mental illness, then the individual is potentially subject to a deeply embedded form of discrimination.⁷⁴⁹ This has important implications, and Ho⁷⁵⁰ has made the point that the health care professional may fail to acknowledge that the person's choices should be respected and goes on to cite Raddon,⁷⁵¹ who amongst others, has argued that the views of

Grinshpoon, A. (2018). Op.cit. n364.

⁷⁴⁷ Crichton et al. (2013). Op.cit. n364. p.11.

⁷⁴⁸ Sanati and Kyratsous (2015). Op.cit. n364. p. 481.

⁷⁴⁹ Leblanc, and Kinsella, (2016). Op.cit. n386. p. 61.

⁷⁵⁰ Ho, A. (2014). Epistemic Injustice. In Jennings, B. (ed). *Encyclopedia of Bioethics*, 4th Edition. New York: Macmillan.

⁷⁵¹ Radden, J. (2012). "Recognition Rights, Mental Health Consumers, and Reconstructive Cultural Semantics." *Philosophy, Ethics, and Humanities in Medicine*. Vol.7. No.6. <http://www.peh->

such individuals have been dismissed as meaningless. Often a person's testimony is perceived to be irrational and indicative of a lack of capacity rather than what they say being representative of their underlying desires and beliefs, albeit that these desires and beliefs may not always correspond with what others would perceive as the norm.

Thus, individuals who have a mental illness or behave in ways that are associated with mental illness, and people who self-injure would fall into this group, are subject to various forms of prejudice that lead to a complex and yet pervasive experience of injustice generally and epistemic in particular. First, the power imbalance between the professional and the patient may result in differentials in the credibility attributed to their testimony. Second, the stigma associated with mental illness creates stereotypes and prejudices that affect the way that society and professionals interpret mental illness. This can challenge an individual's status as a provider of knowledge. Finally, it is important to make some mention of the complex interaction between gender and mental disorder.⁷⁵²

There is no doubt that more women than men are diagnosed with certain forms of mental disorder,⁷⁵³ and this may reflect a societal propensity to diagnose more women than men with a mental illness, a feature particularly noticeable in some disorders, borderline personality disorder being the most prominent example.⁷⁵⁴ Prejudice, stereotypes and discrimination are often a feature of many women's lives and as we shall see they are important in the context of self-injury.

In considering this complex web of injustice, one is reminded of Perlin's⁷⁵⁵ argument that people with mental health problems are subject to a form of 'sanism', which he compares with other forms of discrimination such as racism and sexism. This is an irrational but socially prevalent prejudice that is directed at people with mental health problems. It is associated with stigma and negative stereotypes that are often

med.com/content/7/1/6

⁷⁵² Appignanesi, L. (2008). *Mad, Bad and Sad. A history of women and the mind doctors from 1800 to the present*. London: Virago Press.

⁷⁵³ MacManus et al. (2016). Op.cit. n8.

⁷⁵⁴ Skodol, A.E. and Bender, D.S. (2003). Why are more women diagnosed borderline more than men? *Psychiatric Quarterly*. Vol.74. No.4. p 349-60.

⁷⁵⁵ Perlin, M.L. (1993). On Sanism. *SMU Law Review*. Vol. 46. No. 2. 373-407.

unnoticed or unacknowledged. These forms of prejudice, I will argue, are exacerbated in the case of individuals who self-injure, and it is to this issue that we now turn.

8.6 Are people who self-injure subject to a Testimonial injustice?

A person who self-injures is subject to a testimonial injustice when the health care professional does not perceive the patient's perspective as credible. In doing so, they fail to recognise and/or use the reflective expertise of the person who self-injures, an expertise based on lived experience.⁷⁵⁶ There is some evidence that this has and does occur. In her study of self-injury, Shaverin⁷⁵⁷ uses the narratives of people who self-injure to demonstrate how responses to their actions often left them feeling insecure, invalidated or invisible. This resonates with the view of Harrison⁷⁵⁸ expressed some fifteen years before, who argues that self-injury was the only defence she had, a way of expressing herself because she felt something had been taken away from her and that she had been "silenced." This view was expressed in the context of being contracted to stop cutting and a feeling that her distress was being dismissed. As we shall see this is a common narrative in the literature on self-injury.

In these situations, negative stereotypes may be triggered, and these produce negative epistemic prejudices.⁷⁵⁹ For instance, the speaker may be afforded reduced credibility based on their identity as a "cutter", or as someone who is "just" attention-seeking and manipulative.⁷⁶⁰ Negative stereotypes pervade attitudes to self-injury and understandings of the phenomena often fail to get beyond these stigmatising images. What Tantam and Hubbard⁷⁶¹ term "slighting and alienating language" is

⁷⁵⁶ Fricker, (2017). Op.cit. n355.p. 58.

⁷⁵⁷ Shaverin, L. (2012). *Written in Scars: Stories of Recovery from Self-Harm*. Thesis submitted in partial fulfilment of the requirements of the Doctorate in Clinical Psychology. Hatfield: University of Hertfordshire. p. 48.

⁷⁵⁸ Harrison, D. (1997). Cutting the ties. *Feminism and Psychology*. Vol. 7. p.439.

⁷⁵⁹ Carel and Kidd, (2014). Op.cit. n362.

⁷⁶⁰ Epstein, M. (2006). The Emperors New Clothes: On being invisible and neglected within the mental health system - A gendered perspective from a "Borderline Pioneer". *Keynote address THEMHS conference*: Townsville 2006.

⁷⁶¹ Tantam, D. and Huband, N. (2009). *Understanding Repeated Self-Injury. A Multidisciplinary*

common and may provoke judgmental responses. Furthermore, there is no doubt that gender stereotypes are often linked to perceptions of self-injury and many of the individual's accused of being attention-seeking and manipulative are women. As Shaw⁷⁶² notes the clinical literature on self-injury reproduces a number of distorting perceptions about what facilitates the emergence of self-injury, and these are closely related to issues of gender.

Where a person's actions are dismissed as irrational, manipulative or attention seeking then their testimony is also dismissed, their explanation for their actions is not accepted and with it their experience as a knower. The individual does not hurt themselves because of their emotional distress but in order to manipulate others or to gain attention. The perspective that these actions represent a means of coping rather than of controlling others is dismissed, and the real reasons for their actions are therefore not trusted. Descriptive terms like cutter are instantly pejorative and understanding the person's actions as manipulative or attention seeking instantly reflects negative stereotypes with clinical and moral implications. It is not difficult to see how such perceptions are associated with secondary harms such as poor medical treatment, restrictions on freedom and the use of coercion. For example, people who self-injure and go to Accident and Emergency as a result of their injuries may receive a more negative approach than someone who is perceived to be in genuine need through accident or unforeseen illness.⁷⁶³

We see this process illustrated within a mental health in-patient environment where self-injury is, as we have seen, a common occurrence. In such a setting traditional models of intervention were based on stopping the behaviour. This focus on prevention can be characterised by concerted efforts to prevent the individual from acting in this way. This may include continuous observation, personal searches and the removal of implements that may be potentially harmful.⁷⁶⁴ It is important to be clear that these types of intervention may sometimes be required. As a means of

Approach. London: Palgrave Macmillan.p.x.

⁷⁶² Shaw, S.N. (2002). Shifting conversations on girls' and women's self-injury: An analysis of the clinical literature in historical context. *Feminism and Psychology*. Vol.12. No. 2. 191-219.

⁷⁶³Jeffrey, R. (1979). Normal rubbish: deviant patients in casualty departments. *Sociology of Health and Illness*, Vol.1. No.1. p. 90-107.

⁷⁶⁴ Morrissey et al (2018). Op.cit. n45.

suicide prevention, they may be proportionate and necessary. If used outside these parameters, they may be overly restrictive and unfortunately, when used with individuals who self-injure without suicidal intent, these interventions may fail and have two negative outcomes. First, self-injury may not be prevented and may lead to increased efforts to self-injure using increasingly risky methods. Second, the nature of these interventions may contribute to a sense of alienation and a negative impact on the therapeutic relationship.⁷⁶⁵

It is important at this point to be clear that my analysis is not intended to be a direct criticism of health care professionals. Many healthcare professionals work to develop positive therapeutic relationships that result in positive clinical outcomes. There are, however, very real epistemic reasons that may impact on their ability to provide adequate support to patients who self-injure. The argument goes beyond the personal qualities of the health professional involved. The underlying reason why this occurs is based on the way that mental health care is structured and the social context in which it operates. This brings us to the question of hermeneutical injustice.

8.7 Do people who self-injure experience a Hermeneutical Injustice?

A hermeneutical injustice obscures from understanding some significant realm of social experience in a way that disadvantages a marginalised group. In the case of people who self-injure this occurs due to the way that their actions are understood in a clinical environment. In this context, self-injury is understood in terms of mental disorder and suicide risk. Mental health professionals constantly make judgments in terms of the normality and abnormality of the behaviours they deal with and the level of risk that these behaviours pose. The interpretative framework they use operates using a diagnostic classification and a focus on risk to self and others. This forms part of a broader framework relating to what society defines as normal or otherwise.⁷⁶⁶

⁷⁶⁵ Sullivan, (2017). Op.cit. n71.

⁷⁶⁶ Leblanc and Kinsella, (2016). Op.cit. n386. p. 63.

It is important to note that understanding self-injury in terms of psychiatric psychopathology and suicide risk may be helpful. First, for some people understanding their distress in diagnostic terms may illuminate a person's difficulties and assist in their resolution.⁷⁶⁷ Second, if a person is suicidal, then such a process can be life-saving. The problem is that some people who self-injure would suggest that the process of diagnosis is unhelpful and leaves them without any adequate means of expressing the reality of their distress.

The psychologist, Johnstone,⁷⁶⁸ has made the point that the language used to describe the individual's actions may, "confine the patient to the level of his or her symptoms" and define the problem purely in terms of pathology. In a more recent analysis, Chandler⁷⁶⁹ has made a similar argument based on her interviews with people who have lived experience of self-injury. She argues that many of the people she interviewed described their actions in terms of a rational, if not successful, response to problematic emotions and situations and the act of self-injury allowed them to increase control over uncontrollable feelings. The difficulty is that interpreting self-injury purely as a symptom of mental disorder may obscure from understanding these important elements of the patient perspective. This is because objective accounts based on clinical assessments may fail to appreciate the more subtle messages provided by first-person accounts.⁷⁷⁰ As we shall see, the person who self-injures may have difficulties in articulating their perspective in a way that differs from traditional biomedical constructions of self-injury. This means the individual may find it difficult to describe their pain and distress in a way that the professional may understand.

This phenomenon is illustrated from a real example based on a person's experience in a mental health setting, and although the person's difficulties were not related to self-injury, their experience remains relevant. Steslaw⁷⁷¹ has argued that mental

⁷⁶⁷ Wardrope, (2015). Op.cit. n362.

⁷⁶⁸ Johnstone, L. (1997). Self-Injury and the Psychiatric Response. *Feminism and Psychology*. Vol.7. No. 3. p.422.

⁷⁶⁹ Chandler, (2016). Op.cit. n48.p. 454.

⁷⁷⁰ Carel and Kidd, (2014). Op.cit. n362; Aultman, B.L. (2016). Epistemic Injustice and the construction of Transgender legal subjects. *Wagadu: A Journal of Transnational Women's and Gender Studies. Special issue epistemic injustice in practice*. Vol. 15. p12-34.

⁷⁷¹ Steslaw, K. (2010). Metaphors in our mouths. Silencing of the Psychiatric Patient. *Hastings Center Report*. Vol. 40. No. 4. p.30.

health care is slow to turn its reflective gaze on its own descriptive practices, particularly in terms of how they judge their own descriptions of the patient's experiences as more accurate than that of the patient. She talks of being "unheard" and describes being cut off from meaningful conversation by "the veil of my diagnosis." She argues that "there was a clear and distinctive vocabulary being used to talk about my experience and the vocabulary was not mine" and notes "the distinct feeling of being unheard. Everything I said or did was taken to be a production of my illness and categorised accordingly." Steslaw goes on to describe how she was seen to make progress as she began to talk about her difficulties in relation to her diagnosis. Her analysis is not uniformly critical of the focus on diagnosis; in fact, she argues they provide a provisional truth that provides a framework for understanding. In doing so, it serves a therapeutic purpose, but unfortunately, it can provide only a partial picture of reality.

