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Allow some people to continue to self-injure as part of harm minimization, says researcher

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Some people in mental health units should be allowed to continue to injure themselves as part of a harm reduction regime, says a researcher with experience of mental health care in the *Journal of Medical Ethics*.

For those who are not in immediate danger, such an approach is likely to be less confrontational and distressing, more respectful of their autonomy, and potentially less harmful than the standard methods of dealing with this type of behaviour, argues PhD student Patrick Sullivan, of the Centre for Social Ethics and Policy, University of Manchester.

Harm minimisation is widely used in public health interventions, such as substance misuse. It aims to curb the potentially harmful consequences of engaging in high risk behaviours by providing an alternative to abstinence, in recognition that this may be the best possible outcome.

Critics claim that it sends out mixed messages, fails to get people to kick their addictions, and is not necessarily the most cost effective option.

However, Sullivan argues that the high rates of self-injury among people admitted to mental health units suggest that the standard method of dealing with this behaviour—forcibly stopping that person from doing it—doesn't seem to work.

"There is a strong moral reason to consider alternatives, and harm

minimisation provides an alternative to traditional ways of working," he writes. "Although evidence is weak or not available, proponents suggest it is a more realistic and pragmatic response to a complex health and social issue."

It could include provision of sterile cutting implements, education on how to self-injure more safely to avoid blood poisoning (sepsis) and infection, as well as therapy to help individuals understand what underpins their behaviour, develop alternative coping strategies, and deal with crises without resorting to self-injury, he suggests.

In support of his argument, he says that focusing on restriction could actually make the problem worse: many of those who injure themselves have a history of abuse or trauma, and stopping them from doing it could intensify their feelings of powerlessness.

"This increases the risk that individuals will self-injure covertly, in more dangerous ways, or attempt suicide," he contends, citing anecdotal evidence indicating the increasing use of other forms of self-injury, such as ligatures, among those in mental health units who prefer to cut their skin.

"In some cases this can be fatal. This occurs in spite of high levels of observation," he warns.

People who self-injure do so because the negative feelings they experience threaten to overwhelm them: injury reduces tension and increases control, providing a coping mechanism, says Sullivan.

Infringements of this are likely to be seen as confrontational and distressing rather than therapeutic, he contends. Those who self-injure usually understand the nature and consequences of their actions, so denying them this freedom thwarts their autonomy.

"Where the risks of serious injury are low, limitations on basic freedoms are more difficult to justify," he suggests.

He emphasises that he is not advocating a blanket ban on restrictive measures: where a person's life is in immediate danger, these are, of course, justified, he insists. Nor is he advocating blanket permission for self-injury. Rather, it is about permitting a lesser harm to prevent a more serious one, he says.

He accepts that many organisations may struggle with the practical and legal implications of such an approach, while healthcare professionals may balk at the idea of tolerating harm in the context of a therapeutic relationship.

"However, it has been argued that healthcare professionals may sometimes have good reasons to allow harm, in fact, they routinely do so; allowing harm is not necessarily contrary to the professional's duty of care," he insists.

"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," he writes. "By trying to prevent their injury, we harm them, we may fail to help them. I conclude that healthcare professionals sometimes have an obligation to allow harm."

In a linked blog, Sullivan reiterates: "Harm minimisation is not treatment in its own right, but an adjunct to [appropriate psychological therapy], and must be seen in this way." But he says: "No one who has listened to the stories of people who self-injure can fail to be concerned by the picture they paint of a system that just fails to understand."

In a linked commentary, Drs Hanna Pickard and Steve Pearce, of, respectively, the University of Birmingham, and Oxford Health NHS

Foundation Trust, accept that supporting autonomy and independence among vulnerable people is "fundamental to good clinical practice."

But they point out that Sullivan doesn't distinguish between secure and non-secure units, and that allowing a patient to self-injure in the former would be unethical. But even in non-secure units, the approach would not only be impractical, but also clinically, ethically, and legally dubious, they suggest.

It could also be dangerous for patients as self-injury can be contagious, and extremely distressing for staff, particularly if the continued cutting unintentionally or deliberately resulted in life-changing injury or death.

Furthermore, "sanctioning" such behaviour could reinforce the low self-esteem already associated with self-injury, they contend.

"Of all the various measures that could, in principle, be adopted to help [patients with a history of self-injury], the forms of harm minimisation that Sullivan advocates in inpatient settings do not strike us as the measures we ought to promote," they write.

"For self-injuring patients themselves—let alone when we factor in the potential impact on other patients and staff—the balance between costs and benefits of these forms of harm minimisation for self-injury does not tip in their favour," they conclude.

More information: Clinical ethics paper: Should healthcare professionals sometimes allow harm? The case of self-injury, DOI: 10.1136/medethics-2015-103146

Commentary: Balancing costs and benefits: a clinical perspective does not support a harm minimisation approach for self-injury outside of community settings, DOI: 10.1136/medethics-2017-104152