It could be objected here, that whether Steslaw experienced a form of epistemic injustice is open to debate, given her ability to clearly articulate her position, albeit following recovery. Her account could, in fact, be best described in terms of her experiences been discounted, rather than her not having the language to describe them. What she describes, however, is relevant to my argument. She draws attention to important differences in knowledge between the patient and the professional, and these differences are marked by power dynamics and dependency relationships that make individuals susceptible to epistemic injustice.⁷⁷² She describes a situation where individuals may lack the relevant hermeneutical resources to engage in a dialogue based on equal terms. As Buchanan et al⁷⁷³ have argued, health care institutions and practices privilege some forms of evidence and ways of knowing while excluding others, such as patient experience from consideration. For example, during the development of the NICE guidance on self-injury, the experts by experience involved in the process resigned from the clinical development group associated with this guidance. This appears to have been the result of disagreements over the validity of evidence associated with personal testimonies.⁷⁷⁴

⁷⁷² Carel and Kidd, (2017). Op.cit. n362.

⁷⁷³ Buchanan et al. (2016). Op.cit. n362.

⁷⁷⁴ Spandler, H. and Warner, S. Introduction. In Spandler, and Warner, (eds). Op.cit.n176. p. xiii.

In Fricker's terms, the health care professional is epistemically privileged,⁷⁷⁵ and the structure of the mental health system provides limited hermeneutical resources for individuals to make sense of their situation and to be seen as "knowing subjects in their own right."⁷⁷⁶ They are subject to a form of hermeneutical marginalisation and as a result, disadvantaged. Epistemic and non-epistemic harms are experienced by individuals who are not treated as equal participants in the development of knowledge.⁷⁷⁷ This has important clinical implications as it may alienate the relationship between the professional and the patient.⁷⁷⁸ Let me illustrate my point with an example.

8.8 Clinical implications

Many people who self-injure often receive the diagnosis of borderline personality disorder, a diagnosis that is controversial due to concerns about its validity and moral impact. As Aviram et al have argued,⁷⁷⁹ this diagnosis is often viewed in negative terms by mental health professionals and may have a stigma associated with it that goes beyond those associated with other forms of mental disorder. Moreover, it has been argued that diagnoses such as personality disorder make use of moral concepts and value-laden terms as part of the classification process. Charland⁷⁸⁰ for example draws attention to the Cluster B criteria, that forms part of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and shows how these are morally laden and goes as far as to argue that they are, in fact, moral conditions. Although Charland's work has been subject to challenge,⁷⁸¹ there is certainly evidence that the stigma associated with borderline personality disorder may have a negative impact on how health professionals tolerate the actions of such individuals and these may be perceived in stereotypical terms.⁷⁸² Furthermore,

⁷⁷⁵ Fricker, (2007). Op.cit. n351.

⁷⁷⁶ Kalman, H. Lövgren, V. and Sauer, L. (2016). Epistemic Injustice and conditioned experience: The case of intellectual disability. *Wagadu: A Journal of Transnational Women's and Gender Studies. Special issue. Epistemic injustice in practice*. Vol.15. p.63-81.

⁷⁷⁷ Carel and Kidd, (2017). Op.cit. n362.

⁷⁷⁸ Potter, (2006). Op.cit. n753.

⁷⁷⁹ Aviram, R.B. Brodsky, B.S. Stanley, B. (2006). Borderline Personality disorder, stigma, and treatment implications. *Harvard Review of Psychiatry*, Vol.14. No. 5. p.249-256.

⁷⁸⁰ Charland, L.C. (2006). Moral Nature of Personality Disorders. *Journal of Personality Disorders*. Vol. 20. No. 2. p.116–125.

⁷⁸¹ Zachar, P. and Potter, N.N. (2010). Personality disorders: Moral or Medical Kinds or Both. *Philosophy, Psychiatry and Psychology*. Vol.17. No. 2. p 101-117.

⁷⁸² Lewis, G. and Appleby, L. (1988). Personality disorder: the patient's psychiatrists dislike. *The British Journal of Psychiatry*, 153(1), 44-49; Aviram, et al (2006). Op.cit.780.

people with such a diagnosis report experiencing discrimination, particularly when the diagnosis is associated with self-injury.⁷⁸³

This does not only occur in relation to self-injury, for example, Epstein⁷⁸⁴ and O'Hagan⁷⁸⁵ describe reading their clinical records and describe not only how their distress is reinterpreted in terms of the psychopathology associated with their particular diagnosis, but also how their actions are seen in moral terms. They found documented judgments about the appropriateness or otherwise of their actions and the use of pejorative terms to describe such actions. For example, Epstein describes being “vilified with inflammatory, inaccurate, and at times perniciously judgmental assessments of my integrity.”⁷⁸⁶ O'Hagan notes the shock of reading her notes and the use of terms such as “inappropriate” and “overdramatic”, terms that for her demonstrate a lack of empathy and understanding.⁷⁸⁷ In her memoir, O'Hagan describes how she compared her clinical notes with the journal she kept while in hospital. This comparison she describes in terms of “Two Accounts of Mental distress” in order to emphasise the contrast between the two.

This situation certainly resonates with the experiences of people who self-injure. In the context of self-injury, Shaw⁷⁸⁸ notes that as an in-patient in a mental health unit, her ideas were viewed as an invalid source of knowledge or insight. She talks explicitly about how she felt marginalised in terms of how knowledge was constructed and makes the point there “are fewer more effective ways of devaluing someone’s account of reality than by calling it ‘mad.’” An important source of knowledge regarding self-injury is, therefore closed to the health care professional. If a person’s actions are interpreted in a prejudicial way, seen for example as a means of manipulation or attention seeking, then this has important therapeutic implications that will inhibit the ability to provide effective services for individuals who act in this way. Most importantly, there may be a failure to appreciate the underlying reasons for the person’s actions, and this is something that health professionals need to

⁷⁸³ Veysey, S. (2014). People with a borderline personality disorder diagnosis describe discriminatory experiences. *Kotuiti: New Zealand Journal of Social Sciences Online*. Vol. 9. No. 1.p.20-35.

⁷⁸⁴ Epstein (2006). Op.cit.n761.

⁷⁸⁵ O'Hagan, M. (2014). *Madness Made Me. A Memoir*. Wellington: Open Box.

⁷⁸⁶ Epstein (2006). Op.cit.n761. p. 9.

⁷⁸⁷ O'Hagan (2014). Op.cit. n786. p.180.

⁷⁸⁸ Shaw, C. (2016). Telling Stories. *Philosophy, Psychiatry and Psychology*. Vol. 23. No.314. p. 27.

explore in some detail. The individual's experience of this phenomenon cannot always be seen just in terms of pathology. There may be more to it than this, and real change is not possible until any underlying issues can be resolved.

In other areas of mental health care, this has been challenged. For example, many people who hear voices have questioned the clinical perception of their experiences and argued for a different interpretation based on the meaning it has for them and how it constitutes an important part of their identity.⁷⁸⁹ They define their experience differently and reject the use of knowledge, particularly scientific knowledge, to describe these unique experiences.⁷⁹⁰ Similar developments can be observed in approaches to self-injury. As Millard⁷⁹¹ points out, in the latter part of the twentieth-century views about self-injury began to change, and it is my contention that some of this change was due to the influence of people with lived experience of self-injury. They helped change the way self-injury was understood and in doing so, influenced changes in the way that services were provided. These developments can be interpreted in epistemic terms.

8.9 A different voice

In developing this part of my analysis, I am indebted to the work of Cresswell who has described these developments in some detail although from a different perspective.⁷⁹² I draw heavily on this work in the section that follows. He describes how during, the latter part of the twentieth century, the views of people with lived experience of self-injury began to contribute to a professional debate based on increasing concern regarding self-injury. A number of individuals, predominantly women, began to describe their experiences of self-injury and to be critical of how mainstream mental health services responded to their difficulties. Like other marginalised groups, they developed their own conceptual resources for

⁷⁸⁹ Woods, A. (2015). Voices, identity, and meaning-making. *The Lancet*. Vol. 386. p. 2386-2387.

⁷⁹⁰ Woods, A. (2013). The voice hearer. *Journal of Mental Health*. Vol. 22. No. 3. p. 263-270.

⁷⁹¹ Millard, C. (2015). *A History of Self-Harm in Britain. A Genealogy of Cutting and Overdosing*. Basingstoke. Palgrave Macmillan.

⁷⁹² Cresswell,(2005a). Op.cit. n51; Cresswell,(2005b). Op.cit. n53; Cresswell, M. and Brock, T. (2017). Social movements, historical absence and the problematization of self-harm in the UK, 1980-2000. *Journal of Critical Realism*, Vol.16. no. 1. p. 7-25.

understanding their experiences.⁷⁹³ They used their unique knowledge to provide a critical response to a purely clinical model of self-injury, which defined their problems in terms of diagnostic categories. Moreover, they described how they felt they had been silenced. Their views, they argued, were ignored or not intelligible to healthcare professionals. They described a care system that they felt had let them down and developed a dialogue with health professionals about better ways of responding to their needs.

This dialogue allowed the experiences of individuals with lived experience of self-injury to influence clinical practice. Shaw⁷⁹⁴ describes how such a process works. She recounts how she developed the belief that her experiences were not only a valid source of knowledge but also provided a unique insight into the issues at hand. She reflects on how her narrative became a resource for asserting her agency and for bringing about social change. These developments can be interpreted in epistemic terms. We see how individuals with lived experience of self-injury became credible participants in the process of knowledge construction and helped bring about changes in the epistemic practices that formed part of the thinking of health care professionals. Their perspective and participation then helped to inform clinical practice.

This process can be interpreted using the concept of epistemic resistance as developed by Medina.⁷⁹⁵ He has argued that where people experience oppressive structures, they develop a “subversive lucidity.” This results in clarity of thought about what is happening that can only be available to those who experience it. This brings with it the potential to question assumptions and prejudices and to develop different forms of knowledge. People with lived experience of self-injury were, therefore, able to make use of their own epistemic resources and abilities, to undermine what they perceived to be oppressive normative structures and to develop a very different perspective on how services function and could function.

⁷⁹³ Anderson, L. (2017). Epistemic Injustice and the philosophy of race. In Kidd, I.J. Medina, J. Pohlhaus jr. (eds). *The Routledge Handbook of Epistemic Injustice*. London: Routledge. Chapter 12. p. 216.

⁷⁹⁴ Shaw (2016). Op.cit. n789. p. 278.

⁷⁹⁵ Medina (2013). Op.cit. n371.

This critique had a number of different elements. First, they argued that the meaning of their actions was effectively ignored and as such, invalidated. This resulted in a vicious circle whereby power and control was removed from the person who self-injured and for some this process of invalidation recreated the very circumstances that produced their self-injury in the first place.⁷⁹⁶ Second, the concept of “deliberate self-harm” was rearticulated as a manifestation of distress and a means of coping with distress. The use of the term deliberate was criticised as pejorative, and it was argued that in some cases self-injury might have a positive function that was not necessarily linked to suicide. Third, the understanding of self-injury in terms of mental illness was challenged. For example, Ross argued⁷⁹⁷ that self-injury is “rarely a symptom of so-called psychiatric illness, it’s not a suicide attempt...so what is it? It’s a silent scream...it’s a visual manifestation of extreme distress.” It was argued that there was a need to understand the complexity of self-injury, its relationship with trauma and its role as a coping strategy. Fourth, self-injury was characterised as part of a continuum and the importance of containing rather than stopping people hurting themselves was emphasised. As Pembroke⁷⁹⁸ put it, “self-harm is a continuum, and we are all on it...we all have a responsibility to limit the effects of our distress and self-harm on others. Stopping doesn’t have to be a goal; rather the goal is managing it and finding the least dangerous option.” Finally, the emphasis was on working with health care professionals, whose reactions had often been seen as unhelpful and at worse punitive.⁷⁹⁹ Pembroke argued that “the only way forward is to end the silence. For people with direct experience to share their experiences, and for dialogue to start between self-harmers and service agencies.”⁸⁰⁰

This perspective informed the development of a discourse based on a narrative that focused on the conceptualisation of self-injury as a valid means of coping with distress and a belief that intervention was best served by trying to reduce harm

⁷⁹⁶ Johnstone, (1997). Op.cit. n769. p. 425.

⁷⁹⁷ Cresswell, (2005a). Op.cit. n53.

⁷⁹⁸ Ibid.

⁷⁹⁹ Liebling, H. Chipchase, H. and Velangi, R. (1997). Why do women harm themselves? -Surviving Special Hospitals. *Feminism and Psychology*. Vol. 7. No.3. p. 428.

⁸⁰⁰ Pembroke cited in Cresswell, M. and Brock, T. (2017). Social movements, historical absence and the problematization of self-harm in the UK, 1980-2000. *Journal of Critical Realism*, Vol.16. No. 1. p.7-25.

rather than prevent it altogether. This narrative not only helped many people to understand the phenomenon they were experiencing, but it also began to challenge the normative perceptions of health professionals. The view that for some individual's, self-injury had a very different and alternative meaning resonated with the experience of some health professionals in their work with people who self-injured.

Again, these developments can be interpreted in epistemic terms. It required practitioners to engage in a critical and reflective process that allowed them to challenge the place that negative identity prejudices and negative stereotypes had in shaping views about people who self-injure. In order to understand self-injury from the patient's perspective, health care professionals needed to adopt the language of people who were experts by experience and interpret the experiences they described in a different way. From a position of epistemic uncertainty,⁸⁰¹ came a different understanding of self-injury and with it, the potential to challenge normative structures that may not serve the interests of the person who self-injures. By making space for new meanings and perspectives to develop, it was possible to balance clinical judgment with what the person who self-injures was saying. This had important clinical implications as was demonstrated by the adoption of harm minimisation techniques, by some health professionals who had become frustrated with traditional ways of working.

8.10 Interpreting harm minimisation in epistemic terms.

Harm minimisation, when used to support people who self-injure involves allowing the individual to self-injure as long as it is practiced safely. It has been defined as “an alternative to preventative approaches which aim to prevent people from self-harming. Harm-minimisation approaches accept that someone may need to self-harm at a given point and focus, instead, on supporting that person to reduce the risk and the damage inherent in their self-harm.”⁸⁰² It is thus a means of supporting the

⁸⁰¹ Potter, N.N. (2003). Commodity/Body/Sign: Borderline Personality Disorder and the Signification of Self-Injurious Behaviour. *Philosophy, Psychiatry and Psychology*, Vol.10 No.1.p.1-16.

⁸⁰² Shaw, (2012). Op.cit. n76. p.20.

person while they develop a different range of coping strategies in the longer term.

There are a number of examples of harm minimisation being used to help individuals who self-injure, described in the literature,⁸⁰³ and the approach is recognised as a valid form of intervention by the NICE guidance.⁸⁰⁴ Harm minimisation cannot be considered as a routine measure, but it is a necessary and proportionate intervention that may be helpful where other approaches have not been successful.⁸⁰⁵ A number of accounts dealing with the ethical implications of using the approach have also been developed and are generally supportive.⁸⁰⁶

In accepting harm minimisation as a legitimate approach to intervention, there is recognition of the function that self-injury serves for some individuals, an appreciation of the meaning that it may have and an understanding of the reasons why some people will choose to act in this way. The person's testimony is therefore accepted, and the approach recognises that, although the person's actions are different and challenging, the self-injury may have value for some people as a means of dealing with overwhelming distress. To take it away without providing an alternative means of coping is, therefore, both risky and futile. In being able to promote such approaches, people who self-injure have been able to reclaim responsibility for their actions and promote very different approaches to supporting self-injury. Although harm minimisation approaches are not applied routinely, and some would argue that they can only be used in community settings⁸⁰⁷ the different understandings of self-injury on which this type of approach is based has certainly infiltrated the consciousness of many health care professionals. It is now generally accepted that self-injury provides some individuals with a means of coping with distress, and it is therefore difficult for them to stop unless alternative forms of coping

⁸⁰³ Crowe and Bunclark, (2000). Op.cit. n78; Holley and Horton (2007). Op.cit. n78. Pengally et al. (2008). Op.cit. n77. Holley et al (2012). Op.cit. n77.

⁸⁰⁴ National Collaborating Centre for Mental Health (2004). Op.cit. n4; National Collaborating Centre for Mental Health (2012). Op.cit. n4.

⁸⁰⁵ Sullivan, (2018). Op.cit. n67.

⁸⁰⁶ Guttridge, (2010). Op.cit.n71. Edwards and Hewitt, (2011). Op.cit. n126; Sullivan, (2017). Op.cit. n7;

⁸⁰⁷ Pickard and Pearce, (2017). Op.cit. n113.

are provided. This enhanced understanding of why some people need to act in this way has in some quarters, improved attitudes towards people who self-injure and improved the care they receive. In this sense, it constitutes a form of epistemic justice.

8.11 Conclusion

We have seen that attention to the narratives of people with lived experience has facilitated an active dialogue between people with lived expertise and health professionals with professional knowledge and experience. This has certainly increased understanding of self-injury, and it would be reasonable to suggest it has reduced instances of testimonial and hermeneutical injustice. This has resulted in improvements in clinical practice as less restrictive forms of intervention, such as harm minimisation, have impacted on the care and treatment of individuals receiving treatment from mental health services. It would, however, be misleading to conclude the paper by providing the reader with the impression that all is now well in the treatment of people who self-injure as problems do remain.

Although changes have taken place and harm minimisation does inform the approach to helping people who self-injure in community settings, there is limited evidence of implementation within in-patient facilities. It remains unclear exactly how prevalent interventions such as harm minimisation are.⁸⁰⁸ Although as we have seen the literature that considers the ethical implications of implementing such approaches tends to be supportive, there are complex legal and policy issues that remain unaddressed.⁸⁰⁹ Moreover, the evidence of implementation that is available tends to be focused on isolated case studies in specialist environments. The realities of in-patient care may explain, at least in part, why these initiatives are rarely practiced within such environments, given the high level of acuity and difficulties in developing any real therapeutic ethos in such environments. This is an empirical question that that can only be answered by further research. There is however, a

⁸⁰⁸ James et al. (2017). Op.cit. n79.

⁸⁰⁹ Hewitt. (2004). Op.cit. n71. Warner and Feery (2007). Op.cit. n176. Sullivan (2019a). Op.cit. n619.

more philosophically oriented question that remains.

It is not possible to exclude the possibility that part of the reason for such limited take-up may, in fact, be that epistemic forms of injustice may still be prevalent in many areas of mental health care, particularly in-patient environments. As a consequence, there remains some resistance to ideas that reflect the perspective of individuals with lived experience of self-injury. It is not inconceivable that ideas such as harm minimisation remain underutilised as a result of a failure of professionals to respond adequately based on the epistemic reasons we have considered in this paper. In doing so, they may be guilty of a form of what Dotson⁸¹⁰ refers to as a contributory injustice, whereby professionals may have failed to acknowledge the epistemic tools developed from an alternative perspective and as a result continued to misunderstand and ignore parts of that perspective. This is an important consideration that raises a number of complex issues and is deserving of further attention. Unfortunately, space prevents further analysis, and this remains a discussion for another day.

⁸¹⁰ Dotson, (2012). Op.cit. n372.

Chapter 9: Risk and responding to self-injury: Is harm minimisation a step too far?⁸¹¹

9.1 Introduction

Self-injury is a serious health issue; the long-term outcomes for people who repeatedly self-injure are often poor,⁸¹² and the demands on both general hospital and mental health services are high.⁸¹³ The causes of self-injury are complex and multifaceted, and its treatment involves a range of different approaches and no specific intervention that is supported by a valid and reliable body of evidence.⁸¹⁴ The dynamics of the relationship between the patient and the health care professional is complicated, and clinical staff often struggle to know how to care appropriately for people who self-injure.⁸¹⁵

Self-injury is common in mental health units; research undertaken in mental health in-patient settings indicates that the percentage of patients who harm themselves during the course of their admission varies from 4% to 70%, the rate of self-injury in adult in-patient units being 2,54 per 100 available bed days.⁸¹⁶ In such units, it is often normal practice to try and stop the person hurting themselves, and a range of restrictive practices may be implemented in pursuit of safety.⁸¹⁷ People who self-injure perceive these approaches negatively,⁸¹⁸ and harm minimisation has been proposed as an alternative way of supporting some individuals who self-injure.⁸¹⁹

⁸¹¹ Sullivan, (2019a). Op.cit. n619.

⁸¹² Morgan et al. (2017). Op.cit.n8.

⁸¹³ Tsiachristas, A. McDaid, D. Casey, D. et al. (2017). General hospital costs in England of medical and psychiatric care for patients who self-harm: a retrospective analysis. *Lancet Psychiatry*. Vol. 4. No. 10. p. 759-767.

⁸¹⁴ Hawton, K. Arensman, E. Townsend, E. et al. (1998). Deliberate self-harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *British Medical Journal*. Vol. 17. p. 441-447; National Collaborating Centre for Mental Health (2004). Op.cit. n4.

⁸¹⁵ Morales, Y. M. and Guarnero, P.A. (2014). Non-suicidal Self-injury among Adult males in a correctional setting. *Issues in Mental Health Nursing*. Vol. 35. No. 8. p. 628-634.

⁸¹⁶ James, K, Stewart, D. Wright, S et al. (2012). Self-harm in adult in-patient psychiatric care: a national study of incident reports in the UK. *International Journal of Nursing Studies*. Vol. 49. P. 1212-19.

⁸¹⁷ Sullivan, (2017). Op.cit. n71; Morrissey et al.(2018). Op.cit. n45.

⁸¹⁸ Duperouzal and Fish, (2010). Op.cit. n66.

⁸¹⁹ Guttridge, (2010). Op.cit.n71; Edwards and Hewitt, (2011). Op.cit. n126; Inckle, (2017). Op.cit. n63; Sullivan, (2017). Op.cit. n71.

Harm minimisation accepts that someone may still need to self-injure at a given point in time. Therefore, instead of trying to prevent self-injury, the focus is on supporting the individual in reducing the risks associated with the self-injury.⁸²⁰ The approach is controversial as it allows the patient to continue to self-injure as part of a therapeutic process. The use of some harm minimisation techniques in in-patient facilities has been criticised,⁸²¹ and examples of harm minimisation within such settings are uncommon. In a recent paper, James et al⁸²² interviewed 18 participants drawn from 15 wards. Some of these practitioners had no knowledge of harm minimisation techniques, and only a small number had experience of harm minimisation practices. They point to a number of practical, ethical and complex medico-legal issues that may contribute to this situation.

This paper will consider a number of these issues in attempting to explain why the implementation of harm minimisation is not more widespread. In order to achieve this, the paper will be structured in the following way. First, some preliminary comments will be made about harm minimisation and self-injury. Second, the paper will consider the important role risk plays in mental health services. It will be argued that a preoccupation with risk goes beyond clinical requirements to assess and manage risk and is related to a wider societal preoccupation with accountability. This forms part of what Heimer et al⁸²³ describe as a legalised environment in which not only the law but other types of legal thought and practice impact on the day-to-day work of those providing mental health services. This focus on risk and legal styles of thought is often associated in the minds of health professionals, with the attribution of blame. Third, in light of this context, the paper will consider the complex interrelationship between self-injury and suicide. It will be argued that the way the courts have interpreted the legal obligation to prevent suicide, and particularly the evidence used in supporting the decision-making process may

⁸²⁰ Shaw, and Shaw, (2009). Op.cit. n59.

⁸²¹ Pickard and Pearce, (2017). Op.cit.n113.

⁸²² James, et al. (2017). Op.cit. n79.

⁸²³ Heimer et al. (2005). Op.cit. n483.

result in health professionals erring on the side of caution when working with people who self-injure, given that suicide is always a possibility. Such caution makes the adoption of harm minimisation less likely. Finally, the paper will consider the implications of this situation, and it will be argued that the failure to make use of harm minimisation, may in some situations increase the risk of harm and lead to negative outcomes for the patient.

9.2 Self-injury and harm minimisation

Harm minimisation is an alternative means of dealing with self-injury based on the principles of harm reduction.⁸²⁴ This approach was advocated by people with lived experience of self-injury,⁸²⁵ and it has been adopted in community settings and some in-patient facilities.⁸²⁶ The essence of the approach is that it accepts that attempts to stop self-injury are often futile and may be counterproductive. Therefore, instead of trying to stop individuals from hurting themselves, health care professionals allow harm to continue more safely. Thus, harm is allowed as part of the therapeutic process and as such conflicts with the well-established principle that health care professionals do no harm.

Using harm minimisation approach in supporting people who self-injure includes a number of techniques, which vary depending on the clinical environment. Not all components of harm minimisation are contentious, and the approach consists of a spectrum of interventions some far less controversial than others.⁸²⁷ Guttridge⁸²⁸ describes these interventions in terms of, the provision of advice, the supervision of the action, omitting to remove implements that could be used to self-injure and proactively providing the implement. Alternative methods to self-injury may also be provided. Examples include squeezing ice cubes and snapping elastic bands against the skin. These initiatives, it is argued, replicate

⁸²⁴ Hawk, M. Coulter, R.W.S. Egan, J.E. Fisk, S. Reul Friedman, M. Tula, M. Kinsky, S. (2017). Harm Reduction principles for healthcare settings. *Harm Reduction Journal*. 14:70 DOI 10.1186/s12954-017-0196-4.

⁸²⁵ See, for example, Pembroke, (2006). Op.cit. n647.

⁸²⁶ See, for example, Crowe, and Bunclark, (2000). Op.cit. n78; Holley and Horton, (2007). Op.cit.n78; Pengally et al. (2008). Op.cit. n77; Holley et al. (2012). Op.cit. n77.

⁸²⁷ Hewitt, (2004). Op.cit. n71.

⁸²⁸ Guttridge, (2013). Op.cit. n182.

the feelings associated with self-injury. In addition, psychological therapies are provided in order to support the individual to explore the meaning and function of their behaviour. This forms part of a longer-term strategy to help promote change and is an essential component of the approach. Ultimately the aim is for the individual to change in ways that mean self-injury is no longer used as a means of coping with psychological distress.⁸²⁹

9.3 Risk, legalisation and a blame culture

The concept of risk plays a major role in the provision of mental health services. The idea of risk has its origin in decision theory and the mathematical models associated with statistical probability theory. More recently, it has taken on a wider social meaning associated with the negative consequences resulting from some form of adverse event.⁸³⁰ In various areas of organisational life, including healthcare, risk has taken on a more important function.⁸³¹

At both a theoretical and practical level risk influences mental health care, as Fanning⁸³² has argued that risk determines the nature of the patient's interaction with mental health services. For example, the objective of avoiding or minimising the risks of harm associated with a mental disorder has become central to mental health law.⁸³³ This was illustrated by the amendments made to the Mental Health Act in 2007. These amendments incorporated an increasing requirement to make clinical decisions based on the person's risk to self and/or others in order to detain such individuals for assessment or treatment under the Act.^{834 835} Moreover, the concept has come to dominate decision-making outside the scope of compulsory powers.⁸³⁶

⁸²⁹ Inckle, (2011). Op.cit. n70.

⁸³⁰ Lupton, (2013). Op.cit. n470.

⁸³¹ See Giddens, (1990). Op.cit. n468; Beck, (1992). Op.cit. n468; Luhmann, (2002). Op.cit. n468.

⁸³² Fanning, (2013). Op.cit. n466; Fanning (2016). Op.cit. n460.

⁸³³ Fanning, (2016). Ibid. p. 417-418.

⁸³⁴ Glover-Thomas, (2011). Op.cit. n454.

⁸³⁵ Fanning, (2013). Op.cit. n466.

⁸³⁶ Fanning, (2016). Op.cit. n437.

Both conceptually and clinically, risk can be perceived as either positive or negative. A positive risk approach involves weighing the potential benefits and harms of exercising one choice over another and accepts taking risks in making this decision. A focus on negative risk-taking is more concerned with the mere prevention of harm. It is the latter that appears to be the main focus in mental health care. In this sense risk has two key elements. The possibility of an adverse event, combined with a belief that the prevention of such an event is achievable.⁸³⁷ In a clinical sense, this translates into two practical activities. First, risk assessment, which involves examining the potential outcomes of this probability, and second, risk management, which involves the development of a plan to minimise harm and maximise benefits.⁸³⁸

This preoccupation with risk has been accompanied by a situation whereby the law, legal actors and legal styles of thought have penetrated much more deeply into healthcare.⁸³⁹ This goes beyond a legal responsibility to act in accordance with the law and the development of a litigation culture, to a situation whereby a whole range of legal, regulatory and professional accountability frameworks impact upon the way that health care professionals work. This means that there is pressure to intervene using only techniques, which can be judged defensible in legal and regulatory terms. This suggests Heimer et al,⁸⁴⁰ is partly a response to the pervasive influence of risk. In mental health care as in other areas of healthcare this is illustrated by the increasing role of the civil and criminal law, the role of the Care Quality Commission (CQC) and the legal rules associated with the role of professional bodies such as the Nursing and Midwifery Council and the General Medical Council in maintaining appropriate clinical standards.⁸⁴¹

These factors interact in a way that promotes a drive to ensure that standards of practice do not fall foul of the above requirements and an increasing concern about

⁸³⁷ Lupton, (2013). Op.cit. n470.

⁸³⁸ Callaghan, P. (2015). Risk assessment, in Callaghan, P. and Gamble, C. (EDs) *Oxford Handbook of Mental Health Nursing*. Oxford. Oxford University Press. p. 152-7; Callaghan, and Grundy (2018). Op.cit. n487. p.3.

⁸³⁹ Heimer et al.(2005). Op.cit. n483 p.94

⁸⁴⁰ Ibid. p.95.

⁸⁴¹ General Medical Council. (2013). *Good Medical Practice*. London. GMC; Nursing and Midwifery Council (2015). *The Code. Professional Standards of practice and behaviour for nurses and midwives*. London. NMC.

what is defensible.⁸⁴² In one sense this is unproblematic as there is no doubt that health care professionals must work to agreed standards, and both they and the organisations in which they work should comply with relevant legal and regulatory standards. Furthermore, if problems occur, then, health professionals should be held to account, and public expectations in relation to the performance of health professionals and health organisations have changed in this direction.⁸⁴³ There is however, a concern that the pendulum has swung too far.

Although there is an ongoing debate regarding the importance of an open learning culture as opposed to more punitive forms of accountability, there does appear to be a perception amongst health care professionals that they work in a blame culture.⁸⁴⁴ For example, in a study completed in a mental health setting, seventy-one percent of staff felt responsible for problems in relation to risk assessment and management following an untoward incident.⁸⁴⁵ A concern which has been exacerbated, albeit not in a mental health context, by the case of the doctor Hadiza Bawa-Garba, who was convicted of gross negligence manslaughter and removed from the medical register.⁸⁴⁶ The case has recently been overturned on appeal, and Dr Bawa Garba will be allowed to return to practice.⁸⁴⁷ However, the issues raised by the case remain pertinent. Health professionals have been concerned that the High court failed to look at the realities of clinical practice, particularly the pressures faced by clinical staff and the presence of system-wide failings. They have argued that the case demonstrates the persistence of a culture characterised by an unwillingness to take risks and accept responsibility for errors or mistakes due to a fear of criticism and blame.⁸⁴⁸ As Laurie et al⁸⁴⁹ have previously argued, “somebody, somewhere, must be made to answer for what has happened.” This has both clinical and

⁸⁴² Power, (2007). Op.cit. n476. p. 170.

⁸⁴³ O' Connor, N. Kotze, B. Wright, M. (2011). Blame and accountability 1: understanding blame and blame pathologies. *Australasian Psychiatry*. Vol. 19. No. 2. p. 113-118.

⁸⁴⁴ Khatri, N. Brown, G.D. Hicks, L.L. (2009). From a blame culture to a just culture in health care. *Health Care Management Review*. Vol. 34. Issue 4. p. 312-322.

⁸⁴⁵ Wand, (2017). Op.cit. n488, p.3.

⁸⁴⁶ *General Medical Council v Bawa-Garba* [2018] EWHC 76 (Admin). Op.cit. n563.

⁸⁴⁷ *Bawa-Garba v General Medical Council (British Medical Association and others intervening)*. Op.cit. n563.

⁸⁴⁸ Cohen, D. (2017). Back to blame: the Bawa-Garba case and the patient safety agenda. *British Medical Journal*. Vol. 59:j5534 doi: 10.1136/bmj.j5534.

⁸⁴⁹ Laurie et al. (2016). Op.cit. n175. p.129.

organisational implications.

In recent years health care professionals have seen the development of increasingly formalised policies, procedures and protocols supported by routine and standardised ways of working, which are often developed with an eye to the courts and the regulator. The clinical implication of this situation is that it promotes an approach to intervention that is procedurally rigid. Clinical practice is increasingly focused on the routine use of risk assessments and risk management plans, making use of standardised questions often in the form of checklists. This has led to the criticism that risk assessment is merely a tick box exercise resulting in the development of a paper trail that serves no other purpose than providing an audit trail in the event of an untoward incident. Critics argue that such assessments are implemented without any real concern for the individual needs of the patient.^{850 851}

At an organisational level, there is an impetus to avoid blame and litigation. This fear that something may go wrong becomes associated with a fear that the organisations reputation will be damaged. Power et al,⁸⁵² talk of an underlying cognitive awareness regarding the possibility of being blamed or criticised in some way and they suggest that this has affected the way that organisations work; as a result, practices are increasingly focused on possible reactions to organisational conduct and how this may affect key external perceptions. In these circumstances, being cautious becomes necessary, but the danger is that it will produce approaches to intervention that are risk-averse. If this occurs, then the ability to respond to complex problems in a flexible way is reduced. There is some evidence that this is the case.

In a recent paper, Slemon et al⁸⁵³ argue, that the practices associated with identifying possible risks and taking preventative action constitute the predominant aim of mental health nurses. Their comments could also apply to the work of other

⁸⁵⁰ Morrissey et al. (2018). Op.cit. n45. p. 39.

⁸⁵¹ Manuel, J. and Crowe, M. (2014). Clinical Responsibility, accountability, and risk aversion in mental health nursing: A descriptive, qualitative study. *International Journal of Mental Health Nursing*. Vol. 23. Issue 4. p.336-343.

⁸⁵² Power et al. (2009). Op.cit. n476.

⁸⁵³ Slemon, A. Jenkins, E. Bungay, V. (2017). Safety in psychiatric in-patient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry*. Vol. 24. Issue 4. p.359-76.

health professionals. They suggest that it is more than a goal but a fundamental value and that the pursuit of safety results in an increasingly restrictive approach to practice. They argue that nursing care in in-patient settings is now dominated by risk aversion. The work completed by Guttridge on harm minimisation is cited as an example of a practice that adopts a risk taking approach in the clinical setting for therapeutic purposes.⁸⁵⁴ They do not pursue the challenges that such an approach may encounter, and it is to this issue that we now turn.

9.4 Risk, legalisation and blame: suicide prevention and the implications for harm minimisation.

In their analysis of the reasons why harm minimisation should not be used in mental health in-patient units, Pickard and Pearce⁸⁵⁵ argue that the risk of serious harm or even death cannot be discounted if the patient is allowed to self-injure. This is a particular risk if information is provided about safer ways of self-injuring as this information could be used to cause increased harm. This is exacerbated if the means to self-injure are provided or not removed. Notwithstanding the serious implications that such an untoward event would have for the patient, their family and friends, and the emotional repercussions on the staff involved, there are also questions about how the practices that lead to such an event may be perceived in a context where health professionals are increasingly risk-conscious and more aware of the legal implications associated with their work.

The possibility of serious harm or death brings the issue of risk into focus. On the one hand, risk is permitted if an overriding concern would justify it,⁸⁵⁶ on the other hand if the level of risk cannot be justified, this may raise questions regarding culpability.⁸⁵⁷ The legal implications of harm minimisation are not clear and Hewitt's⁸⁵⁸ observation that a lack of precedent in the civil or criminal courts make it only possible to speculate on how the courts would view such practices still stands.

⁸⁵⁴ Guttridge, (2010). Op.cit. n71.

⁸⁵⁵ Pickard and Pearce, (2017). Op.cit. n113.

⁸⁵⁶ Pillsbury, S.H. (1996). Crimes of indifference. *Rutgers Law Review*. Vol. 49. p. 105.

⁸⁵⁷ Stark, F. (2016). *Culpable Carelessness: Recklessness and Negligence in the Criminal Law*. Cambridge. Cambridge University Press.

⁸⁵⁸ Hewitt, (2004). Op.cit. n71.

However, such speculation is to some extent now informed by the way that the law has addressed risk in its deliberations, not in relation to self-injury, but in the related matter of suicide. These deliberations have taken place not in the criminal courts or in relation to clinical negligence but under the auspices of human rights law. They are important, as an untoward incident arising in the context of a harm minimisation programme could be the result of suicide or a suicide attempt.

Before considering the developments in human rights law, it is worth making a brief comment about the civil and criminal law. In the right circumstances, both could be engaged. For example, there is a theoretical possibility that a charge of gross negligence manslaughter could be brought.⁸⁵⁹ However, the circumstances would need to be quite exceptional. A case of suicide has never resulted in such a charge.⁸⁶⁰ Moreover, gross negligence manslaughter requires a high threshold for conviction.⁸⁶¹ A high level of recklessness would be required on the part of the health professional.

A civil action is more likely as such actions are common as people are increasingly well informed, more minded to use the courts as a form of redress and access to legal advice through no claim no fee arrangements make funding such a course of action less problematic. However, it is difficult to pre-empt the outcome as the legal tests are complex, and there is a high threshold for success. For example, the existence of a causal link between a harm minimisation programme and serious injury may be difficult to demonstrate. It could be argued that given the patients existing propensity to self-injury, the harm would have occurred in spite of the harm minimisation programme rather than because of it. Alternatively, the expert witnesses may have very different views about the validity of harm minimisation as a therapeutic option, particularly given the potential risk of suicide. This could make its practice difficult to defend. In the absence of any case law dealing with such a civil claim, this is mere conjecture, but this is not the case in relation to human rights law, where expert witnesses have provided their views.

⁸⁵⁹ Ibid.

⁸⁶⁰ *R (on the application of the Secretary of State for Justice) v Her Majesty's Deputy Coroner for the Eastern District of West Yorkshire* [2012] EWHC 1634 (Admin).

⁸⁶¹ *R v Adomako*. Op.cit. n523.

Suicide could result in a claim made on the basis of Article 2 of the European Convention on Human Rights, whereby the state has a responsibility to protect an individual's right to life. This is formalised in European Law which was incorporated into the United Kingdom's legal framework through the Human Rights Act 1998. Article 2 imposes quite stringent responsibilities on health care professionals to prevent suicide. In a mental health context, this duty has been established in English law and relates to patients detained under the Mental Health Act ⁸⁶² and those admitted to hospital voluntarily.⁸⁶³ This position is confirmed in the European jurisprudence. ⁸⁶⁴

The clinical implications of this are illustrated in the case of *Rabone v Pennine Care*.⁸⁶⁵ If a healthcare professional knew or ought to have known that there was a real and immediate risk to life, then reasonable steps have to be taken to preserve that life. Risk of harm, even serious harm, would be insufficient. The legal test in use in such a claim is exacting. First, evidence of the threat of death occurring from a real and immediate threat to life must be compelling. Second, the actions taken must not impose a disproportionate burden on the defendant. This appears to suggest that there is an implicit recognition that the risk cannot be eliminated. This has led to the proposition that the high threshold required in an Article 2 case may mean that its application is limited to a small number of extreme situations.⁸⁶⁶ The fact that there has been no significant influx of cases since those of *Savage* and *Rabone* supports this argument. It would appear that unless there are exceptional circumstances, then a case is unlikely to succeed. However, there is some indication that such cases may have resulted in increased risk aversion amongst health professionals,⁸⁶⁷

⁸⁶² *Savage v South Essex Partnership NHS Foundation Trust*. Op.cit.n578.

⁸⁶³ *Rabone v Pennine Care NHS Foundation Trust*. [2012]. Op.cit.n579.

⁸⁶⁴ *Reynolds v The United Kingdom* (App.No 2694/080) [2012]. ECHR

⁸⁶⁵ *Rabone v Pennine Care NHS Foundation Trust*. [2012] Op.cit.n579.

⁸⁶⁶ Allen, N. (2013). Op.cit.n600.

⁸⁶⁷ Department of Health. (2018). *The Independent Review of the Mental Health Act. (2018). Interim Report*. London. Department of Health.

Furthermore, what *Rabone* does, is give an important steer around the way that courts may interpret the evidence concerning risk and the implications are important.

9.5 Risk and *Rabone*

Expert evidence is crucial to any legal case in health care regardless of the legal context. For example, in a case of clinical negligence, the *Bolam* test and its subsequent modification in *Bolitho* require expert evidence to possess a logical base.⁸⁶⁸ Such evidence would also be key in a gross negligence manslaughter prosecution. The *Rabone* case gives some indication of how such evidence would be interpreted from a human rights perspective. This is important given the absence of any precedent in either the civil or criminal courts as it may have wider relevance. The expert evidence used in *Rabone* focused around the risk of suicide. There is no dispute here with the findings of the court; what is important is the way that evidence was used by the court in drawing their conclusions.

The judgement concerned itself with matters of risk assessment and management and required the experts involved to comment on the standard of these assessments and plans. This evidence was then used to make judgements about the overall standard of care provided and whether it was possible to ascertain whether there was a real and immediate threat to Miss *Rabone*'s life. The court concluded there was. However, in drawing these conclusions, the court appeared to attribute the process of risk assessment with a degree of certainty, which the clinical evidence available would suggest it does not have.

All patients are subject to a risk assessment and risk management plans are developed based on these assessments. As Newton-Howes⁸⁶⁹ argues, this implies that such assessments can adequately categorise risks in a way that can be linked with appropriate intervention. This will reduce the chance of a negative outcome. The problem, as Newton-Howes states, is that such an argument fails to stand up to

⁸⁶⁸ *Bolam v Friern Hospital Management Committee*. Op.cit. n205.; *Bolitho v City and Hackney Health Authority*. Op.cit. n206.

⁸⁶⁹ Newton- Howes, G. (2018). Risk in mental health: a review on and of the psychiatrist. *Journal of Mental Health Training, Education and Practice*. Vol. 13. Issue 1. p. 15.

scrutiny in relation to suicide. The empirical evidence available would suggest that the level of risk is difficult to predict in a specific individual. As Sarker⁸⁷⁰ points out, although the actuarial risks are well established, there is no algorithm that can identify the actual risk of suicide in a specific individual. Although the risks may be obvious with hindsight, the very 'obvious' nature of such risks is an illusion. For example, based on the use of a routine risk assessment, 60% of suicides are assessed as low risk and only 3 % of those categorised as high-risk result in suicide.⁸⁷¹ Furthermore, even when assessment makes use of formal measures designed to assess suicide risk, the situation does not improve. The NICE guidance relating to self-harm⁸⁷² has recognised this fact and warned against the routine use of such measures in clinical practice. Recent research⁸⁷³ has confirmed the empirical basis of this advice.

At this point, it is pertinent to return to the paper by Newton-Howes,⁸⁷⁴ he concluded that the ability to predict suicide in a clinically meaningful timeframe is not possible.⁸⁷⁵ In spite of this, both experts in *Rabone* made use of risk calculations. They provided numerical assessments of the risk of suicide using percentage scores to indicate the level of risk and how the degree of risk changed during the events before Miss Rabone's death. The evidence accepted by the court suggested that a high degree of predictability was possible in the assessment of suicide risk.⁸⁷⁶

This points to the possibility that the law may interpret risk in a different way than the health professional. If this position was replicated in other legal cases, then this could have implications for undertaking therapeutic activities that may incorporate a high level of risk. This very point is made by Horton⁸⁷⁷ in his analysis of the *Savage* case. He argues that risk management strategies are increasingly subject to legal

⁸⁷⁰ Sarker, J.(2013). To be or not to be: legal and ethical considerations in suicide prevention. *Advances in Psychiatric Treatment*. Vol. 19. p. 297.

⁸⁷¹ Allen, (2013) Op.cit. n867.

⁸⁷² National Collaborating Centre for Mental Health. (2012) Op.cit. n6.

⁸⁷³ Quinlivan, L. Cooper, J. Meehan, D. (2017). Predictive accuracy of risk scales following self-harm: multicentre, prospective cohort study. *British Journal of Psychiatry*. Vol. 210. p.429-436.

⁸⁷⁴ Newton-Howes (2018). Op.cit. n870.

⁸⁷⁵ Ibid p. 20.

⁸⁷⁶ *Rabone v Pennine Care NHS Foundation Trust*. [2010]. UKSC 2.

⁸⁷⁷ Horton, D. P. (2010). Making sense of Risk in a mental health facility. *Medical Law Review*. Vol. 18. No. 4. p.581.

scrutiny. Making use of the work of Luhmann, Horton argues that different professionals make use of different modes of communication, and this means they have different ways of looking at the same phenomena and will process similar events differently⁸⁷⁸ As Horton points out, evidence in court is only meaningful if it is objective and follows legal rules. Risk will, therefore, be interpreted in terms of tort, human rights or criminal law for example, and a judge may struggle to interpret formulations of risk such as those used by a health professional, which do not follow legal rules. This could have important clinical implications.

9.6 Risk, Rabone and the implications for Harm minimisation

The law has a significant influence on the normative environment in which any activity is undertaken, and organisations must adapt based on legal decisions.⁸⁷⁹ This poses the practitioner with a real problem given the fact that to implement harm minimisation safely, the health professional needs to be clear that the person who self-injures does not pose an active suicide risk. This would be unproblematic were suicide and self-injury quite distinct phenomena. In reality, the relationship between suicide and self-injury is complex and distinguishing between the two is not easy. This means that the health professional is faced with a serious clinical conundrum, and as Sarker⁸⁸⁰ asks, how is it possible to differentiate between a patient who is actively suicidal from a patient who wishes to self-injure for different reasons. In spite of the court's perspective, risk assessment can never be an exact science. If risk cannot be assessed accurately, then it is not possible to provide an objective measure on which to base a decision about the threshold at which the risks associated with harm techniques become acceptable. What constitutes an unacceptable level of risk should ideally be an objective decision; in reality, it is a subjective judgement.⁸⁸¹ Thus, the clinical team proposing to allow a person to continue to self-injure has no objective threshold by which to judge the acceptability of the risks being proposed. There is no place on a sliding scale of probabilities,

⁸⁷⁸ Ibid.

⁸⁷⁹ Edelman, (1999). Op.cit.n465. p.1442.

⁸⁸⁰ Sarker, (2013). Op.cit. n871.

⁸⁸¹ Craddock, G. (2004). "Risk Morality and Child Protection: Risk Calculation as Guides to Practice" in *Science, Technology & Human Values*. Vol. 29, No. 3. p. 325.

which marks the point where harm minimisation techniques become appropriate or inappropriate.

Harm minimisation thus presents a number of problems. First, there are risks to the patient if the approach is not implemented safely as serious harm or even death could be the outcome. Second, the limitations in terms of both the validity and the reliability of the assessment tools available to the health professional prevent objective decision making, so it is difficult to differentiate between suicide and self-injury without suicidal intent. Third, if this is then combined with an institutional requirement to avoid blame, litigation and reputational damage, then an innate cautiousness may be inevitable. Given the pressure to ensure that every decision and intervention is clinically and legally defensible, the easiest way to achieve this is to err on the side of caution. This may result in foregoing the adoption of harm minimisation approaches on the basis that it is difficult to square the circle in relation to permitting self-injury and allowing harm in a situation where suicide could be a potential outcome. Unfortunately, this may not prevent harm from coming to the patient as the adoption of more restrictive types of intervention may also be problematic.

As has been noted, in a hospital setting the normal approach to dealing with self-injury is to try and prevent it occurring. Such an approach can in its most extreme form be highly restrictive; including for example, searches of the person and their possessions, removal of harmful objects and the use of continuous observation. Individuals may, in some circumstances, be detained under the Mental Health Act and therefore subject to restrictions on their movement and subject to enforced treatment. These initiatives bring with them their own set of problems and Sullivan⁸⁸² has described this in terms of the “paradox of preventative practice”. He argues that the means used to try and prevent self-injury produce a confrontational rather than therapeutic relationship that exacerbates rather than contains the risks.

Self-injury has for some people a positive coping function, and if this is removed, then both their distress and desire to self-injure may increase. This leads to a

⁸⁸² Sullivan (2017). Op.cit. n71.

situation where an individual may attempt to self-injure covertly, in more dangerous ways, or even attempt suicide. For example, patients who when living at home may self-injure through cutting their skin inflicting only minor injuries, may when admitted to hospital use methods such as hoarding medication to overdose or using clothing to ligature. Both are difficult to control and can be fatal. This may occur in spite of high levels of observation. This leads Sullivan⁸⁸³ to conclude that the actions taken to prevent harm may be more harmful than the original behaviour itself.

Now it is clear that when a person's actions may lead to harm, then action should be taken to reduce that harm. However, the action taken must be proportional to the seriousness of the situation. Moreover, it must have a reasonable chance of achieving its aim. The argument supporting harm minimisation in this situation is that by respecting the individual's autonomy and by developing a more therapeutic relationship, the likelihood of reducing the chance of serious harm or even death is reduced. Furthermore, the interventions used are both proportionate and necessary, as the approach constitutes the least restrictive form of intervention and the least harmful way of achieving the therapeutic goals agreed with the patient.

It may be argued that the risk of suicide overrides all other considerations. Unfortunately, this could be detrimental for some individuals. While there is no doubt that the risk of suicide is increased in those who self-injure, there is also some evidence that there are some people who may injure themselves, not because they wish to die, but to provide relief from a situation that threatens to overwhelm them.⁸⁸⁴ Although it is difficult at times to differentiate between the two, this does form part of routine clinical practice. Even if harm minimisation is not a consideration, the use of restrictive interventions in all situations where suicide may only be a possibility cannot be justified. Although when a suicide occurs, its impact is significant it must be remembered that such occurrences are rare. Most individuals admitted to hospital will not end their lives through suicide. It is therefore important not to overuse coercive forms of intervention that are neither proportionate nor necessary. A risk-averse approach may lead to lost opportunities to reduce self-injury and lead to an

⁸⁸³ Ibid.

⁸⁸⁴ National Collaborating Centre for Mental Health. (2012). Op.cit. n4.

increase in the risk of harm. Moreover, it may increase the risk of suicide in the longer term. The right approach is to consider the issue on a case-by-case basis, as no two cases of self-injury are the same. What is required in a given situation depends on the nature of that situation and in some situations, harm minimisation may constitute a realistic therapeutic option. In these circumstances, the law, healthcare organisations, regulators and society more generally need to recognise that this may be the only option, and progress is not always risk-free.

9.7 Conclusion

This paper has considered the implications of using harm techniques when working with people who self-injure and provided an argument for why its use appears limited within in-patient environments. It has been argued that a preoccupation with risk and an increasingly legalised clinical environment has been perceived by many health professionals as associated with accountability and blame. This has contributed to a cautious mindset amongst many health professionals, which has resulted in the development of a risk averse approach to care. This paper has illustrated how this process may affect the adoption of harm minimisation approaches particularly, given the relationship between self-injury and suicide. It has been argued that the adoption of more restrictive forms of intervention used in the pursuit of safety may also bring with them their own difficulties.

In the final analysis, harm minimisation approaches include a number of complex and sophisticated interventions that require an environment in which there are the skills, knowledge and experience available clinically to implement the approach, as well as the will to contain the anxiety that such an approach may produce in both individual clinicians and the wider organisation. This is an environment where healthcare professionals can innovate and to take risks and to engage in meaningful therapeutic activity, sometimes in challenging circumstances. It has to be conceded that this is not the position in many mental health units, where opportunities for real therapeutic engagement are limited. In the final analysis, harm minimisation may be a step too far for most health care organisations. This is a situation that must change, people who self-injure deserve better and heightened concerns about relatively rare events accompanied by concerns about legal liability, regulatory action

and reputation must work with and not against the patient's interests. It is important that demands for accountability do not become overly burdensome and fail to work in the interests of the patient. A process that would be assisted by the completion of research studies providing more empirically based analysis of the benefits or otherwise of harm minimisation approaches in this area of clinical practice, thus promoting more informed decision making at a clinical, managerial and organisational level.

Chapter 10: Conclusion

10.1 Introduction

This thesis has considered the use of harm minimisation approaches in supporting people who self-injure. The approach is controversial as it involves allowing self-injury to continue as part of the therapeutic process. The focus of the analysis has been in-patient mental health care. The thesis has focused on a number of clinical, ethical and legal issues that inform practice and has contrasted harm minimisation with attempts to prevent self-injury. These two different approaches can be conceptualised in terms of the ongoing tension between autonomy and paternalism that characterises mental health care. This tension is illustrated by the experience of individuals who self-injure, particularly when this behaviour takes place within a hospital environment. These issues are important, both theoretically and practically. At a theoretical level, they allow us to apply an analytical perspective to the complex issues that arise when attempting to balance a person's right to autonomy with the professional's responsibility to intervene to prevent serious harm. At a practical level, it illustrates the constant need to balance care and control within a mental health setting. It is important as the analysis has the potential to impact on policy and in so doing have a direct effect on the care and treatment of individuals who self-injure.

The thesis has attempted to add to the existing body of knowledge regarding the ethical and legal implications of adopting harm minimisation approaches with people who self-injure. In pursuit of this aim, five papers have been published in peer-reviewed journals, and a sixth will be published in December 2019. Four of these papers form the basis for the arguments developed in this thesis. This work has added to the existing literature, building on the existing body of knowledge and providing new insights. Concepts from ethics and law supported by the use of relevant clinical information have been used to develop arguments grounded in the realities of clinical practice. They try to reflect the perspective of individuals who have lived experience of self-injury, while also recognising the concerns of healthcare professionals who work in a practice environment that is influenced by important legal and policy concerns.

10.2 The research questions and the four papers

My thesis has focused on four key questions. First, I asked whether health care professionals should sometimes allow harm and concluded that in certain circumstances, they should. Second, I considered whether harm minimisation is just a misguided collaboration between the healthcare professional and the person who self-injures that is clinically and morally questionable. I concluded that it was not, and that harm minimisation could be supported on both moral and clinical grounds. Third, I articulated a perspective on self-injury and harm minimisation based on the perspective of those individuals with lived experience. To achieve this, I made use of the concept of epistemic injustice. Finally, I turned my attention to some of the legal and policy issues and asked the question whether, in the “age of risk”, harm minimisation is just a step too far. I concluded that a preoccupation with risk and an increasingly legalised clinical environment focused on accountability perceived by many healthcare professionals as associated with blame may reduce their willingness to take therapeutic risks and promote the adoption of more defensive approaches to intervention. This may militate against the actual use of harm minimisation approaches in practice.

Each paper was written with a particular focus but read together the papers provide a more cohesive body of work. The first two papers can be viewed as constituting a philosophical defence of the practice of harm minimisation. The first outlines a supportive argument, while the latter considers a specific objection. The second paper ends with a very clear reference to the role of individuals with lived experience in both challenging thinking about self-injury and influencing the development of more innovative and less restrictive ways of working. The importance of this voice is recognised in the third paper. This paper focuses on the importance of knowledge and power in understanding self-injury and recognises the role of individuals with lived experience in the development of harm minimisation. The final paper turns the analytical lens onto the healthcare professional, acknowledging the anxiety that such professionals may have about an intervention that is controversial and risky and considering the context for implementation.

10.3 Original contributions to the literature

The first paper develops an argument supporting harm minimisation, and the conclusions are similar to those drawn by others. However, the paper contributes to the literature in two ways. First, it generated interest in the debate regarding harm minimisation. The article was published in the *Journal of Medical Ethics*, where it was accompanied by an invited response, which was a well-argued critique of my perspective.⁸⁸⁵ I responded to this response in a later publication.⁸⁸⁶ The paper generated considerable interest academically⁸⁸⁷ and was covered in the media. Second, the paper served to clarify the exact nature of the controversy around harm minimisation. This focus was on one particular element of the debate; the provision of sterile blades and teaching individuals to harm safely. Coverage in the media,⁸⁸⁸ on the Internet and the response by Pickard and Pearce all focused on this issue in some detail. Reflecting on the responses to my paper, I was struck by how this emphasis, although important, detracts from a wider more nuanced consideration of harm minimisation, which I believed the paper had provided.

Such a focus can narrow the parameters of the analysis and give the impression that harm minimisation involves the routine provision of sterile blades. This is a limited understanding of the approach that fails to see it in the context of an overall approach to intervention. On this basis, it is possible to develop a counterargument that is difficult to refute. It can be argued that harm minimisation is based on a proposal to provide sterile blades to individuals who may pose a significant threat to themselves and even to others.⁸⁸⁹ The risks of serious harm to self and others are therefore emphasised at the expense of a more objective consideration of the range of options available. The arguments supporting harm minimisation are then

⁸⁸⁵ Pickard and Pearce, (2017). Op.cit.113.

⁸⁸⁶ Sullivan, (2018a). Op.cit. n67.

⁸⁸⁷ Between January 2017 and April 2019, the abstract was downloaded on 8631 occasions and the article 1606 and the PDF 856 times. The altimetric score was in the top 5% scored. The paper has been viewed in a number of countries across the world

⁸⁸⁸ Gallagher, P. (2017). *Mental Health patients 'should be given clean razors and taught how to self-harm safely'*. www.inews.co 9 February 2017.

⁸⁸⁹ Pickard and Pearce (2017). Op.cit.n113.

undermined with ease.⁸⁹⁰ Although the provision of sterile blades continues to generate controversy, it is only one of several techniques that may be used. What I believe this paper and my response to some of its critics provided was a more informed and balanced consideration of the wider issues.

The second paper also supports harm minimisation and engages with two important conceptual arguments, one ethical and the other clinical. The paper is important for a number of reasons. First, the idea of harm is examined in a more theoretical way than in the first paper and overall, the paper is more theoretically driven. Second, the importance of autonomy in the debate is complemented by more focused attention on the problem of harm and a recognition that the particularities of the situation are significant. Third, responding to the objection articulated by Scanlon and Adlam is important as if substantiated, it would undermine the credibility of harm minimisation as a therapeutic intervention. Scanlon and Adlam,⁸⁹¹ it is worth remembering, argued that harm minimisation invites the clinician into an active collusion that allows the individual to inflict injuries because the health professional is not willing to confront the real issues that need to be dealt therapeutically. As I argued in chapter 6, if the therapeutic alliance is undermined and the patient does not engage in psychological therapy, then the arguments supporting harm minimisation are severely weakened. Finally, the paper recognises the importance of lived experience and concludes with an explicit reference to such individuals in the context of self-injury. This provides a link to the third paper.

In the third paper, the concept of epistemic injustice is used to provide a means of explaining the important role that people with lived experience of self-injury have played in facilitating a different understanding of self-injury and promoting harm minimisation as an approach. The paper reflects an important development in both thinking and approach. In considering harm minimisation, I became increasingly uncomfortable with my role as a third-person observer of events that were intimately related to the experience of people who experience self-injury. Discovering Fricker's work on epistemic injustice not only changed my perspective, but it also gave me the

⁸⁹⁰ Sullivan, (2018a). Op.cit. n67.

⁸⁹¹ Scanlon and Adlam, (2009). Op.cit. n114.

tools to recognise the debt that professionals have to individuals who self-injure in developing different ways of thinking about their care. This conceptual framework has previously been applied to mental health care, but this is the first time that it has been used in relation to self-injury. This paper, therefore, provides an original contribution to the literature on both epistemic injustice and self-injury.

The final paper turns the focus on to the healthcare professionals. This paper constitutes the first attempt to view the arguments about harm minimisation through the conceptual lens of risk. It recognises that theoretical arguments have practical implications and that the laws of liability and the regulatory context do not generally acknowledge the unique environment of mental health care or the value of taking risks. It is, therefore, difficult to square the circle between risk and safety on the one hand and autonomy on the other. The danger of a more paternalistic approach to intervention then becomes a real danger. In conjunction with a second published paper,⁸⁹² this paper attempts to provide, at least in part, an explanation of what appears to be a limited uptake of harm minimisation in clinical practice particularly within in-patient environments. In doing this, it pays particular attention to the important relationship between self-injury and suicide and the legal context in which this is perceived.

10.4 Issues for further consideration

The four papers view self-injury and harm minimisation from several different perspectives. They provide answers to some questions but like in any academic endeavour, some questions remain unresolved and other issues come to the fore. In some cases, this results in changes to thinking and/or approach such as the work that resulted in the third paper. At other times they suggest areas where further study is required. In the interests of completeness, the most important of these must be mentioned.

⁸⁹² Sullivan (2019b). Op.cit. n515.

10.4.1 Morality and self-injury

In chapter 7, I noted that self-injury is both disturbing and difficult to understand. Such actions challenge the normal social order and deeply held values about what is and is not normal. The nature of the injuries themselves can be disturbing and can have a profound effect on other people, including healthcare professionals. Injuries to the body, such as “bloody wounds” often provoke feelings of revulsion.⁸⁹³ In the face of such wounds, others may feel the need to withdraw.⁸⁹⁴ This has therapeutic implications that have to be addressed through training and supervision. It also has ethical implications if such actions are interpreted in moral terms. For example, James et al⁸⁹⁵ identified a small subgroup of clinical staff that perceived self-injury as something to be prevented, as it was morally wrong. This points to an underlying ethical issue alluded to by Guttridge and Calladine.⁸⁹⁶

They argue that the idea of allowing people to self-injure may produce both unease and disgust in others. They use the Watkins⁸⁹⁷ case and the media coverage regarding a decision to allow an autistic child to cut himself⁸⁹⁸ as examples of this phenomenon. Guttridge also notes how an academic colleague told her that the abstract regarding her doctoral work on self-injury made them feel nauseous.⁸⁹⁹ Although they do not use the term, they refer here to what the literature often terms the “Yuck factor.”⁹⁰⁰ This refers to the relationship between disgust and ethical decision-making. The exact nature of the relationship is disputed, but evidence suggests that disgust does play a part in the way that individuals make ethical judgments.⁹⁰¹ The implication is, that if the general public or even health care

⁸⁹³ Rozin, P. Haidt, J. McCauley, C.R. (2000). Disgust. In Lewis, M. Haviland-Jones, J.M. and Barrett, L.F. (eds). *Handbook of Emotions*. New York, Guilford Press. p.757-776; Chapman, H.A. and Anderson, A.K. (2013). Things rank and gross in nature: A review and synthesis of moral disgust. *Psychological Bulletin*. Vol. 139. No. 2. p. 300-327; Ivan, C.E. (2015). On disgust and moral judgements: A review. *Journal of European Psychology Students*. Vol. 6. No. 1. p. 25-36.

⁸⁹⁴ Chapman and Anderson (2013). *ibid.* p. 301.

⁸⁹⁵ James et al. (2017). *Op.cit.* n79.

⁸⁹⁶ Guttridge, K. and Callidine, (2013) Cutting Class: Thinking about self-harm without disgust. *Journal of Medical Ethics* Blog. March 29, 2013.

⁸⁹⁷ See section 2.5.1.

⁸⁹⁸ See section 3.5 p.114.

⁸⁹⁹ Guttridge and Callidine, (2013). *Op.cit.* n897.

⁹⁰⁰ Kelly, D. (2011). *Yuck! The nature and significance of moral disgust*. London. MIT press.

⁹⁰¹ See Rozin et al. (2000). *Op.cit.* n894.

professionals perceive allowing self-injury as abhorrent, and self-injury is considered in moral terms, then harm minimisation is going to be perceived as ethically unacceptable.

The difficulty that this poses is, as Guttridge and Calladine argue, is that such a moralised attitude fails to provide any solution for people who self-harm. I would go further and argue that it detracts from more progressive attempts to support people who self-injure and undermines any attempt to engage in an informed debate about self-injury and harm minimisation. Making either explicit or implicit moral judgements about people who self-injure is not helpful. I consider this issue briefly in chapter 7 but certainly do not resolve the matter. I would follow Nussbaum in taking the view that any such an association with disgust is likely to be a distorting influence on any moral judgements that are made.⁹⁰² This position does, however, need to be defended, and a detailed consideration of the complicated relationship between disgust, self-injury and harm minimisation would be a welcome, albeit controversial addition to the literature.

10.4.2 A contributory injustice

In chapter 8, I concluded the paper with an unanswered question regarding the presence of epistemic injustice. I suggested that it was not inconceivable that harm minimisation remains underutilised as a result of the continued existence of what Dotson⁹⁰³ has termed contributory injustice. When Dotson speaks about contributory injustice, she is referring to a situation where individuals can articulate their experiences, but those articulations fail to gain acceptance due to the hermeneutical resources used by the perceiver.⁹⁰⁴ In maintaining the existing hermeneutical resource, the hearer is guilty of what Pohlhaus Jr terms wilful hermeneutical ignorance.⁹⁰⁵ This occurs when “dominantly situated knowers”, in this case, healthcare professionals, refuse to accept knowledge developed from experience in a marginalised social group, in this case, the knowledge of self-injury based on the

⁹⁰² Nussbaum, (2004). Op.cit.709.

⁹⁰³ Dotson, (2012). Op.cit. n372.

⁹⁰⁴ Ibid. p. 32.

⁹⁰⁵ Pohlhaus Jr, (2012). Op.cit. n372.

experiences of those with lived experience. This refusal means that health care professionals continue to misinterpret or ignore the perspective of the individual who self-injures.

Contributory injustice differs from the forms of epistemic injustice described in chapter 8. It is not that the individual is not believed or cannot make sense of her world. It is instead a culpable failure of a powerful group, in this case, healthcare professionals, to understand a perspective developed by a less powerful group, in this case, people with lived experience of self-injury.⁹⁰⁶ This is a serious allegation to make; it is saying that the healthcare professional has failed to understand the exact nature of self-injury by not making use of available knowledge developed outside a professional framework. This is despite the fact that this information certainly exists and is not difficult to acquire. In effect, the healthcare professional fails to step outside the biomedical model and accept that individuals who self-injure have a legitimate contribution to make in relation to knowledge about self-injury and the best means of providing support. This then perpetuates a view of self-injury that is not always recognised by those who experience it.

At this point, I could be accused of portraying healthcare professionals as paying no attention to the voice of their patients and approaching them in a Procrustean way, that reduces the individual to a set of symptoms. Such an argument would be simplistic and overblown, as many healthcare professionals do not behave in this way. They are empathetic and understand the perspective of the person who self-injures. Furthermore, they make use of harm minimisation in their clinical practice. However, as Tate⁹⁰⁷ has argued, individual efforts on the part of healthcare professionals to avoid contributing to such an injustice are an insufficient response to the problem and a more systemic approach is required. As an example, he uses work associated with individuals who hear voices but have challenged the view that this is always a symptom of schizophrenia. He argues that such individuals still face problems in getting their perspective accepted in spite of this knowledge being widely available.

⁹⁰⁶ Ibid. p. 716.

⁹⁰⁷ Tate, (2019). Op.cit. n378.

I have already commented in chapter 8, on the similarities between the process of knowledge development that occurred concerning voice hearers and that, which occurred in relation to self-injury.⁹⁰⁸ It is not inconceivable that this failure to take into account alternative perspectives applies equally to the case of self-injury. In a hospital environment, a reliance on a medicalised approach to intervention can be helpful for some; for others, it fails to explain their distress in a way they recognise. My concern is that health care professionals are failing to apply such knowledge due to an adherence to a particular model of working and a refusal to take seriously a perspective that has developed outside a biomedical understanding of self-injury. Health care professionals then commit an epistemic injustice because they do not and will not enter into a situation of epistemic interdependence with those who self-injure.⁹⁰⁹ If the healthcare professional recognises and uses the epistemic resources developed by those who injure, then it becomes more difficult to resist the arguments for harm minimisation. If they fail to do this, the arguments supporting harm minimisation are likely to be undermined. This underlying argument requires further development and consideration.

10.4.3 The link between self-injury and suicide

Support for harm minimisation is based on the view that there is a subset of individuals who self-injure, whose clinical profile is indicative of a low association with suicidal behaviour. Research suggests such a group of individuals exists.⁹¹⁰ However, set against this, self-injury has a clear relationship with suicidal behaviour. The NICE guidance indicates that the motivation driving the two is complex and does not fall neatly into two distinct categories.⁹¹¹ Moreover, there is evidence that self-injury is as strong a predictor of future suicide attempts as past suicide attempts.⁹¹² Of more worry is an association between self-injury and suicide attempts amongst in-

⁹⁰⁸ See section 8.8.

⁹⁰⁹ Pohlhaus Jr (2012). Op.cit. n372.

⁹¹⁰ Selby, et al (2015). Op.Cit .n33.p. 86.

⁹¹¹ James, K. A. (2015). *The characteristics of in-patient self harm, and the perceptions of nursing staff*. A thesis submitted in fulfilment of the requirements of Doctor of Philosophy. The Institute of Psychiatry.

⁹¹² Selby et al (2015). Op.cit. n33.

patients.⁹¹³ The exact nature of this relationship is not properly understood in spite of theoretical attempts to explain the connection. The situation is complex, and I have argued elsewhere that there are a number of different clinical groupings that can be identified.⁹¹⁴ First, a large number of people self-injure, and a small number of these individuals will die by suicide. Second, some people who self-injure may never attempt suicide, and many people who die as a result of suicide have no history of self-injury. Third, there are some individuals who self-injure who become suicidal, but there are a number of individuals who self-injure who are not suicidal. Finally, there are a group of individuals where self-injury and suicidal behaviour coexist. Differentiating between these different groups does form part of normal clinical practice but is fraught with difficulty.

If all patients are considered suicidal, then the approach will be overly restrictive and paternalistic, however where the possibility of an actual suicide attempt is inadvertently excluded, then the outcome may be tragic. This represents a significant clinical challenge, and as Walsh⁹¹⁵ points out, during any programme of intervention, the clinical team must be aware that an individual who self-injures may also be or may become suicidal. Unfortunately, as we have seen, the ability to distinguish between suicide and self-injurious behaviours that lack suicidal intent is not easy.⁹¹⁶ Add to this the fact that James⁹¹⁷ found a lack of understanding amongst nursing staff regarding this complex interaction. Practitioners were inclined to overlook the strong association between self-harm and suicide and many characterised these behaviours as occurring in different types of people.⁹¹⁸ This resulted in expressions of suicidal feelings amongst individuals who self-injure not been taken seriously.⁹¹⁹ More work is required at both a clinical and a theoretical level to resolve this complicated clinical conundrum. It does, however, have the potential to seriously undermine the arguments supporting harm minimisation.

⁹¹³ Singh et al. (2016). Op.cit. n610.

⁹¹⁴ Sullivan, (2019b).Op.cit. n515.

⁹¹⁵ Walsh, (2012). Op.cit. n90.

⁹¹⁶ Sarker, (2011). Op.cit. n100.p. 439

⁹¹⁷ James, (2015). Op.cit. n912.

⁹¹⁸ James et al. (2017). Op.cit. n79. p. 6.

⁹¹⁹ James, (2015). Op.cit. n912. p. 160.

10.4.4 The problem of evidence

Although this thesis has dealt with the ethical and legal implications of using certain interventions to support people who self-injure, it is important to draw attention to the fact that there remains an important empirical claim that remains unresolved.

Healthcare professionals need to have good reasons for believing that an intervention will be effective and should be used.⁹²⁰ This issue has been picked up in recent additions to the literature. Recently, Dickens and Hosie⁹²¹ using one of my papers as an example, make the important point that much of the literature on harm minimisation is focused on the legal and ethical implications of the approach. What is missing they argue is empirical data. They state: “ it is only by the generation or acquisition of new data that we can truly move the debate forward...new evidence can create the conditions for change.”⁹²² In making this point they go on to cite two recent additions to the literature based on empirical research: their work⁹²³ and that of James et al.⁹²⁴

I have previously referred to the work of James et al.⁹²⁵ This found only limited take-up of harm minimisation in in-patient settings. Furthermore, they argued that the evidence for using harm minimisation approaches in supporting people who self-injure is limited.⁹²⁶ They concluded that further research to examine the “safety, acceptability and efficacy of the approach” is required.⁹²⁷ The second study by Dickens and Hosie⁹²⁸ also focuses on in-patient units. They attempt to quantify support for different approaches to the management of self - injury through the development and use of the “Attitudes to Self-cutting Management Scale (ASc - Me).” This is achieved by identifying the methods used to support people who self-

⁹²⁰Kleinig, J. (2006). Thinking ethically about needle and syringe programs. *Substance use and misuse*. Vol. 41. Issue 6-7. p.. 815-825; Kleinig (2008). Op.cit. n334.

⁹²¹ Dickens, G.L. and Hosie (2018a). Self-cutting and harm reduction: Evidence trumps values but both point forward. *Journal of Psychiatric and Mental Health Nursing*. Vol. 25. p. 529-530.

⁹²² Ibid. p. 529.

⁹²³ Dickens, G.L. and Hosie, (2018b). Harm-Reduction approaches for self-cutting in in-patient mental health settings: Development and preliminary validation of the Attitudes to self-cutting management (ASc-Me) Scale. *Journal of Psychiatric and Mental Health Nursing*. Vol. 25. p. 531-545.

⁹²⁴ James et al. (2017). Op.cit. n79. See also chapter 9.

⁹²⁵ Ibid.

⁹²⁶ Ibid. p. 72.

⁹²⁷ Ibid. p. 67.

⁹²⁸ Dickens and Hosie, (2018a). Op.cit. n922.

injure. Eighteen types of intervention are distinguished, including both permissive and preventative approaches to self-injury. Both these studies add to the empirical literature on harm minimisation but are limited by the size of the sample and the generalisability of the findings. Dickens and Hosie make this point when they note how their study represents the preliminary development of a measure that requires more intensive work.⁹²⁹ This involves improving the validity and reliability of the instrument in order to make use of it with a larger sample.

These two studies, in spite of their merits, do not resolve the main empirical problem facing harm minimisation and further research is required. At the moment only limited empirical evidence regarding the use of harm minimisation is available, and this evidence is confined to case studies in isolated units. There is no substantial analysis of the prevalence and practical difficulties associated with the implementation or of its effectiveness when it is implemented. As James (2015) has argued, there is no rigorous evaluation of the impact of harm minimisation on rates of self-injury or patient outcomes. This situation will only be resolved by empirical work that tries to answer three important questions. First, how prevalent is the use of harm minimisation in clinical practice? Second, where it does occur exactly what actual techniques are used? Third, how effective are these approaches as judged by clinical outcomes? I have to concur with Dickens and Hosie who suggest that although consideration of the principles underpinning harm minimisation are important, only the presence of empirical evidence will resolve some of the complex problems associated with the approach. Although many well-accepted healthcare interventions in a mental health setting also lack a robust evidence base,⁹³⁰ the lack of evidence could leave harm minimisation open to the accusation that it is a minority practice that is of dubious value.

10.4.5 The realities of in-patient care in 2019

⁹²⁹ Dickens and Hosie, (2018b). Op.cit. n924.

⁹³⁰ Read, J. Runciman, O. Dillon, J. (2016). In search of an evidence-based role for psychiatry. *Future Science OA*. Vol. 2. No.1. 10.4155/fsoa-2015-0011

In the conclusion to chapter 9, I conceded that the therapeutic milieu required to implement harm minimisation is not an environment found in many in-patient mental health units. The evidence continues to support this view. A report published in 2016 describes a spectrum of quality and performance with some services in constant crisis.⁹³¹ Based on comprehensive inspections completed between 2014 and 2017, the Care Quality Commission identified problems around safety and the persistence of restrictive practices.⁹³² In its most recent report regarding the monitoring of the Mental Health Act, it noted that although some improvements have been made, concerns remain about the quality and safety of some in-patient facilities. They noted problems with the quality of care planning and a failure to comply with the requirements concerning patient and carer involvement.⁹³³ Unfortunately, these are all-too-common findings. Many in-patient units are characterised by a lack of resources, poor environments, the rapid turnover of staff and patients and with many patients presenting with a high level of acuity associated with acute psychosis. This often results in a chaotic and volatile environment in which violence and untoward incidents are commonplace. The situation on many of these units has certainly deteriorated during the course of my research. If we then add to this, a long-standing concern about the therapeutic ethos of in-patient mental health units and the difficulties of implementing therapeutically orientated approaches within such environments, then an intervention that allows harm to occur as part of such a process may be unrealistic particularly given the continued emphasis on risk. That the overall ethos of some in-patient units needs to change is uncontroversial, but even with fairly radical changes, I am no longer convinced that harm minimisation is a realistic prospect in many in-patient units. As my work progressed, I have increasingly come to the view that the therapeutic engagement and the clinical skills required to implement such an approach is unlikely to occur outside a specialist in-patient facility or a unit designed with the specific needs of people with self-injury in mind.

10.5 Supporting arguments and conclusion

⁹³¹ Crisp, N. Smith, Nicholson, K. (2016). *Old Problems, New Solutions – Improving acute psychiatric care for adults in England*. Final Report. London. The Commission on acute adult psychiatric care.

⁹³² Care Quality Commission. (2018). *The state of care in mental health services 2014 to 2017*. London. HMSO.

⁹³³ Care Quality Commission, (2019) Op.cit.n47. p. 6.

As my thesis comes to a close, it is helpful to summarise the arguments that have been presented and then to outline my overall conclusion. The latter is dependent on six underpinning arguments.

First, harm minimisation respects and enhances autonomy, working from the perspective that for some individuals self-injury may be an autonomous decision providing a means of coping with distress, which serves an essential function for the patient. Moreover, even if the patient is not fully autonomous, he or she may have the capacity to consent to such a programme of intervention that serves to promote autonomy and independence. This must be set against attempts to prevent self-injury that often result in restrictive forms of intervention that infringe on autonomy and are paternalistic in nature.

Second, in certain circumstances, harm minimisation is a viable and ethical approach to intervention that is based on a net reduction in harm, albeit that there are genuine constraints on implementation that may mean that these approaches are difficult to contemplate outside a specialist environment. Although healthcare professionals have a duty not to impose harm, in some circumstances, the imposition of harm is not necessarily a bad thing. This view is based on a consideration of the harms and the benefits of different forms of intervention. Although the person may be harmed in a narrow sense that is through cutting the skin, they are not harmed in a more global sense as we respect their autonomy in a way that paternalistic interventions cannot. By allowing harm to occur in a controlled and safe way, a more significant harm is prevented by avoiding the possibility that more risky methods of self-injury may be adopted. As such, the health care professional is morally justified in allowing harm and as such, cannot be subject to moral blame.

Third, I am critical of more preventative forms of intervention that serve to contain rather than resolve the problem and, in some cases, constitute an example of hard paternalism. This can be difficult to justify as it implies that the individual lacks moral agency and needs to be saved from themselves, a view that in many cases, cannot be substantiated. In fact, attempts to stop self-injury will often increase harm as the

individual may attempt to harm themselves in more covert or extreme ways. As a result, the therapeutic relationship between the patient and the healthcare professional may be damaged in a way that can be detrimental to patient safety. Allowing harm may help facilitate the patient's participation in psychological work that may help support change. I do not rule out the use of paternalistic interventions in some cases, but as a general rule, they should be avoided.

Fourth, the views of people who self-injure raise questions about the value of more preventative forms of intervention and provide important support for harm minimisation. Such individuals possess essential knowledge about the nature and reasons for self-injury and the support that is required. Personal narratives and phenomenologically informed accounts of self-injury provide an ethical underpinning for this approach that must be taken seriously. Unfortunately, there are continuing concerns that this perspective continues to be undermined in a way that risks perpetuating well-established stereotypes and prejudices that impede the development of more progressive forms of intervention and perpetuate traditional ways of working. Where we fail to respect the perspective of those with lived experience of self-injury, we undermine their autonomy and damage the potential for more positive therapeutic engagement.

Fifth, I contrast this position with the anxieties of healthcare professionals working in clinical practice. The literature provides only limited examples of harm minimisation in practice, and I argue that this is due to a policy and legal framework focused on risk reduction. This focus on risk and the increasing influence of the law and legal styles of thinking often associated with the allocation of blame has produced a more risk-averse clinical environment. This makes the adoption of harm minimisation approaches difficult. More widespread adoption of such techniques would require significant changes in perspective for such practices to be adopted more widely.

Finally, I have two areas of concern that make me slightly more reticent about some of the practical implications of implementing harm minimisation approaches and particularly the more risky techniques described in this thesis. First, I am increasingly concerned about the absence of a firm evidence base for harm minimisation. I am still of the view that harm minimisation is still an option for some people who self-

injure and that this serves to meet their needs and support their rights. This argument does, however, need to be supported by empirical evidence, as without it, the debate cannot be resolved. Second, where such an approach is considered appropriate for an individual, this is less likely to be an option given the current focus on risk reduction and the perception amongst many health care professionals that if things go wrong, they will be blamed. This is a situation that needs to change. This requires a systemic perspective that considers some complex structural and organisational problems that affect the way that healthcare professionals' practice in a mental health in-patient setting. There are major cultural and organisational issues that need to be addressed, and serious questions remain about what society expects from services provided for its most vulnerable citizens.

10.6 Conclusion

My overall conclusion is that harm minimisation is in certain circumstances, an option that provides an ethical alternative to more traditional forms of intervention.⁹³⁴ In these circumstances, such a position is legally defensible. Judgements regarding whether the right circumstances exist can only occur on a case-by-case basis, but where they do, it is possible to work differently with people who self-injure, respecting their autonomy and facilitating an overall reduction in harm. The strength of the approach is its foundation in the perspective of the individual with lived experience of self-injury, although the approach may not have transformed services for people who self-injure in the way some envisaged. This has not been helped by the fact that although the ethical arguments are persuasive, they need to be substantiated by empirical research regarding the clinical effectiveness of the approach. In spite of this, elements of the perspective now form part of mainstream thinking about self-injury even if traditional understandings of self-injury persist in some quarters and barriers to using the approach remain. The latter is not helped by a societal preoccupation with risk and accountability and the complexities of defending the approach in both clinical and legal terms should an untoward event occur, although it must be remembered that more paternalistic alternatives to harm minimisation are not immune to the majority of these criticisms.

⁹³⁴ Sullivan, (2018). Op.cit.n65. p.209.

There is always a balance to be struck between preventing and allowing harm, and in this thesis, the standard management of self-injury in an in-patient setting has been contrasted with harm minimisation. This dichotomy between harm prevention and harm minimisation reflects the broader tension between autonomy and paternalism. In comparing these different perspectives, it is important to avoid applying an overly simplistic binary that drifts into Manichean thinking. Things are never simple, and although this may work for analytical purposes, it rarely provides a definitive answer. Ultimately this may not be available in either ethical or clinical terms. Polarised arguments are often emotionally charged, and the problem is framed in terms of two mutually exclusive alternatives. This tension can hide an opportunity for constructive resolution.⁹³⁵

There are some individuals who are able to make decisions regarding participating in a harm minimisation programme, and there are circumstances where such initiatives are clinically indicated and can be defended. However, there are undoubtedly occasions when such an approach is inappropriate and a more paternalistic approach to intervention that may involve more restrictive forms of intervention are both clinically and ethically required. In some situations, action may be required to protect individuals from themselves, and this will be necessary and proportionate. In these circumstances, harm minimisation techniques would be dangerous and without ethical foundation.

I have never advocated harm minimisation as a routine measure in working with people who self-injure. Respecting the individual's autonomy requires attention to the person's specific interests and particular situation. In the final analysis, it is the ability of the health care professional to recognise the concrete, specific and personal circumstances of the particular clinical situation with which they are faced and to act accordingly. When seen in this way harm minimisation is sometimes a possibility, not always a consideration, but certainly, it can never be excluded as an option.⁹³⁶ This

⁹³⁵ Denfeld Wood, G. and Petriglieri, J. (2005) Transcending Polarization: Beyond Binary Thinking. *Transactional Analysis Journal*. Vol. 35, No. 1. p. 31-39.

⁹³⁶ Sullivan, P.J. (2018). Sometimes, not always, not never: a response to Pickard and Pearce. *Journal of Medical Ethics*. Vol. 44. No. 3. P. 209-1

is something that should be aimed for, although for the reasons I have given it may be only an aspiration in some quarters. That this is a reality does not make it right and change is something that should be strived for. If we do otherwise, we will be failing many individuals who self-injure to cope with trauma and distress. There are moral and clinical reasons to strive for greater diversification of approaches to self-injury and a more therapeutic ethos across in-patient mental health units more generally. People who self-injure have the right to receive appropriate care which considers their views and validates the reasons for their actions. Each individual has the right for his or her autonomy to be respected, and this includes supporting coping mechanisms that work for them although, others may find it difficult to comprehend why.⁹³⁷

⁹³⁷ Martinson,D.(2017). Bill of Rights for people who self-harm. www.fortuge.com

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Appendix

The papers below are all referred to in the course of the thesis and the first four constitute the main body of the research.

Should healthcare professionals sometime allow harm? The case of self-injury. *Journal of Medical Ethics*. Vol. 43.p. 319-323. 2017.

Allowing harm because we care: Self-injury and harm minimisation. *Clinical Ethics*. Vol. 13. No. 2. p. 88-97. 2018.

Risk and responding to self-injury: is harm minimisation a step too far? *The Journal of Mental Health Training, Education and Practice*. Vol. 14 Issue. 1, p.1-11. 2019.

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(Copies of the final papers have been removed from the submitted thesis for copyright reasons)